Mental health experiences among African migrants in Scotland: The role of cultural beliefs, stigma and discrimination in attitudes to help-seeking and behaviours

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Author declaration

This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.

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Abstract

Migration from the Global South to the Global North has a long history, yet the literature addressing the elevated risk of mental health issues among first-generation migrants remains limited. Existing research highlights a notable prevalence of conditions such as depression, post-traumatic stress disorder and anxiety, particularly affecting this demographic. Moreover, the higher susceptibility of Black African and Caribbean individuals to being "sectioned" under the Mental Health Act in the UK adds urgency to the need for focused investigation in this area. This study investigates the factors influencing mental health attitudes and engagement with support services among Sub-Saharan African migrants in Scotland.

This study focuses on migrants from Sub-Saharan Africa who have moved to Scotland. The policies and practices in Scotland advocate for inclusive mental health services however these are not reflected in participants' accounts. Qualitative research was undertaken during the COVID-19 pandemic, and this involved two focus groups (15 people in total) and interviews with 17 first generation African migrants with lived experiences of ill mental health. The concepts of Critical Race Theory and Intersectionality were used to analyse the various structural and individual barriers that African migrants found to impact their engagement with mental health support.

The findings revealed a central theme of pre-migration stigmatisation intersecting with perceived institutional barriers to seeking help. Post-migration challenges, including anti-immigration discourses and racialised experiences, further compounded the difficulties faced during and after migration. The absence of a conducive space for discussing ongoing challenges at personal and institutional levels perpetuated barriers to seeking help before the onset of mental health issues. This research contributes new knowledge to research with migrant groups by offering nuanced insights into the multifaceted barriers to help-seeking within the context of the African migrant experience in Scotland. By tracing participants' experiences before they left their countries of origin in Africa to post-migration, the study demonstrates how intersecting social, cultural, and political conditions sustain mental health disparities within this group.

Dedication

To my mom MaZondi, who instilled in me the importance of education and perseverance.
This thesis is as much yours as it is mine.

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Chapter 1

Introduction

1.1 Context and focus of this thesis

Disparities in the experience and management of mental health issues have been found to exist between different ethnic groups in the UK (Devonport et al., 2023). Black African and Caribbean people are two to eight times more likely to be diagnosed with severe mental health conditions compared to white people (Bignall et al., 2019, Miller et al., 2021). Research has focused on the social determinants linked to increased vulnerability, such as employment, income, housing and exposure to criminality and substance abuse. Although research continues to explore the disparities in an attempt to understand the cause, there is a lack of research examining the role of multilevel racism in mental health issues (Meghji and Niang, 2022). This thesis considers multilevel racism as an essential factor when exploring the factors affecting mental health support among African migrants in Scotland. This thesis holds paramount significance in addressing a critical gap in understanding and providing mental health services for this demographic. African migrants constitute a diverse and growing population within Scotland, contributing significantly to the cultural and social fabric of the nation. However, despite their increasing presence, there is a lack of research comprehensively examining the unique mental health challenges faced by African migrants and the factors influencing their engagement with mental health support systems.

Exploring the perceptions and experiences of mental health and healthcare among African migrants is crucial in unveiling the intricacies of their journey within the Scottish healthcare landscape. This investigation seeks to illuminate the cultural, social, and systemic factors that may impact how African migrants perceive mental health, experience healthcare services, and ultimately navigate the complexities of seeking support. Understanding the factors that influence help-seeking behaviours among African migrants, directly from their perspective, is pivotal for developing interventions and support structures that align with their unique needs and preferences. By addressing these factors, the research aims to enhance the understanding of mental support services, exploring ways in which they can be accessible, culturally sensitive, and responsive to the diverse backgrounds and experiences of African migrants. Moreover, exploring how immigration shapes mental health behaviours and experiences adds another layer of complexity to the study. Migration is often a transformative life event that can

significantly impact mental well-being. By investigating this aspect, the research aims to uncover the nuanced ways in which immigration influences mental health, offering insights that can inform tailored mental health strategies for African migrants in Scotland. The findings have the potential to inform policy, practice and interventions that better support the mental health and well-being of African migrants, ultimately contributing to a more inclusive and equitable healthcare system.

1.2 Situating the study in the context of policy and previous research

A complex interplay of cultural beliefs, stigma, and experiences of discrimination influences the mental health challenges faced by African migrants (Schomerus and Angermeyer, 2008, Fox et al., 2018, Schomerus et al., 2019, McCann et al., 2018). Recent research has highlighted the need to better understand these factors in order to develop adequate mental health support and promote help-seeking behaviours within these communities (Yohani et al., 2020, Salami et al., 2022, Punjani et al., 2024, Alaazi et al., 2022). In addition to empirical research, migrant mental health is particularly relevant given recent events such as the COVID-19 pandemic and changes in immigration policies in the UK, which have disproportionately impacted ethnic minority groups. In addition to understanding attitudes and beliefs, research has been concerned with vulnerable groups such as asylum seekers and refugees (Pollard and Howard, 2021, Linney et al., 2020, Vahdaninia et al., 2020). Whilst these are all important research agendas, African migrants who do not fall into the category of asylum seekers and refugees have been underrepresented in public discourse and research on mental health. Moreover, the role of racism and discrimination has not been intricately discussed through a Critical Race Theory lens in this context. This gap in the literature suggests a need for more comprehensive research that includes the experiences of all African migrants and addresses the structural and systemic factors that impact their mental health.

To understand the perceptions and experiences of the mental health of African migrants in Scotland, the policy context will be outlined briefly. The mental health policies for African migrants in the UK are shaped by a combination of national mental health strategies, migrant health policies, and targeted interventions that address the unique needs of this population. The UK's National Health Service (NHS) plays a central role in this framework, with overarching policies such as The Five Year Forward View for Mental Health (NHS, 2014) and The NHS Long Term Plan (Alderwick and Dixon, 2019). These documents outline commitments to

improving access to mental health services, reducing inequalities, and providing comprehensive mental health care across all demographics, including migrants. These frameworks emphasise the need to expand mental health services and focus on vulnerable groups, which inherently include migrant populations.

Migrant health policies in the UK provide additional layers of support specifically for migrants. Public Health England's Migrant Health Guide (Crawshaw and Kirkbride, 2018), for instance, offers detailed information on the health needs of migrants, including mental health, to assist healthcare professionals in delivering appropriate and effective care. Additionally, specific guidelines such as those from the National Institute for Health and Care Excellence (NICE), the United Nations Refugee Agency cater to refugees and asylum seekers, acknowledging the mental health challenges posed by experiences of trauma, displacement, and the stress of resettlement (Excellence, 2018, UNHCR, 2019). These policies and guidelines offer recommendations and ways of practice to ensure migrants receive comprehensive health assessments and tailored mental health care, addressing their unique circumstances. Despite these policies and guidelines, several challenges persist in effectively addressing the mental health needs of African migrants in the UK.

While the UK is often referred to collectively in discussions of healthcare, it is important to acknowledge the devolved nature of health systems in England, Wales, Scotland, and Northern Ireland, each of which has its own legislative and policy frameworks. In the context of this study, which is situated in Scotland, the implications of devolved governance are particularly relevant for understanding the landscape of mental health care provision (Anderson et al., 2022, Bevan et al., 2014).

In England, mental health policy is primarily shaped by the Department of Health and Social Care (DHSC) and NHS England, with strategic oversight informed by national frameworks such as the NHS Long Term Plan (2019) and the Mental Health Implementation Plan (NHS, 2019). These strategies have emphasised a shift towards Integrated Care Systems (ICSs), aimed at coordinating health and social care across localities to provide more holistic and person-centred services. A key pillar of recent reforms is early intervention, particularly in youth and perinatal mental health, recognising that timely support can significantly improve long-term outcomes and reduce pressure on crisis services. There has also been a renewed emphasis on community-based care, moving away from hospital-centric models and seeking to embed mental health provision within primary care networks and local voluntary sector partnerships.

While these initiatives represent important progress, implementation has been uneven across the country. Significant regional variation in service availability, workforce capacity, and waiting times persists, often reflecting deeper socio-economic inequalities and differences in local commissioning priorities. Concerns have been raised about the accessibility and cultural responsiveness of mainstream services, particularly for racialised and marginalised communities (NHS England, 2023).

In Wales, the approach is underpinned by the Mental Health Wales Measure 2010, which places legal duties on health boards to provide timely and comprehensive mental health assessments and care coordination (Thornicroft and Tansella, 2010). Wales has also taken a distinctly rights-based approach, aligning mental health services with the principles of social justice, inclusion, and dignity, as outlined in key Welsh Government frameworks such as Together for Mental Health (2012) and its subsequent delivery plans (Welsh Government, 2012). These strategies advocate for co-production, the meaningful involvement of people with lived experience in designing, delivering, and evaluating services and reflect a broader political commitment in Wales to integrated and person-centred care (Welsh Government, 2012, Thornicroft and Tansella, 2010).

In Northern Ireland, mental health policy has historically lagged when compared to the other devolved nations, in part due to political instability and legacy issues. However, significant steps have been taken in recent years with the publication of the Mental Health Strategy 2021–2031, which outlines a ten-year roadmap for building a modern, trauma-informed, and recovery-oriented system (Dawson and Millman, 2024). It also emphasises the importance of addressing historical trauma, improving crisis care, and investing in workforce development. Unlike in other parts of the UK, services in Northern Ireland continue to face structural challenges due to underinvestment and fragmentation between health and social care sectors (Northern Ireland Human Rights Commission, 2021).

Similarly, Scotland has its own Mental Health Strategy and distinct institutions, such as the Mental Welfare Commission for Scotland, which influence how services are delivered and how issues of equity and access are addressed (Dewison et al., 2024, McKay and Welsh, 2015). Notably, minority ethnic communities in Scotland continue to experience significant inequalities in mental health outcomes, access to culturally appropriate services, and engagement with statutory systems.

The Mental Welfare Commission (2021) report highlighted that individuals from minority ethnic backgrounds are less likely to access early support and more likely to come into contact with services through crisis or coercive pathways. The findings that ethnic minority individuals particularly Black women are disproportionately detained under the Mental Health Act represents a deeply troubling indicator of systemic racism within Scotland's mental health infrastructure. This pattern of coercive intervention not only undermines the principle of equitable care but also exposes the failure of early detection and culturally informed prevention strategies. The higher rates of compulsory detention suggest that minority groups are more likely to reach crisis points before receiving support, often due to barriers such as language, stigma, mistrust of services, or lack of access to culturally competent care. This reflects a broader institutional failure to recognize and adapt to the specific needs of diverse communities. The gendered dimension, where Black women face particularly harsh outcomes also points to the intersectional nature of discrimination, compounding race, gender, and mental health stigma in harmful ways. Rather than being isolated anomalies, these disparities are emblematic of how race and structural power operate within supposedly neutral statutory frameworks. Similarly, the Mental Health Equality Evidence Review highlighted the persistent structural barriers and lack of representation faced by these communities, as well as the need for more culturally sensitive and inclusive models of care (Scottish Government, 2023b).

The devolved nature of the UK's health systems has led to markedly different approaches to mental health policy and provision in England, Wales, Northern Ireland and Scotland. While this divergence allows for policies to be tailored to local needs and contexts, it also results in fragmented service delivery and inconsistent access to care. The variations in mental health policy in the UK raise critical concerns about equity and cohesion across the board. Despite each nation's strengths, the absence of a unified mental health framework has led to a postcode lottery, where the quality and accessibility of services depend largely on geographic location. Moreover, structural issues such as workforce shortages, uneven implementation of policies, and underdeveloped data systems complicate cross-national evaluation and learning. While devolution enables innovation and responsiveness, it also highlights the limitations of a siloed approach to mental health governance.

Migrant health strategies in Scotland

Migrant health strategies are also largely focused on specific migrant cohorts such as asylum seekers and refugees. The New Scots Refugee integration strategy is a framework designed to

promote the integration of refugees and asylum seekers into Scottish society. The strategy includes a focus on health and wellbeing, recognising the specific health challenges faced by these populations, such as trauma, mental health issues, and barriers to accessing healthcare services (Scottish Government, 2024). The Scotland's Mental Health Strategy (2017-2027) outlines a commitment to improving mental health services for all, including asylum seekers and refugees. Recognising the high levels of mental health issues within this population, including trauma, depression, and anxiety, the strategy seeks to expand access to mental health services through the NHS and third-sector partners, train healthcare professionals to provide trauma-informed care and develop culturally competent mental health services (Scottish Government, 2017). Although Scottish policy looks favourable to asylum seekers and refugee health, these strategies do not include other groups of migrants such as international students, migrant workers and those here through family reunification.

Existing policies and guidelines also make no delineation between migrants from difference backgrounds, the aims in the strategies make little mention of the diversity in asylum seekers and refugees. This can be a source of disconnect between policy and practice for the mental health of African migrants. Policies may not adequately address the cultural and linguistic diversity within African migrant communities. There may be a lack of cultural competence among policymakers and service providers, resulting in services that do not effectively meet the specific needs and preferences of African migrants (Gopalkrishnan and Babacan, 2015). Policies such as Scotland's Mental Health Strategy (2017) outline mental health services available to migrants, but in practice, there are significant barriers to accessing these services. These barriers can include language barriers, lack of awareness about available services, stigma associated with mental health issues, and fear of immigration consequences (Mantovani et al., 2017). Moreover, mental health services, including those tailored for migrants, may be underfunded or not allocated sufficient resources to meet the demand. This can lead to long waiting times, limited availability of culturally competent providers, and inadequate support for mental health promotion and prevention programs (Memon et al., 2016, Murray, 2020).

In 2020 the National Health Service (NHS) Race and Health Observatory was established to understand and address racial health inequalities within the UK's NHS (National Health Service, 2020). Although this initiative aims to improve health outcomes for ethnic minority groups, generally policies do not adequately address or mitigate structural and systemic racism that African migrants may encounter within mental health services and broader societal

contexts. This includes discriminatory practices, unequal access to services, and the perpetuation of racial inequalities in health outcomes (Ben et al., 2017, Nazroo et al., 2020).

Even when policies and initiatives are well-intentioned and designed to be inclusive, significant challenges often arise in their implementation and monitoring, leading to gaps between policy goals and the lived experiences of those accessing mental health care. Although policies may appear progressive on paper, their effectiveness is frequently undermined by insufficient integration across sectors, leaving migrants to grapple with institutional obstacles that limit their access to essential services. The NHS Race and Health Observatory initiative (National Health Service, 2020) is a critical example of efforts aimed at addressing such disparities. This initiative brings together experts from both the UK and international contexts to offer thorough analysis and policy recommendations. One of its primary objectives is to systematically collect and analyse data on race and health disparities, with the intention of using this data to inform evidence-based interventions (Kmietowicz, 2020, National Health Service, 2020). For African migrants, this offers a promising approach to better understand and address the specific mental health challenges they face. Through the development of a more comprehensive data collection framework, there is potential for more tailored policies that directly respond to the unique needs of African migrants, as well as other minority communities. Such a framework would allow for the monitoring of progress and the identification of areas that require more focused interventions.

The timing of the NHS Race and Health Observatory's establishment, alongside the findings of this research, is particularly pertinent. As highlighted in this thesis (covered in chapter 7), there is a notable lack of race-sensitive policies and practices in the realm of mental health and health in general. Without targeted policies, African migrants often find themselves navigating a system that is neither equipped to meet their needs nor informed by an understanding of the cultural, social, and economic factors that shape their mental health experiences. This emphasises the necessity of race-sensitive and culturally informed approaches in both policy design and implementation. Without this, the well-meaning intentions of current initiatives risk being ineffective, ultimately perpetuating the very inequalities they seek to address. A more concerted effort to create cohesive, inclusive, and race-informed mental health services is therefore essential to bridging the gap between policy and practice.

The decision to focus on African migrants and mental health in Scotland in this thesis is informed by several key factors. Firstly, Scotland presents a unique political environment

regarding migration, characterised by advocacy for a more welcoming and inclusive approach to immigration, particularly in light of Scotland's unique demographic challenges, such as an aging population and a need for skilled workers to support economic growth (Scottish Government, 2023). Over the past decade, there has been a noticeable increase in the African migrant population, making it an important demographic for targeted mental health research. Secondly, Scotland offers distinct migrant support frameworks, such as the New Scots Refugee Integration Strategy, which promotes integration efforts for migrants, as discussed earlier in this chapter. These frameworks provide a relevant context for examining how African migrants interact with healthcare and mental health services. Lastly, despite progressive efforts, Scotland, like many parts of the UK, continues to grapple with health inequalities and mental health disparities, particularly among ethnic minority groups. This was timely as the research was conducted amid the concern of the impact of COVID-19 on people from ethnic minority groups. This research seeks to contribute to the growing body of evidence addressing these disparities, with the aim of informing policies and research aimed at improving mental health outcomes for African migrants.

This thesis addresses two gaps in migrant mental health research: the experiences of African migrants who are not asylum seekers or refugees and it uses a Critical Race Theory (CRT) lens to understand how experiences and institutional racism impact their mental health.

1.3 Research questions

In focusing on these key gaps in mental health research in Scotland, this thesis has explored factors influencing mental health support amongst African migrants living in Scotland. This research sought to explore three research questions:

1. What are African migrants' perceptions and experiences of mental health and healthcare in Scotland?
2. What factors influence help-seeking for mental health amongst African migrants?
3. How does immigration play a role in mental health behaviours and experiences?

This thesis builds on the limited literature on African migrant mental health in Scotland (El-Ghorr et al., 2010, Isaacs et al., 2022, Quinn, 2014). A systematic review by Botchway-Commey et al. (2024) shows a need to further this research to include voluntary migrants as it underscores the unique factors affecting mental health help-seeking. In this review the findings highlighted that mental wellbeing was impacted by not only personal factors but systemic

factors which aligns with the findings of this research. Moreover the review discusses risk factors such as racial discrimination, a need to fit into the host country's new culture and perceiving/experiencing negative attitudes from local people which I argue are important in migrant mental health research. In locating race and intersecting social identities as the core of post-migration and mental health issues, this research was analysed through a Critical Race Theory lens. By looking at these experiences, this research explores engagement with mental health support, and the findings contribute significantly by offering nuanced insights into the multifaceted barriers to help-seeking within the context of the African migrant experience in Scotland.

1.4 Structure of the Thesis

Chapter 2, Literature review, examines the various academic perspectives on mental health research in African migrant populations in the United Kingdom. The first part of the chapter reviews research and theoretical contributions on African migration to the Global North. It looks at the various theories used to understand the reasons behind migration and its psychological impact on migrants. This part also provides an overview of immigration policy in the UK and the academic perspectives on these policies' influence in broader discourse on immigration. The second part of this chapter explores the concept of race, which leads to the discussion of migrant mental health and the various factors that have been found to have an impact on their well-being. In this chapter, I also identify the critical gaps in understanding mental health and help-seeking as experienced by African migrants in Scotland. I explore how systemic factors affect their experiences and mental well-being.

Chapter 3, *Theoretical Framework,* discusses the applicability of Critical Race Theory (CRT) and Intersectionality as one of its tenets in researching mental health help-seeking in the context of African migrant experiences. In this chapter, I draw on critical theoretical concepts such as the ordinariness of racism, interest convergence and intersectionality from CRT to develop a nuanced understanding of African migrants' help-seeking behaviours and mental health outcomes.

Chapter 4, *Methodology*, begins with the theoretical foundations of this research and then provides a rationale for adopting an exploratory methodology to address the research questions. This chapter then provides an overview of the sampling recruitment strategy and qualitative

data collection methods. The last part of this chapter provides an overview of the data analysis of the key findings.

Chapters 5 and 6 present the findings of this research, which map African migrants' experiences pre and post-migration and link these to the vulnerabilities they experience in their mental health and how this influences help-seeking. Chapter 5 focuses explicitly on participants' pre and post-migratory experiences, analysing the data from the qualitative interviews and focus groups as part of the fieldwork. It begins by mapping out the pre and post-migratory experiences of the participants, highlighting their reasons for migration and their adjustment experiences in trying to adapt to their new surroundings. It then covers findings on experiences and perceptions of racism and how this impacts their well-being. In Chapter 6, I explore participants' perceptions, attitudes and beliefs about mental health. With these accounts, I argue that participants' perceptions, attitudes and beliefs are significantly based on their pre-migratory cultures. With these findings, I present findings which may allow us to understand the unique challenges and perspectives African migrants face when dealing with mental health issues.

Finally, *Chapter 7* summarises the key findings of this research and discusses the contributions related to online data collection and a novel way of using CRT to examine mental health experiences and help-seeking in Scotland. The chapter then outlines the limitations of the current study. It proposes recommendations for future research and changes to policy and practice for improving mental health help-seeking for African migrants.

Chapter 2

Literature review

2.1. Overview

This chapter reviews the literature on African immigrants living in the United Kingdom (UK), specifically focusing on mental health research. It aims thus to provide a foundation for the rest of the study. The first section critically examines the history of African migrants in the UK and presents recent statistical trends to paint a demographical picture of the study population. The second section explores several migration theories to contextualise various reasons for international migration and the implications thereafter. The third section examines the policies on immigration and identifies the issues of discrimination and anti-migrant sentiment associated with these policies historically. The fourth section explores mental health research on ethnic minority populations and compares and critiques previous studies addressing this topic. These sections are collated to a) position the current study within the migration and mental health research, b) justify the theoretical and methodological underpinnings of the study and c) position research participants' lives within their broader socio-economic contexts. The last section summarises the findings from the literature review.

2.2 History of African migration to the United Kingdom

Early evidence shows that Black African migrants have settled in Britain since the sixteenth century (Killingray, 2012, Higgins, 2012). Archival evidence of enslaved Black Africans living in central London goes back to the seventeenth century. Reasons for migration were mainly through slavery trading up until the twentieth century. In the twentieth century, several Black Africans were registered in the British navy, forming over a quarter of the navy's constituents (Aspinall and Chinouya, 2016). As the African empires grew in the later centuries, Africans migrated for interests such as education and official capacities (Killingray, 2012). Most of this migration was through missionaries who provided education and freedom to enslaved Africans living in London (Aspinall and Chinouya, 2016). During this time, British colonisation began in several African countries, such as Somalia, Sierra Leone, Nigeria, and South Africa. Though often omitted from historic African colonisation discourse, Scotsmen were also amongst the soldiers and governors who took part and became settlers in various parts of Africa (Miles and Muirhead, 1986). In 1945, Africa witnessed the departure of the

European administrators after decades of wars and domination. This, however, only gave way to white populations who settled in Africa and continued to exploit resources and reap the benefits which colonisation had sowed. Britain's policies of segregation remained in the African countries and fuelled systemic racism, which had long-lasting consequences (Aspinall and Chinouya, 2016). Although there had been a steady influx of Africans on Britain's shores, the numbers vastly increased post-colonisation, alongside an introduction of early migration laws (Killingray, 2012, Killingray and Plaut, 2020). By the early 1970s, numbers had grown substantially, mainly from English-speaking Commonwealth countries, predominantly from Sub-Saharan Africa (Killingray, 2012, Chattoo et al., 2019).

African migrants in the United Kingdom: recent trends

Most African countries have steadily improved economically over the past ten years. Nonetheless, socioeconomic inequalities remain at an all-time high, often resulting in increased migration trends (McKay *et al*., 2015). The number of African people living in countries outside of the African countries has grown from 17 million in 2015 to 19.5 in 2020, and these figures continue to grow (McCauliffe et al., 2019). The 2021 census revealed that approximately 1.4 million people of African origin lived in the UK in 2019, and 30,000 lived in Scotland (Fitch, 2023). In the year 2021, the most common reason for migration overall is to join family members (226,000), followed by other reasons such as marriage, asylum seeking or visiting (110,000), work-related (103,000), and lastly, formal study (77,000) (Vargas-Silva and Rienzo, 2022). The UK's five most common African nationalities are Nigeria, South Africa, Zimbabwe, Ghana, and Somalia (Office of National Statistics, 2021).

In Scotland, the Scottish 2022 Census revealed that the population had reached its highest at 5.4 million, with 4% comprising minority ethnic groups after a steady population decline . The Census also revealed that 1.3% of the population was identified as African in 2022, with Nigeria, South Africa and Zimbabwe as the most common nationalities (National Statistics, 2023). The Census categorisation is broken down into African, African Scottish, African British, and other African; as a result, the categorisation of the population may not adequately represent the various nationalities that exist. These figures provide a general depiction of the intended target population for this study; however, the relatively small African population provides contextual details that will benefit this research.

2.3 Migration theories

Migration theories explain why international migration occurs and its impacts on individuals, the economy and society. Each proposition uses concepts, ideas, and different frames of reference to describe the same phenomena, varying from each theory's perspective (Massey *et al*., 1993). Furthermore, these theories do more than just provide an understanding of migration; they are also used to justify migration policy as it changes through the years (Piché, 2013). Migration theories try to explain this move through lenses from various disciplines and levels, often used as empirical research underpinnings. The theories frequently assist in answering the three following questions: (1) What factors affect who and how many persons migrate? (2) What factors affect what happens to migrants after they arrive in receiving countries? (3) What effects do migrants have on those countries after they arrive? (Brettell and Hollifield, 2014).

Early migration theories focused on linear interactions between the supply and demand for the labour market. The earliest migration theory of *Neoclassical economics* shaped public thinking on migration and immigration policies in the early years of economic development (Massey *et al*., 1993). The theory is divided into macro and micro theories. The macro theory attributes international migration to geographical labour supply and demand differences, with movement occurring between labour-abundant, low-capital countries and labour-scarce, high-capital countries. However, it assumes the labour market solely drives immigration and that wage differential will eventually halt migration. The micro theory focuses on individuals' cost-benefit analyses based on potential monetary gains, neglecting factors like family reunification, displacement, and education (Porumbescu, 2018, Massey et al., 1993).

The *dual labour market theory*, similar to economic theories, attributes international migration to pull factors in receiving countries' labour markets, needing high-skilled (primary) or low-skilled (secondary) labour (Jennissen, 2007). Over time, migration theories evolved from viewing migration solely as an economic process to considering it a multidimensional linkage of numerous systems, as seen in the migration systems theory (Bakewell, 2014). This approach, characterised by circular migration theorised in 1976, views international migration as continuous flows and counterflows of tangible, regulatory, and relational linkages involving sending and receiving countries, moving beyond earlier theories that focused only on receiving countries' economies (Piché, 2013).

Contemporary migration theories have shifted their focus beyond labour market demands, emphasising various factors that influence migration dynamics (Wickramasinghe and Wimalaratana, 2016). Geographical proximity, availability of social networks and institutional support, and cultural and historical ties are pivotal in shaping migration patterns (De Haas, 2010). The *networks theory* demonstrates this perspective by highlighting the role of interpersonal connections among migrants, their relatives, friends, or compatriots. These relationships facilitate the transmission of information, provision of financial resources, and access to employment opportunities and housing in destination countries (Dustmann et al., 2005). Moreover, such networks contribute to forming transnational communities that sustain and propagate their sociocultural practices across borders, influencing economic activities in both origin and destination nations (Arango, 2000). Similarly, the *migration system theory* suggests that migration triggers multifaceted transformations in both sending and receiving countries' economic, social, cultural, and institutions. At the micro-level, familial and friendship ties are crucial in individuals' migration decisions and experiences. Macro-level factors, including economic structures, political systems, and cultural norms, further shape migration flows and their societal impacts (De Haas, 2010, De Haas, 2021). This theoretical framework highlights migration as a complex phenomenon that intertwines individual aspirations with broader structural forces, influencing local, national, and global societies (Wickramasinghe and Wimalaratana, 2016).

In this chapter I acknowledge the role past theories have played in showing how structural factors and actors have shaped migration over the decades. However I focus on the role of human agency and cover the concept of human security (see section 5.2.1) as a reason for participants' migration reasons in this study. Migration theories can help explain the dynamic process of migration and contemporary theories highlight their potential to reshape communities and societies. This fosters the emergence of transnational identities and influences economic and cultural landscapes in sending and receiving countries. By recognising migration as a multifaceted phenomenon, I discuss various concepts associated with migration in the next sections.

2.4 Migration experiences

2.4.1 Acculturation

The early definitions of the acculturation process referenced the cultural change and adaptation that occurs when groups of individuals from different cultures come into contact and learn and incorporate the values, beliefs, mannerisms and customs of either one or both cultures. This process has implications for the individual's behaviours and psychological aspects, which are overt and covert (Berry, 1997, Molina et al., 2017, Schwartz et al., 2010). The presumption underlying acculturation is that the individual entering the new society adopts the dominating, homogenous culture of the receiving country, often studied among immigrants settled in a new country. It was initially theorised that migrants discard their cultural heritage and largely adopt the one of their host country (Gibson, 2001, Schwartz et al., 2010, Molina et al., 2017). This notion has been challenged because research has shown that newly arrived migrants tend to settle in more culturally familiar communities and retain some of their homeland culture, which disputes the presumption of acculturation to a more dominant culture (Gibson, 2001, Grzymala-Kazlowska and Phillimore, 2018). This theory also asserts that limited acculturation can cause some problematic behaviours or poor mental health.

The academic shift in the early 1980s acknowledged that migrants do not discard their own beliefs, values and attitudes once exposed to their new environment in the receiving country. Berry then further proposed a model of acculturation, which saw acculturation as an intersection of two independent cultures. He devised four acculturation categories: assimilation, separation, integration and marginalisation (Berry, 1997, Schwartz et al., 2010). Research often suggests that integration produces the best psychosocial results, resulting in lower mental ill health and higher social adjustment (Schwartz et al., 2010). In reality, acculturation will usually be influenced by the societal composition of the communities in which migrants settle, which may be vastly diverse from the host ethnic majority of the host country (Gibson, 2001, Phillimore, 2021).

Phillimore's (2021) take on acculturation highlights the needs to focus on the receiving host's role in supporting and providing the context for integration. Phillimore critiques the dominant models that primarily centre on the refugees' ability to adapt and instead proposes a multi-dimensional approach that considers the role of the host society in shaping integration outcomes. She introduces five key host society opportunity structures: locality, discourse,

relations, structure, and initiatives/support. These frameworks are essential for understanding how different factors within the host country impact refugees' ability to integrate. Phillimore (2021) argues that integration cannot be fully understood through a one-sided lens, where the responsibility for successful integration is placed solely on refugees. Instead, it is a dynamic, two-way process that is heavily influenced by the social, economic, and political environment of the host country. By incorporating these broader structural factors, policymakers and researchers can gain a more nuanced understanding of the integration process and address gaps that persist in current models.

This shift in focus has practical implications for improving refugee integration policies, urging societies to reflect on how their structures either facilitate or hinder the process. My research aligns with Phillimore's stance on integration, particularly her emphasis on the importance of host society structures in shaping the integration outcomes of migrants. Like Phillimore, I argue that focusing solely on the adaptability of African migrants ignores the broader social, economic, and institutional barriers that significantly affect their access to mental health services. Phillimore's framework, which highlights the role of local contexts, support initiatives, and structural inequalities, resonates with my argument that the disparities in mental health care for African migrants are not simply a matter of individual adaptation but are deeply influenced by the lack of race-sensitive policies and coordination between healthcare and social services which will be a recurring theme throughout the thesis.

Psychological effects of acculturation

There have been inconsistencies in research findings on the effects of acculturation on mental health. Some studies report that it harms psychological well-being, while others find it beneficial (Balidemaj and Small, 2019, Chun et al., 2003, Oppedal et al., 2004). However, Schwartz and colleagues (2010) critique that most research utilises the unidimensional approach to acculturation rather than the bi-dimensional approach, as proposed by Berry, to determine the implications of the lack of acculturation. To say that a bi-dimensional approach is a better way to research this topic is still simplistic because of the complexity of acculturation in real life. To understand acculturation, there are various aspects to consider, such as migrant individuals' situation before migration, educational levels, occupational skills, social affiliations, media preferences and even their previous exposure to Western culture (Gibson, 2001, Ventriglio and Bhugra, 2019, Schwartz et al., 2010). Furthermore, the reasons for migration may significantly influence the willingness to adopt alternative cultures and

lifestyles. Structural and contextual factors in the receiving country may also play a vital role where racial discrimination and social exclusion could make it difficult for an immigrant to fit in (Gibson, 2001).

However, some studies have sought to explore the impact that acculturation has on migrants' mental health. One such study was conducted by Green et al. (2019) on Syrian refugees in Germany. The study employed an adapted acculturation rating scale to assess their affiliation with the German and Syrian cultures. It also made use of a 12-item depression scale to measure the outcomes of mental well-being. Using regression models, Green et al. (2019) found that there was a negative relationship between affiliation with Syrian culture and mental well-being. Furthermore, the study additionally found that over and above the stress of the acculturation process worsening depressive symptoms, there is also a chance that acculturation builds on pre-existing conditions such as post-traumatic disorder (PTSD). The inconsistencies in the studies exploring acculturation and psychological impact show the complexities of understanding the adjustment into new societies. This indicates a need to further the understanding of migrants' adjustment to new surroundings.

2.4.2 Transnationalism

Transnationalism encompasses the networks that connect migrants to their countries of origin. Myers and Nelson (2019: p.1206) define transnationalism as *"the act of participating in multiple cultures simultaneously, incorporating aspects of a home culture while integrating into a new culture"*. Schiller et al. (1995) also states that transmigrants are immigrants whose daily lives are dependent on the multiple and constant connections across borders, which influence their identities across borders. Basch et al. (1994, p.7) also defined it *"as the processes by which immigrants forge and sustain multi-stranded social relations that link their societies of origin and settlement"*. Many researchers have further tried to define the concept of transnationalism and what the content of transnational activities entails. This participation can include cultural, religious, political and economic activities and often happens unconsciously daily. Though transnationalism is frequently explored at an individual level, the act of sending remittances, buying property, or travelling to migrants' countries of origin can have a positive effect on the macro-level of the town or even the country from which they originate (Portes, 2003, Pasura, 2014). As a result, the theory of transnationalism has challenged the way social scientists have viewed migrants' social inclusion (Murphy and Mahalingam, 2004, Pasura, 2014). This theory is often seen as a development on the earlier

concepts of acculturation proposed by Berry (1997). It also shows that immigration research has shifted from linear assimilation theories to more multidimensional concepts (Schiller, 2018).

Evidently, this concept goes beyond the national borders the individuals cross; instead, it is embedded in multi-level and multi-site social fields that contribute to a person's identity, values and belief systems and, ultimately, how they live their lives (Levitt and Schiller, 2004, Schiller, 2018). The complexity of transnationalism also lies in its fluidity, which differs in each aspect of a migrant's life. Generally, psychosocial factors, such as strong social support, are associated with positive overall immigrant health outcomes (Samari, 2016, Berkman, 2000). Whilst bodies of literature emphasise the role of transnationalism in social integration, there is a shortage of research focused on mental health (Samari, 2016, Murphy and Mahalingam, 2004). This complexity is shown in the fact that some research yields mixed findings on the mental health effects of social ties. Some individuals express a burden for sending remittances, which impacts their daily stress and ultimately affects their psychological well-being (Murphy and Mahalingam, 2004, Samari, 2016). Moreover, social ties in their home country might create a form of nostalgia, which might be difficult for individuals who cannot travel for visits (Murphy and Mahalingam, 2004). The mixed findings, or lack thereof, complicate the relationship between transnationalism and mental health.

2.4.3 Resilience

The concept of resilience has gained significant attention in migration-related research, as it sheds light on the complex interplay between the challenges faced by migrants and their ability to adapt and thrive (McCormack and Strezov, 2021). The contemporary understanding of resilience can be theorised through two perspectives. The first is the social-ecological perspective that emphasises how individuals and communities adapt to external threats. This theory is often critiqued for neglecting the influence of social structures, institutional inequalities and power relations (Preston et al., 2022, Cretney, 2014). Compared to the social-ecological perspective, the social resilience perspective emphasizes the ability of individuals, groups, and institutions to adapt and transform when facing challenges, while also acknowledging the influence of power dynamics and institutional frameworks in shaping those capacities (Webber et al., 2020, Betteridge and Webber, 2019). Adaptive capacities involve surviving and recovering from challenges by either returning to a previous state or maintaining similar structures and functions through preventive actions. In contrast, transformative

capacities involve resistance and proactive measures. This perspective focuses on changing existing structures and practices to not only cope but to improve conditions, potentially creating a more equitable situation that benefits the vulnerable, marginalized, and the broader community (DeVerteuil and Golubchikov, 2016).

One of the key aspects of the term resilience in migration research is its focus on the capacity for positive adaptation rather than solely on the deficits or vulnerabilities of migrants. This shift in perspective allows researchers to identify and amplify the strengths, resources, and competencies that enable migrants to overcome adversity and maintain well-being. Moreover, the resilience approach emphasises the dynamic and context-specific nature of the migration experience, acknowledging that resilience may manifest differently across different risk conditions and individual circumstances (Herberg and Torgersen, 2021, Solà-Sales et al., 2021, Hosseini et al., 2017).

At the same time, applying resilience in migration research is challenging. The multidimensional and complex nature of resilience can make it difficult to measure and operationalise, leading to inconsistencies in how the concept is defined and applied across studies (Wu et al., 2018, Masten, 2014). Additionally, there is a risk of oversimplifying the resilience of migrants, overlooking the structural and systemic barriers they face, and potentially placing undue responsibility on individuals to overcome adversity (Boardman et al., 2011, Betteridge and Webber, 2019). Research needs to be mindful of these limitations and strive to adopt a nuanced and critical approach to studying resilience in the context of migration. By examining both the positive and negative aspects of resilience, scholars can contribute to a more comprehensive understanding of the migration experience and inform the development of interventions and social policies that support the resilience and well-being of migrants.

2.5 Immigration policy in the UK

In order to examine migrant experiences in the UK, it is crucial to consider the context of UK immigration policy and its influence on the socio-political landscape of migration. Various scholars have categorised migration types in diverse ways, yet they all highlight similar entry pathways. For this study, we will adopt Koppenberg (2012) framework, which classifies migration into two categories: voluntary and forced/involuntary. The former includes individuals who migrate voluntarily for reasons such as employment or education, while the

latter encompasses asylum seekers and undocumented migrants who flee their home countries due to fear of violence or persecution based on race, religion, nationality, membership in a specific social or political group, and the exercise of their right to international protection (Koppenberg, 2012).

2.5.1 A brief history of immigration policies

Up until the beginning of the Second World War, border control witnessed many migrants who were fleeing persecution attempting to enter Britain, often with no success. The British government continued to recruit migrants from various Eastern European, Caribbean and Indian countries to join the growing labour force when necessary (Brown, 1995, Hepburn and Zapata-Barrero, 2014). The ever-increasing numbers of immigrants challenged the Conservative government, which received pressure from voters to halt ethnic minority immigration to the UK (McLaren and Johnson, 2007). Nonetheless, the government maintained a supposed open-door policy to strengthen linkages with Commonwealth countries and address labour shortages. However, there were covert administrative regulations and government circulars that did restrict the entry of immigrants of colour through restricting certain countries (McLaren and Johnson, 2007, Paul, 1997). Some would further argue that the negative connotations associated with non-white immigrants in public opinion were spread through politics to prove the necessity of immigration control policies, which is somewhat evident in politics today (Paul, 1997, Shorthouse and Kirkby, 2015).

Migration policies that emerged in the early 20th century were founded on the principle that immigration was a privilege, not a right (Piché, 2013). This further ensured that immigration policies served to control receiving states' fundamental interests (Hamilton, 1997). One of the key interests of the UK government was to increase the number of skilled migrants by allowing employers to recruit and transfer individuals through work permits for in-demand skills (Dell'Olio, 2004). The first piece of immigration legislation was the Aliens Act of 1905 (Wray, 2006) which marked the start of Britain's administrative structure to control immigration. This Act resulted from the growing numbers of Jewish migrants who had settled in Britain in the 1800s (Wray, 2006). Though this Act did not exhibit the harsh statutes that future legislature would subsequently include, this was the start of Britain's increasingly punitive and restrictive approach to border controls after decades of free entry. Decades later, the monumental British Nationality Act of 1948 was passed under the Labour government. This Act redefined British Nationality to include all the Crown's subjects and their colonies and allowed approximately

500,000 Commonwealth citizens the right to enter (Hansen, 1999, Wade, 1948). Many of these were Caribbean immigrants who are now commonly referred to as the Windrush Generation (Peplow, 2020). This was a particularly pivotal moment in British history because it brought a diversity of ethnicities, which remains evident today. As the number of immigrants continued to rise, negative racial attitudes perpetuated. However, after almost two decades, immigration laws changed once again.

Stringent immigration policies emerged in the early 1960s when the Commonwealth Immigration Act was passed in 1962 (Geddes and Scholten, 2016). This Act aimed to reduce Commonwealth immigration into the UK, mainly from the new Commonwealth countries. Until this period, British nationality was defined loosely and applied to individuals who were residents of the United Kingdom and the remaining colonies (Coleman, 1995). Furthermore, it allowed all citizens of the Commonwealth to retain their citizenship, even after their country's independence. However, once immigration began and the 1962 law was passed, there was a change to distinguish citizens according to their nationality, which separated British citizens from immigrants (Coleman, 1995). Another vital Act was passed during this time: the Race Relations Act 1965 (Hepple, 1966). This was the first piece of legislation that addressed the prohibition of racially driven hate and discrimination in public places. If broken, the perpetrator would be punishable by law. However, it has been criticised for not addressing racial discrimination in other spheres, such as employment and housing, amongst others. This led to a revised Race Relations Act in 1968 (Hepple, 1966).

The Immigration Act of 1971 was also a pivotal moment for British policy. It established a permanent legislature that would clarify legal positions for immigration and deportation of individuals entering and living in the UK (Evans, 1972). Subsequent immigration laws have been modifications of the Immigration Act of 1971. Essentially, the law allowed Irish and nationals of European Economic Area countries freedom to live and work in Britain. Commonwealth citizens with British passports or the right to definite or indefinite leave to enter or remain in the UK were also given the right to live and work there (Evans, 1972, Hatton, 2005). If one did not fit into any of the categories mentioned above, they were required to obtain a work permit through their employer, and the right to a permit depended on the level of qualifications one had or specific occupation demands. Short-term work permits were also granted for various occupations such as au pairs, journalists, diplomats, and sports people, to name a few (Hatton, 2005). Students were given the right to remain for their studies, but could

not work. The policy also included the right to seek asylum, based on the 1951 Refugee Convention and its 1967 protocol (Hatton, 2005). Notably, African immigrants entering the UK increased following the 1971 Act. This coincided with the process of decolonisation of most African countries, and many immigrants from British colonies entered the UK for various reasons (Coleman, 1996, Van Mol and de Valk, 2016).

The 1981 British Nationality Act brought about a drastic change in how entry to the UK was granted. Dixon (1983) explains how the Commonwealth ideal soon diminished, and Britain moved towards more robust relationships with the European community. This new law introduced three new categories, namely: British Citizenship, British Dependent Territories Citizenship and British Overseas Citizenship, depending on whether individuals were "closely connected" to Britain to one of the remaining dependencies (colonies) or those who did not fit in either of the first two categories (Dixon, 1983). This policy change, which was during Margaret Thatcher's term in office, attempted to provide Britain with a fresh start by preserving national identity and limiting the growth of minority ethnic groups. It emphasised the need to categorise an individual by nationality and saw an introduction to visas, which was a first in Britain's immigration policies (Bloch, 2000). One of the most notable restrictions was the abolition of the *ius soli,* which was the principle that allowed every person born in Britain to gain citizenship regardless of their parents' nationality (Dixon, 1983). This restriction played an influential role in reaffirming the sentiment that minority ethnic groups did not belong in the country.

Non-EEA migrants' inflows in the early 1990s were often due to the Work Permit System (WPS) or seeking asylum. Though the other ways of entering the UK were fairly stringent, seeking asylum was perceived as less restricted by the public. During the early 1990s, asylum applications in the UK began to rise drastically, with almost 40,000 applications in 1992, which has now decreased to half in 2019 (Sturge, 2019). This prompted the passing of the first Act specifically for asylum. In 1999, the Immigration and Asylum Act was passed, and it revoked asylum seekers' right to social security and replaced it with food vouchers and £10 daily for each individual. Furthermore, this Act introduced the compulsory dispersal of asylum seekers to various parts of Britain to relieve the strain on the most populated city, London (Bloch, 2000).

The numbers reached their highest in 2001 and 2002, sharply declining. This decline was not a result of fewer individuals seeking refuge; it was a result of tougher controls and changes to

policy (Geddes and Scholten, 2016). These policy changes were accompanied by claims that asylum seekers were "draining the government welfare resources, which they do not contribute towards and are undeserving of" (Spencer, 2011, McDonald and Billings, 2007). These claims are often without evidence and further perpetuate a climate of discrimination and exclusion towards asylum seekers, which still exists today. However, contrary to popular belief, Andersson *et al.* (2019) proved through their research that the significant increase of refugees in the UK had a small but positive impact on the economy's growth. Current policies on the rights of refugees and asylum seekers have been amended to provide certain mainstream benefits and permission to enter the labour market for those with indefinite or temporary leave to remain. In contrast, asylum seekers receive £49,18 per week and accommodation on a no-choice basis in the UK (GOV.uk, 2023).

The point-based system (PBS) was introduced in the late 2000s and provided a more systematic way for individuals to enter the UK (Devlin et al., 2014). Through the years, amended versions of the PBS have been passed to ensure that migrants entering the UK "are the brightest and the best to reduce improper usage of the system" (Devlin et al., 2014). The year 2010 marked another major shift in immigration policies when Theresa May was appointed Home Secretary. While the country was celebrating the 65th anniversary of the Windrush's arrival, the Home Office implemented policies that contributed to what some claim has led to a "hostile environment" (Peplow, 2020). These new rules were aimed at creating a hostile environment for migrants, by limiting access to essential services such as housing, healthcare and employment to force them to leave the UK voluntarily. This also came with the Immigration Act of 2014, which allowed the Home Office to deport individuals whose asylum applications had been rejected before their appeal.

Consequently, these policies contributed to the Windrush Scandal in 2018 (Peplow, 2020). The hostile environment resulted in thousands of (mainly Black) British residents who had arrived during the Windrush period being asked to prove their right to stay whilst being deprived of their essential services; some were detained, and others were deported unlawfully. The Home Office had not documented those granted indefinite leave to remain through the 1971 Immigration Act, which led to them being asked to provide proof of their stay from the date of arrival, which was virtually impossible (Peplow, 2020). The Windrush scandal was not the only issue relating to immigration policy changes; Britain was also preparing to leave the EU. There was a decrease in arrivals from the EU, triggered by the Brexit Referendum vote in June

2016 for Britain to leave the EU; the Referendum passed and announced the start of the Brexit agreement. The net migration of EU citizens dropped by 70% going from 501,400 before Brexit to 151,000 in the year 2022 (Cuibus, 2023).

In 2019, the new Immigration and Social Security Co-ordination (EU withdrawal) Bill was passed, which meant the UK would no longer be a part of the 27 EU countries, which ended free movement into Britain (Macdonald, 2019). The Referendum did come with other changes, such as post-study work visas for international students beginning their studies in the 2020/21 academic year and amnesty for undocumented migrants, amongst other things. Brexit has had profound and multifaceted impacts on the UK, affecting its economy, politics, and society. Economically, Brexit has led to trade disruptions, a decline in investment, and labour shortages, particularly in sectors reliant on EU workers, such as agriculture and healthcare. Politically, it has exacerbated divisions within the UK, fuelling national identity and sovereignty debates and straining relations between the UK and EU member states (Tetlow and Stojanovic, 2018). Socially, Brexit has influenced public attitudes towards immigration and has been linked to a rise in xenophobia and nationalism (covered in more detail in the next section).

The Rwanda bill, formally known as the "UK-Rwanda Migration and Economic Development Partnership," represents a significant shift in the United Kingdom's approach to managing asylum seekers and immigration. Introduced in April 2022, the bill aims to deter irregular migration by sending asylum seekers who arrive in the UK illegally to Rwanda for processing, asylum, and resettlement. The UK government has justified the bill on grounds of reducing the pressure on its asylum system, curbing human trafficking, and preventing perilous journeys across the English Channel (Birkinshaw, 2024, El-Ouaz, 2024). However, this policy has sparked considerable controversy and debate, both domestically and internationally, regarding its ethical, legal, and practical implications. From a legal standpoint, the Rwanda bill has raised concerns about its compatibility with international law, particularly the 1951 Refugee Convention and the European Convention on Human Rights (ECHR) (Birkinshaw, 2024). Critics argue that outsourcing asylum processing to a third country, such as Rwanda, could undermine the principle of non-refoulement, which prohibits the transfer of asylum seekers to countries where they may face persecution or serious harm. Additionally, questions have been raised about Rwanda's capacity to ensure fair and humane treatment of asylum seekers, given its own human rights record. The legality of the Rwanda bill has faced several challenges in

UK courts, which have debated whether such a policy aligns with the UK's international obligations (El-Ouaz, 2024, Leyland, 2024).

In 2023-2024, the UK once again implemented several significant changes to its immigration laws to reduce net migration. One of the key changes is the increase in the minimum salary threshold for the Skilled Worker visa from £26,200 to £38,700 (McKinney and Gower, 2024). This change aligns the threshold with the median full-time salary for similar jobs and aims to restrict the number of migrants entering the UK through this route. Additionally, the minimum income requirement for sponsoring family members has increased to £38,700, a substantial rise from the previous £18,600 (McKinney and Gower, 2024). This change is intended to ensure that sponsors have sufficient financial means to support their family members without relying on public funds. Moreover, the Health and Care Worker visa route has been tightened, with restrictions on dependents and sponsorship only allowed for roles regulated by the Care Quality Commission (Abugideri, 2023). This move aims to address high net migration levels and concerns about non-compliance and worker exploitation. Other notable changes include the abolition of the shortage occupation list, which will be replaced by an Immigration Salary List, and the capping of dependents for Student visas to one per student. Additionally, the Immigration Health Surcharge and fines for illegal working will see significant increases from January 2024 (McKinney and Gower, 2024). These changes reflect the Conservative government's efforts to manage immigration more strictly in response to high net migration figures and political pressure (Abugideri, 2023).

Attitudes to immigration policies

Attitudes on immigration policies extend further than just public opinion. Politics and the media often shape and influence them, which usually have an associated relationship in creating public perceptions of immigration. These attitudes may result from direct influence or inferences from policymakers and the media (McLaren and Johnson, 2007, Duffy, 2014). Attitudes are often varied in relation to different categories of migrant, where economic migrants and students are seen more positively by the general public than refugees or asylum seekers (Blinder and Allen, 2016, Dell'Olio, 2004). Burns et al. (2022) highlights that the administrative processes that underpin the categories in which migrants are placed is viewed as benign and objective. However this categorisation has far reached implications on the rights they 'deserve' which focuses more on their mode of arrival to the UK rather than their needs. Thus certain groups are labelled as 'bad' or 'good' migrants due to their mode of arrival and

the perceptions of the impact they may have on national resources. This illustrates that immigration processes are not in fact benign however it is not easy to gauge whether politics influence public attitudes or whether an individual subscribes to specific media and a political ideologies because of their personal opinions. However, there is enough evidence that politics and media substantially influence how immigration is portrayed in the UK (Blinder and Jeannet, 2018, Bleich et al., 2015, Garnham, 2020).

Political influence on immigration attitudes

The rise of support for right-wing politics has been accompanied by the general increase in anti-migrant attitudes across the UK and the rest of Europe (Bakhtiari et al., 2018, Berry et al., 2016). However, the consequences of more stringent citizenship and immigration laws extend beyond the right to remain in the country. These policies define not only the legal but often cultural and social belonging of individuals who move to the UK. The policies further stratify access to public resources such as healthcare, education, and the labour market. The stratification of these resources also perpetuates a lower socioeconomic status for specific groups and their "othering" in society. This was particularly evident in the Windrush scandal, where the actions taken against the affected individuals were said to have betrayed the British values of fairness, tolerance, human rights and immigrant appreciation (Peplow, 2020). However, many opinions pointed out that the public only supported "worthy" immigrants and that if the Windrush scandal had been perpetrated on the less desirable group of minorities, the silence would have been deafening. This reflects the mixed/variable or changing attitudes on immigration and implies that the idea of British values is differently applied based on the type of migrant.

Findings on the British public attitudes towards immigration reveal a complex interplay of positive and negative sentiments (Bohman and Hjerm, 2016). These attitudes are significantly reflected in voting patterns, indicating varying support levels for different political parties' immigration policies. According to a briefing paper by the Migration Observatory (2023), attitudes towards immigration softened between 2015 and 2022. However, from 2022 to 2023, there has been a shift, with a growing number of people advocating for reduced immigration. This shift is attributed to the heightened prominence of political discourse on immigration-related issues during this period. Furthermore, public opinion on which countries of origin should be allowed to stay in the UK is particularly nuanced, with less favourable attitudes towards individuals from Nigeria and Pakistan. When surveyed about asylum seekers, 37% of

respondents believed that the process for asylum seekers to enter the country should be more stringent. Interestingly, this sentiment does not extend to Ukrainians, with only 10% of respondents advocating for more difficult entry conditions for them (Richards et al., 2023).

It was also found that people are highly misinformed about immigration and the number of immigrants in the UK and have a preference for some migrant groups over others (Richards et al., 2023). One of the significant factors in anti-immigration attitudes is the increase in the popularity of radical right-wing politics across Europe and globally. Bohman and Hjerm (2016) explain the role of right-wing politics in influencing public opinion through group threat theory and the framing theory. Simply defined, the group threat theory is the prejudice response the in-group may have toward the out-group because of the perceived threat of inter-group struggle over scarce resources (Dixon, 2006, Hjerm, 2007). According to the National Institute of Economic and Social Research (NIESR), perceived economic and cultural threats are significant drivers of immigration attitudes. Lower economic satisfaction and job insecurity, alongside perceived threats to national identity, religion and beliefs, are findings which support the group threat theory to anti-migrant attitudes (Runge, 2019). Hostile political rhetoric often heavily influences these perceived threats, whether there is actual truth to the threat migrants present to the in-group. These attitudes play a role in services provision and service delivery and are then less based on the actual socio-economic realities but rather on political prejudice (Sides and Citrin, 2007, Bohman and Hjerm, 2016).

Most recently riots in the UK erupted in July 2024 following the death of three young girls. These riots reflect deep-seated frustrations with the current political climate, highlighting a growing sense of disillusionment among right wing constituents (Reuters, 2024). The unrest can be traced to a backdrop of economic inequality, perceived governmental neglect, and political decisions that many see as exacerbating social divides. Protests and riots often arise from a convergence of grievances, including austerity measures, rising living costs, and cuts to public services, which have intensified feelings of marginalization. The political climate, marked by increasing polarization and a lack of trust in leaders, plays a significant role in fuelling these tensions, as individuals and groups express their dissatisfaction with a system they believe is failing to address their needs and concerns (Holdsworth and Holdsworth, 2020, Waddington and Moran, 2020).

Media influence on immigration attitudes

Naturally, when a society undergoes perceived drastic changes, such as an increase in the number of newly arrived migrants, the public seeks information on the cause and effects of the change (Joris and De Cock, 2019). This information often comes via the media through newspapers, television news coverage, and social media platforms, which are typically easily accessible yet habitually the least (Joris and De Cock, 2019, D'Haenens et al., 2019). This is especially evident in the modern age of internet usage, where information-sharing regulations have not been able to curb incorrect fact-sharing successfully. The media often serves as a correspondent between political actors and the public by relaying information they deem newsworthy (Bleich et al., 2015, Berry et al., 2016). With immigration being one of the most discussed topics in the UK, the melting pot of political and media agendas further exacerbates the negative public opinions, which have a direct influence on how immigrants are viewed and treated (Joris and De Cock, 2019, Berry et al., 2016).

Joris and De Cock (2019) described the framing approach as a way to interpret and communicate certain aspects of a story "to promote a particular problem definition, causal interpretation, moral evaluation and/or treatment recommendation" (Entman, 1993, Bleich et al., 2015). The framing approach is often used in media and is highly subjective to the aspects the news outlet wants to be more visible to the public. Paired with the sensationalism of what may otherwise be mundane headlines, this may have implications that encourage in-group-out-group attitudes between immigrants and other citizens (Esses et al., 2013). The framing of migration varies from country to country. Compared to other European countries, the UK has one of the most negative media coverage of asylum and immigration (Berry et al., 2016, Dempster and Hargrave, 2017). Stories in British media often dehumanise refugees and migrants and use derogatory words such as influx and invasion or focus excessively on the number of arrivals. These stories focus less on the education of the masses by using the correct terms and instead use words like migrant, asylum-seeker and refugee interchangeably, further perpetuating negative connotations to the terms (Dempster and Hargrave, 2017, Crawley and McMahon, 2016). Efforts to counteract the negative immigration stories in the media have been taken up by civil society groups such as the Migrant Voice or The 3 Million, which are migrant-led organisations working to strengthen the voices, participation and representation of migrants in the UK (Dempster and Hargrave, 2017). The efforts made by these organisations are

relatively new which indicates that there is a need for continued work to dismantle the impact of these negative stories.

The approach to immigration in Scotland

Scotland's approach to immigration has been perceived to be substantially different from the rest of the UK (Blinder and Allen, 2016, Hepburn and Rosie, 2014). While immigration policies in the UK reinforce more stringent entry rules, the Scottish stance has encouraged social and political integration of migrants settled in Scotland. However, Scotland does not have devolved control over immigration. The concern over the demographics of the Scottish population was sparked by the 2001 Census, which showed a decline in the number of births and an increase in emigration (Blinder and Allen, 2016). This resulted in the projection of an ageing population and shrinkage in population, which might affect the economy and, ultimately, the standard of living. In response to the predictions, the Scottish Government launched their "Fresh Talent" initiative in 2004 to encourage inward migration by extending work permits for international students. However, their efforts in implementing this initiative were disrupted by immigration restrictions that Westminster had set for the whole of the UK, which largely reflected the labour needs of England (Hepburn and Rosie, 2014). Over the years, Scottish politics has retained their public humanitarian sentiment and remained less hostile towards immigration than their counterparts (McCollum et al., 2016). However, there has been very little public mention of the historical and contemporary institutional racism in Scotland. The lack of this public discourse has led to the false belief of the absence of racism. The interest in retaining migrants has also been driven by Scotland's labour need for a young population, which serves the government's interest rather than the migrants' (Davidson et al., 2018, Miles and Muirhead, 1986).

Hepburn and Rosie (2014) hypothesise four reasons why immigration has been positively viewed in Scottish political circles. First are the low barriers that stand in the way of integration as a nation member. Obstacles to national membership may be a place of birth, residence, ancestry, language, accent and engagement in the national culture as opposed to other sub-state nations such as Flanders or Quebec. Scottish identity is not distinguished by a language different from other nations within the state, which is marked as one of the most common barriers to national membership. The second hypothesis is the low immigration levels and a demographic labour shortage. As discussed previously, low immigration rates and failure to retain migrants have caused concern for the nation's demographic. Third is the low polarisation

on immigration that Scottish politics has. Conflicting immigration ideologies of mainstream parties may cause an unstable political climate on immigration. Whilst politics in the UK is based on the left-right axis on immigration issues, Scottish parties have mutual agreement. The consensus on the necessity of higher immigration rates in Scotland reduces the pressure that ruling parties may have to accommodate immigration restrictions. Lastly, the limited control over immigration policies may reduce party polarisation. This subsequently requires more time for the development of policy. Scotland's less control over immigration policies gives them more time to deal with other regional concerns, such as economic development or education (Hepburn and Rosie, 2014).

A study conducted by Curtice and Montagu (2018) on the analysis of social attitudes surveys on both the British and Scottish populations respectively aimed to determine whether or not there is a difference in public views on immigration. Noticeably, Scotland seemed to have a more positive view of immigration. Most responses were in the middle, suggesting that the participants felt neither negative nor positive about migration. However, one of the surveys sought the perceived impact of migration on the British economy through participants' votes in the 2017 general election. The majority of the Scottish National Party voters surveyed expressed a mainly positive view on the perceived impact of migrants in society, followed by voters for the Liberal Democrats and the Labour Party. The Scottish Conservative party voters trailed with the lowest perceived positive impact but had a relatively high response of neither good nor bad (Curtice and Montagu, 2018). Though one cannot conclude on public attitudes purely on the ruling party's perceptions, it does indicate the voters' attitudes.

2.6 Defining race, culture, and ethnicity

The anti-migrant attitudes and the "othering" of ethnic minority groups discussed in the previous section are indicative of the racism and discrimination that exists in the UK. Experiences of racism or racial prejudice have profound impacts on the engagement of services and the general well-being of migrants. In the studies conducted with African migrants in the UK, it is evident that most Black African migrants have frequent experiences of racism in the UK. The repeated exposure to racial prejudice not only undermines their sense of belonging but also hinders their ability to fully participate in society, leading to social exclusion and economic disadvantage (Burns et al., 2006, Dodds, 2006, Howarth, 2006). To provide a

conceptual background, briefly discussing the concepts of race, culture, and ethnicity is essential.

The history of the classifications of races can be traced back to the eighteenth and nineteenth centuries in Europe, where it was primarily based on skin colour (Fernando, 2010). Race is "a concept that signifies and symbolises social conflict and interests by referring to different types of human bodies" (Omi & Winant, 1994: p. 54). The term *'race'* was used as an objective measure, which was assumed to be genetically determined. It constructed and categorised humankind whilst enforcing misconceptions about what it meant to be Black or White (Fernando, 2010). In 1937, Barzun (1937) coined the term 'race thinking' to refer to the singling of traits, which could be accurate or not, could exist in one individual or not and generalising those traits to a single group of people. This generalisation based on physical similarities between two or more individuals was closely linked to the concept of *culture*. In social studies, culture refers to the shared patterns of behaviour, beliefs and attitudes that inform how people live. Culture exists in various contexts that describe how people live in society, institutions, and professional settings (Fernando, 2010). The concept of culture has evolved over the years from being seen as synonymous with race to a broad understanding of a worldview adopted by individuals of the same groups. Culture is also a dynamic variable with historical roots passed on through generations (Fernando, 2010). Consequently, ethnicity can be seen as an overlap between race and culture. It cannot be characterised only by physical attributes but also refers to social similarities and a sense of belonging to a particular group. Hall (1992: pp. 257) defines ethnicity 'as a term that acknowledges the place of history, language and culture in the construction of subjectivity and identity'. Fernando (2010) summarises all three concepts in Table 1 and differentiates how each is characterised, perceived, assumed to be and in reality.

Table 2 . 1 Race, culture and ethnicity, adapted from Fernando(2010)

	Characterised by	Perceived as	Assumed to be	In reality
Race	Physical appearance	Physical, permanent	Genetically determined	Socially constructed
Culture	Behaviour, attitudes etc.	Social, changeable	Passed down by parents etc.	Variable and changeable blueprint for living
Ethnicity	Sense of belonging	Psychosocial, partially changeable	How people see themselves in terms of background and parentage	Culture-race mixture

In the diverse and dynamic landscape of the United Kingdom, the concepts of race, culture, and ethnicity hold profound significance, shaping society's social fabric and individual experiences. These constructs, though distinct, are often intertwined, with complex and nuanced implications for how people perceive and navigate their national identity (Bhambra and Holmwood, 2021, Bhambra, 2022). Ethnicity, in particular, has emerged as a crucial factor in understanding the complexities of identity and belonging within the UK context. Ethnicity is commonly used to refer to a person's cultural, national, and ancestral affiliations, encompassing factors such as language, religion, and shared customs. The ways in which individuals from diverse ethnic backgrounds understand and express their Britishness can vary widely, as evidenced by research exploring the "thick" and "thin" conceptualisations of national identity among young people (Chattoo et al., 2019, Bhambra, 2022). This diversity of perspectives demands the need for a more inclusive and nuanced approach to discussions of nationality and belonging, particularly in the wake of pivotal events like Brexit that have brought these themes to the forefront of the socio-political discourse. The role of family structures and cultural transmission further complicates the relationship between ethnicity and national identity. As individuals from ethnic minority backgrounds navigate their place within British society, the influence of their familial and community ties can profoundly shape their understanding and expression of Britishness (Twumasi-Ankrah, 2019, Bhambra, 2022).

Alongside ethnicity, race has also been a subject of ongoing debate and examination within the UK context. While the terms "race" and "ethnicity" are often used interchangeably, they are distinct constructs, with race typically referring to physical and biological characteristics, while

ethnicity encompasses cultural and ancestral affiliations. The lack of widely agreed-upon definitions for these terms adds to the complexity of understanding their implications for identity and belonging. As the UK continues to grapple with the challenges and opportunities of its multicultural society, the need for a more nuanced and inclusive understanding of race, culture, and ethnicity becomes increasingly pressing. This is especially pertinent as racism continues to be a persistent and destructive issue within the UK context and must be directly addressed in discussions of race, culture, and ethnicity.

Experiences of racism and xenophobia in the UK

As the concept of race became more accepted, the term *racism* was born (Fernando, 2017a). Much of racism today is expressed in complex racial prejudice that occurs across a range of socio-economic situations. Though race prejudice and racism are closely linked, they do have varying definitions, associations and likely causes. Fernando (2010) defines racial prejudice as a psychological state that is felt as a result of faulty or inflexible generalisations. Racism is characterised as the behaviour that results from these faulty generalisations. Racism also extends to institutional systems that often have unequal distribution of power based on racial differences. Experiences of racism date back to the eighteenth century during slavery times when enslavers perpetuated distorted beliefs on racial differences. White was viewed as reasonable and Black as bad (Bernasconi, 2016, Fernando, 2017b). There is a considerable shortage of literature on the levels of racism in the UK. However, there have been increasing reports of racially aggravated crimes against ethnic minorities. Coupled with xenophobia, which is defined as anti-foreigner feelings and behaviours, the line between racism and xenophobia is often blurred. Studies conducted on ethnic minorities in Scotland reported having frequent experiences of racism (Hopkins, 2004a, Hopkins, 2004b, Davidson et al., 2018, Quinn, 2014). The Race Relations Acts passed in the UK make it a crime to perpetuate racially aggravated crimes. Notwithstanding, racism has moved from blatant public behaviours to covert institutional racism existing in the structures of society. Public discourse on racism tends to focus on condemning racial slurs and the attitudes and beliefs of individuals. However, the less overt racist nuances are embedded in the structures of society (Bernasconi, 2016).

Racism and xenophobia are deeply ingrained societal issues that can have far-reaching consequences, particularly on the mental health and well-being of marginalised communities in the UK. A growing body of research has shed light on the complex interplay between experiences of discrimination, structural barriers, and the mental health outcomes of

individuals and ethnic minority communities. Experiences of racism, whether in the form of overt acts of discrimination or more subtle, institutionalised barriers, have been consistently linked to poorer mental health outcomes (Schouler-Ocak and Kastrup, 2021). Structural inequities in areas such as housing, education, and healthcare have been found to create chronic stress and adversely affect the psychological well-being of historically marginalised populations. Moreover, the pervasive nature of these systemic barriers can lead to internalised racism, further compounding the negative mental health consequences. Groups that are often more vulnerable to these systemic barriers are Black migrants, who often face institutional discrimination when accessing public services, such as facing language barriers or being denied equal opportunities, which can contribute to feelings of exclusion and disempowerment (Alegría et al., 2017, Olukotun et al., 2019, Garcini et al., 2021). Beyond the impact of institutional racism, interpersonal experiences of discrimination and xenophobia also take a significant toll on mental health. Individuals who face hostility, prejudice, and exclusion in their daily lives are at an increased risk of developing mental health issues such as anxiety, depression, and post-traumatic stress disorder (Alegría et al., 2017, Vines et al., 2017).

Understanding the impact of harsh immigration policies and racism is crucial for examining mental health issues among African migrants. The following section will review existing literature on mental health within Black migrant populations, aiming to connect the underlying causes and their effects on mental well-being.

2.7 Migrant mental health research in the UK

This section examines the evidence of mental health research on ethnic minority groups in the United Kingdom. It will explore various themes related to patterns of mental health problems, risk factors, attitudes, beliefs and knowledge, stigma, migrant engagement with mental health services, factors impacting engagement, and prevention and early interventions. By critically discussing these themes, the groundwork for the study will be laid to understand the factors affecting engagement in mental health services in Scotland. Since there is insufficient up-to-date migrant mental health research specific to Scotland, studies done in the rest of the UK and other similar countries will be explored in this review. Mental health in the context of migration is a particular concern as the number of people relocating to the UK continues to increase. As migration is a known contributing factor to stress in various aspects of a migrant's life, there is evidence (Hynie, 2018, Gleeson et al., 2020, Salami et al., 2017, Alegría et al., 2017, Schouler-

Ocak et al., 2020) that comorbid disorders accompany mental ill health. This is reflected in higher mortality rates from cardiovascular disease, diabetes and respiratory diseases amongst ethnic minority populations, which are known to be associated with ill mental health and stress (Das-Munshi et al., 2017). By exploring the factors impacting engagement in the hope of informing intervention strategies and growing the body of knowledge, the prognosis of both mental ill health and its comorbidities can be improved.

2.7.1 Patterns of mental health problems within minority ethnic communities in the UK

Patterns of mental health problems amongst minority ethnic communities have been an intricate research phenomenon for decades. Research conducted on the mental health of immigrants offers mixed findings; however, there is a considerable amount of evidence that asserts the prevalence of common mental disorders amongst ethnic minorities as opposed to the British population (Brown et al., 2014, Bhugra, 2004). Conditions such as dementia, schizophrenia, mania, depression and anxiety are found to be the five most common amongst Black African or Caribbean populations in the UK (Masood et al., 2019, Adelman et al., 2011). Unfortunately, minority populations are also found to participate less in mental health research, with researchers reporting difficulties with recruitment. This challenges the study and subsequent development of tailored services for these groups (Brown et al., 2014). Moreover, the UK, like other European countries, do not have policies which mandate the inclusion of ethnic minorities in clinical trials, which further lessens the likelihood of participation in mental health research, affecting representation (Masood et al., 2019, Brown et al., 2014).

There is a growing body of literature that asserts that there are higher numbers of people living with dementia amongst Black African and African Caribbean people in the older age groups (Adelman et al., 2009, Berwald et al., 2016). One study conducted by Pham et al. (2018) in the UK analysed the incidence of dementia in primary care in a population of older people. The findings of this study indicated that, by contrast, Black women and men were more likely to have a new dementia diagnosis than other ethnic groups. The study also highlighted that the figures presented in this study were most likely not accurate as there were more Black men that have been undiagnosed for dementia (Pham et al., 2018). This may be due to attitudes towards dementia which are highlighted by a qualitative study that found that participants felt that dementia was a ‘white person’s illness’ (Berwald et al., 2016). As a result, the prognosis for people from ethnic minority groups who present with dementia tends to be poor. This tends to

be primarily because of late diagnosis, which results from various factors that will be discussed later on (Berwald et al., 2016).

Black African and Caribbean migrants living in Europe have a higher risk for schizophrenia and psychosis than the host population (Dealberto, 2013, Halvorsrud et al., 2019, Karlsen et al., 2005). The rates of incidence of schizophrenia are similar for all generations of migrants, with the first cases documented dating back to the end of the Second World War. Whilst there is a lack of recent studies investigating schizophrenia and psychosis amongst African migrants, there is a body of evidence supporting the higher incidence rates. Some research argues that the high incidence rates may be owed to the diagnostic bias from the assessment tools that do not adjust for age and socioeconomic status. However, there is a lack of evidence in clinical studies to support this assertion (Selten et al., 2020, Morgan et al., 2017a, Pinto et al., 2008). Additionally, there is a well-known association between schizophrenia and high mortality rates. This is not only attributed to unnatural deaths such as suicide but is also associated with natural causes such as cardiovascular disease, diabetes and respiratory diseases (Das-Munshi et al., 2017). This fact points to the susceptibility Black Africans and the Caribbean may have to such comorbid diseases, which creates a double burden of disease for the population.

Depression is described as a life-threatening disorder with associated implications such as tobacco use, alcohol consumption, self-harm, suicide, loss of productivity, cardiovascular disease and diabetes mellitus (Das-Munshi et al., 2019, Cuijpers and Smit, 2002, Williams et al., 2015). Various research reports lower mortality rates caused by unnatural deaths amongst ethnic minority groups diagnosed with depression. However, there are more frequent deaths among these groups associated with natural causes such as cardiovascular diseases and diabetes (Das-Munshi et al., 2019). There are mixed findings on the prevalence of depression amongst minority ethnic groups in the UK. Higher reports of depression are evident in studies such as one conducted by Williams et al. (2015) that found that older first-generation Black Caribbean migrants were twice as likely to report depressive symptoms. On the contrary, reports of lower rates of depression may be attributed to biased diagnostic tools, the healthy migrant effect or reduced help-seeking patterns for depressive symptoms (Papadopoulos et al., 2004).

The persistent patterns of mental health problems among minority ethnic communities in the UK, particularly those involving Black African and Caribbean populations, highlight deep-seated structural inequalities and systemic racism. The higher prevalence of mental health disorders such as dementia, schizophrenia, and depression among these populations can be

attributed to the cumulative effects of historical and contemporary racial injustices. The intersection of their social identities, such as race, socioeconomic status, and migration status, compounds the vulnerability of these populations. Stigmatising attitudes such as those highlighted by Berwald et al. (2016) reflect internalised racism and cultural misconceptions stemming from systemic exclusion and lack of culturally sensitive health education. Although research has sought to explore the perceptions, attitudes and beliefs that ethnic minority groups hold for mental health issues there is still a need to situate these in the context of racialised institutions.

2.7.2 Risk factors of mental health problems amongst migrant populations

Migration has been identified as one of the leading social determinants of mental health, especially in cases of marginalisation, discrimination, and pre-migration stressor events (Carta et al., 2005, Castañeda et al., 2015). There are numerous risk factors for the most common mental disorders among migrants, which may be due to an interplay of biological, psychological and social factors (Bhugra et al., 2011). However, it becomes more difficult to identify specific causes of mental health because of the complex process of migration and its consequences. Bhugra (2004) distinguishes four stages of migration: premigration, initial stage, middle stage, and final stage. Throughout these stages, various stressors are risk factors for certain psychological disturbances, which will be briefly discussed.

Premigration stressors have been investigated extensively, particularly among asylum seekers and refugee groups (Silove et al., 1997). Increased risk of premigration stressors is often associated with asylum seekers and refugees because their reasons for migration are usually due to deprivation, persecution due to political affiliation, sexuality or religion. Notably, stressors caused by traumatic life events such as war, death, political unrest, poverty and difficult travel experiences to the UK may trigger psychological reactions which affect the quality of life (Brijnath et al., 2020, Warfa et al., 2006, Jannesari et al., 2020, Fernando, 2010). Though economic migrants are said to be voluntary travellers and less likely to suffer from post-traumatic disorders, reasons to migrate from low-income countries are often involuntary and might also be associated with premigration stressors.

Stressors experienced during all the stages of migration are often related to adjustment and discrimination issues. Worries about home country situations and family left behind the differences in expectations and reality of their new life, discrimination, racism and lack of employment. Long-term migration stressors could be related to isolation and overall social

defeat in their new surroundings (Schouler-Ocak et al., 2020). The label of being a migrant has stressors that extend through generations and decades of settlement. One such case can be seen in the Windrush scandal (see section 2.5). Closely related to stress related to migration is the *acculturation stress hypothesis*, which is defined as the relation between acculturation, stress and health. According to Berry (1997), an interplay of socio-political, demographic, attitudes and social support of the host country and individual factors all influence the outcomes of acculturation (covered in section 2.4). Acculturative stress occurs when the individual feels that the acculturation process is undesirable, unpredictable, or uncontrollable. Therefore, like any other form of stress, a prolonged period of feeling stressed and the lack of mitigating efforts can result in the development of clinical symptoms of somatisation, anxiety, depression, social dysfunction and delinquency (Elgorriaga et al., 2019).

Additionally, several studies suggest that as a result of individuals living in areas of high density of ethnic minority groups, their risk of tobacco use, alcohol consumption, suicide and self-harm are lowered (Termorshuizen et al., 2015, Mathur et al., 2017). The link between psychological well-being and social isolation has been proven for decades, supporting the fundamental human need for positive interpersonal relationships. However, the possibility that social networks, ethnic density and community involvement may play a positive role in curbing unnatural deaths associated with mental ill health needs further investigation. The findings of this relationship may be beneficial in fostering prevention efforts for other minority groups in the UK. Research on social relationships shows that social capital in social trust, reciprocity, and civic participation are linked to higher levels of self-defined mental health and overall health (Poortinga, 2012, Marinucci and Riva, 2020). These social relationships are also said to buffer the negative impacts of discrimination or social exclusion in new environments.

It is essential to acknowledge that the term ‘African migrant population’ encompasses a diverse and heterogeneous group, with variations in language, culture, religion, historical experiences, and health beliefs. Within countries most represented in the African migrant population in Scotland namely Zimbabwe, South Africa, and Nigeria. Each of these countries carries distinct historical and socio-political contexts that significantly influence the cultural understanding, stigma, and prevalence of mental illness.

Zimbabwe experienced one of the biggest economic collapses in Sub-Saharan Africa which contributed to decades of political and economic instability, coupled with high levels of poverty and forced migration. Undoubtedly this has contributed to elevated rates of psychological

distress, with depression and anxiety being prevalent but often unacknowledged due to stigma and limited access to mental health services (Asante, 2013, Ndakaripa, 2021, Tevera and Zinyama, 2002). Although the economic collapse was gradual, the year 2003 witnessed more than a quarter of the 11 million population displaced as migrants all over the world (Clemens and Moss, 2005). Many Zimbabwean migrants experienced xenophobia, poverty, discrimination and unemployment, with asylum seekers experiencing the worst treatment. The combination of the continued psychological stressors throughout the process of migration significantly affected the mental health outcomes of Zimbabwean migrants (Idemudia et al., 2013).

South Africa, bearing the enduring legacy of apartheid, continues to grapple with the psychological consequences of structural violence, deep-seated inequality, and intergenerational trauma. The apartheid regime systematically disenfranchised the majority Black population, enforcing spatial, educational, and economic segregation that persists in many forms today. These historical injustices have laid the groundwork for entrenched structural risk factors that continue to shape mental health outcomes, particularly among communities that remain economically and socially marginalised (Kim et al., 2023, Knight, 2019). Studies have consistently shown that exposure to community violence, gender-based violence, and systemic poverty are significant risk factors contributing to high rates of post-traumatic stress disorder (PTSD), depression, anxiety, and substance misuse (Foell et al., 2021, North et al., 2020, Stansfeld et al., 2017). Further compounding these risks is economic insecurity, with many South Africans facing high unemployment, poor housing conditions, food insecurity, and limited access to quality education and healthcare. These factors not only increase vulnerability to mental illness but also act as barriers to seeking help or receiving appropriate care.

Nigeria, the most populous country in Africa, has a rich cultural heritage but is also deeply affected by political instability, economic inequality, and the legacy of conflict, all of which contribute to significant mental health challenges. The socio-political context of Nigeria marked by prolonged exposure to military rule, civil war (the Biafran War), and the ongoing Boko Haram insurgency has created a landscape where violence, displacement, and fear are pervasive elements of daily life (Kuznar, 2019, Dauda and Oyeleke, 2021). Nigeria has one of the highest levels of internal displacement in Africa, with millions of people living in refugee-like conditions due to ongoing insurgency, ethnic conflict, and political instability. This trauma

exposure, particularly in the northern regions of the country, has led to high rates of post-traumatic stress disorder (PTSD), depression, and anxiety (Jegede et al., 2024).

Beyond the direct effects of conflict, systemic poverty is another significant risk factor for mental illness in Nigeria. Despite being one of the largest economies in Africa, Nigeria is plagued by widespread poverty, inequality, and unemployment, especially among youth. Limited access to education, healthcare, and basic services means that a large portion of the population, particularly those in rural and underdeveloped areas, face chronic stressors that increase vulnerability to mental health issues. Poverty-related stress including food insecurity, inadequate housing, and lack of access to sanitation, exacerbates existing mental health challenges and creates new ones, such as substance abuse and self-harm (Jidong et al., 2024).

These socio-political and cultural contexts have long-term health implications for individuals who have migrated from these regions. Research across global contexts indicates a strong link between exposure to trauma and violence and chronic physical conditions such as cardiovascular disease, hypertension, and diabetes, alongside mental health issues like depression, PTSD, and somatic symptoms. For African migrants, these vulnerabilities may be compounded by the stress of resettlement, racialised healthcare experiences, and limited access to culturally safe services in Scotland.

Therefore, migration stands as a crucial social determinant of mental health, significantly influenced by factors such as marginalisation, discrimination, and pre-migration stressors. While research has explored the pre and post-migratory experiences and mental health, there is still a lack of research on specific groups such as African migrants in Scotland.

2.7.3 Attitudes, beliefs and knowledge of mental health

The World Health Organization (WHO) defines mental health as: “a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his or her community” (WHO, 2005, p.10) . While this definition has been widely accepted, some authors argue that it associates the absence of mental illness with having positive feelings, which is not always the case. This limitation becomes more apparent when considered alongside the biomedical model of mental health, which has dominated global mental health approaches. The biomedical model positions mental distress primarily as a biochemical imbalance or neurological dysfunction, often treated through clinical diagnosis and pharmaceutical intervention. This paradigm has

been historically exported to the Global South through colonial and neo-colonial institutions, with little regard for the cultural and contextual factors influencing mental well-being.

During colonial rule, psychiatric institutions were frequently used as tools of social control, pathologising indigenous populations who resisted colonial authority (Fernando, 2017a, Hickling and Hickling, 2021). European psychiatric classifications were imposed without recognition of local cultural understandings of distress, reinforcing the dominance of Western epistemologies in defining what constitutes "normal" and "abnormal" behaviour. Post-colonial scholars argue that this dominance continues today through the globalisation of mental health initiatives, which often promote Western psychiatric models as universal while disregarding indigenous healing practices and community-based approaches (Bhugra et al., 2021). Critics highlight that such frameworks tend to medicalise social suffering, ignoring structural inequalities, historical trauma, and the socio-political roots of mental distress.

Within the psy-disciplines, critical psychologists and psychiatrists have challenged the biomedical model for its reductionism and failure to account for the complex socio-cultural dimensions of mental health. The anti-psychiatry movement, led by figures like Frantz Fanon, Thomas Szasz and R.D. Laing, questioned the legitimacy of psychiatric diagnoses, arguing that they often serve as mechanisms of social control rather than objective scientific classifications (Domaradzki, 2021, Szasz, 2007, Quinn, 2017). Fanon powerfully illustrated how psychiatry functioned as a tool of colonial domination, dehumanising colonised subjects and pathologising resistance. In The Wretched of the Earth (1963), Fanon argued that colonial violence engendered profound psychological trauma, but also that Western psychiatry could not adequately understand or heal that trauma because it ignored the structural and racialised violence at its core. His work remains vital for understanding how mental health systems often reproduce racial hierarchies and suppress difference, rather than promote genuine healing (Fanon et al., 1963, Quinn, 2017).

Building on this anti-psychiatry lineage, Lisa Cosgrove and colleagues have offered contemporary critiques of psychiatric institutional power, particularly in relation to the medicalisation of distress and the influence of the pharmaceutical industry (Cosgrove and Wheeler, 2013). Central to Cosgrove's work is a detailed examination of the medicalisation of human distress, wherein ordinary experiences of suffering, trauma, and social adversity are increasingly framed as individual pathologies requiring psychiatric diagnosis and pharmaceutical intervention (Whitaker and Cosgrove, 2015). She challenges the assumption

that diagnostic systems, particularly the DSM (Diagnostic and Statistical Manual of Mental Disorders), represent objective, value-neutral classifications. Instead, Cosgrove argues that they are deeply shaped by industry interests, especially those of pharmaceutical companies, which exert significant influence over the construction and expansion of diagnostic categories (Cosgrove et al., 2006).

Critically, Cosgrove's work exposes how this institutionalised framework privileges biomedical narratives while marginalising psychosocial, cultural, and structural understandings of mental health. It problematises the dominance of pharmacocentric models that fail to address the root causes of mental distress, such as poverty, racism, gender-based violence and social isolation (Cosgrove and Shaughnessy, 2020, Whitaker and Cosgrove, 2015). In doing so, her analysis aligns with broader calls from critical psychiatry, mad studies, and disability justice movements for epistemic justice that is, the recognition and inclusion of alternative ways of knowing and experiencing mental health. These critiques demand not only greater transparency and accountability in psychiatric governance but also a radical reimagining of mental health care that is not driven by profit motives but grounded in community, relationality, and social equity.

Similarly Mad Studies in particular, challenge dominant biomedical and individualised understandings of mental distress, instead foregrounding lived experience, collective resistance, and the social and political dimensions of psychiatric oppression (Gersitz, 2024). Disability studies similarly critique normative assumptions around mental functioning, instead emphasising how ableism intersects with race, class, and gender to shape who is pathologised, how, and to what end (Hall, 2019). These frameworks offer vital tools for interrogating how systems of power operate within mental health discourse and practice not only in terms of access to services, but in defining what counts as illness, wellness, or recovery. This perspective reveals how psychiatric and psychological categories often reflect dominant norms about productivity, rationality, and emotional expression, which marginalise those who do not or cannot conform. Within this framework, ableism is not only a form of exclusion but also a means by which society regulates bodies and minds, reinforcing existing hierarchies of power.

Crucially, disability studies foreground the ways in which ableism intersects with race, class, gender, and coloniality to shape who is labelled as disordered or deficient, how they are treated, and whose voices are legitimised in clinical and policy spaces. For instance, racialised

individuals are often disproportionately subjected to coercive mental health interventions, while those from working-class backgrounds may be pathologised for behaviours shaped by socioeconomic precarity rather than illness. Such dynamics emphasise that the processes of diagnosis and treatment are not merely scientific or therapeutic, but deeply political.

These theoretical interventions are especially valuable for analysing how mental health systems institutionalise power, not only in terms of access to services but in shaping the very definitions of illness, wellness, and recovery. What counts as a mental disorder, who is seen as credible, and what forms of support are deemed legitimate are all shaped by underlying social, cultural, and political ideologies. Together, these perspectives expose the limitations of mainstream mental health models that treat mental illness as an individual biomedical dysfunction, and call instead for approaches that foreground social justice, power, and lived experience. They also raise pressing questions about how marginalised communities, particularly those affected by racialisation, migration, or economic precarity are constructed within mental health discourse, often through frameworks that obscure rather than illuminate the roots of their suffering.

Galderisi et al. (2015) offered a definition of mental health that realistically conceptualises mental health that reflects the positive and negative feelings experienced by people in their day-to-day lives.

> *"Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognise, express and modulate one's own emotions, as well as empathise with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium."*

This concept also incorporates and acknowledges the reality that mentally healthy people may experience appropriate human emotions, including fear, anger, sadness, and grief, whilst possessing sufficient resilience to restore the dynamic state of internal equilibrium (Galderisi et al., 2015). Moreover, mental health is a socially constructed concept, which means that different groups, cultures and societies have their way of understanding what mental health means and what to do when mental ill health occurs (Amuyunzu-Nyamongo, 2013). Therefore, it is unsurprising that an individual's or group's health beliefs are one of the primary barriers to help-seeking behaviour, early diagnosis and treatment (Byrow et al., 2020).

Health beliefs are a fundamental concept in health psychology, encompassing the attitudes, values, and perceptions that individuals hold regarding their health, the causes of illness, and the behaviours or actions they believe will lead to positive health outcomes (Conner and Norman, 2005). An individual's socio-cultural perspective is influential in the way they perceive health. Moving away from a universal perspective, understanding one's health beliefs considers the context in which specific health phenomena occur. This alternative perspective is known as the cultural relativist approach. According to Baghramian and Coliva (2019) and Corin (2017), cultural relativism emphasises that health phenomena cannot be fully understood without considering the cultural background and societal norms that shape an individual's beliefs and practices regarding health and illness. This approach recognises that what is considered a health issue, its causes, and appropriate treatments can vary significantly across different cultures. It challenges the biomedical model's dominance by highlighting the importance of traditional healing practices, cultural definitions of health, and the impact of social and cultural factors on health behaviours (Corin, 2017). Understanding these diverse health perspectives is essential for providing culturally competent care and developing effective health interventions tailored to the needs of different cultural groups.

Cultural influence on attitudes, beliefs and knowledge of mental health

Dating back to the pre-colonization era, many of the health problems in Africa were approached in a cultural context, and this included mental ill-health. The lack of substantial literature prior to Western medicine does not allow research to examine the earlier beliefs and treatments for mental illness. Much like other countries and regions, African countries have their constructions of mental health and illness (McCann et al., 2018, Amuyunzu-Nyamongo, 2013). However, cultural beliefs and practices are carried on through generations and change over time (Akyeampong et al., 2015). In more recent history, the overwhelming burden of infectious diseases in SSA (Correction Naghavi et al., 2015) leaves little to no health promotion efforts on non-communicable diseases such as mental disorders (Akyeampong et al., 2015). This leads most communities to understand and perceive mental health in a more familiar way. For some migrants, this is compounded by the fact that there are glaring differences between mental healthcare in low to middle-income countries (LMICs) and high-income countries (HICs). Taking into consideration that Westernised notions of mental health have little to no regard for multicultural lenses of approaching mental health, an individual's cultural understanding of

mental health might be vastly different than that of their new surroundings post-migration (Fernando, 2010).

Some common attitudes towards common disorders are still largely stigmatising, misunderstood and taboo amongst African communities (Amuyunzu-Nyamongo, 2013). Common causes of illness are attributed to spiritual forces, such as bewitchment, perceived wrongdoing, drug usage or demon possession. Some nonpsychotic symptoms may be perceived as being too worrisome or forgetful (Akyeampong et al., 2015, Berwald et al., 2016). Very few research results studies cite genetics, family relationships or socio-economic as possible risk factors named by participants in qualitative research on mental health. Further stigma on a social level affects not only the individual but also the family, who fears discrimination and ostracism from the community. This could lead to hiding mentally ill family members or not providing adequate care for the individual (Amuyunzu-Nyamongo, 2013).

Faith and spirituality as an influence on attitudes, beliefs and knowledge of mental health

Many African communities rely on religion and spirituality in many aspects of their lives. It is common for mental illness to be attributed to one being 'possessed' by evil spirits or as a punishment from God. In addition to modern-day mainstream religious practices, most Africans rely on spirituality in their daily lives (Kpanake, 2018, Onyigbuo et al., 2019). Human life is believed to go beyond the mortal body and extend to spiritual entities that protect and guide a person daily. These forces include God, ancestors, divinities and spirits (Kpanake, 2018). Faith also plays a vital role in shaping the health and care of many people (Tomalin et al., 2019). There is significant evidence of the role of faith leaders and communities in ethnic minority group's well-being. A study conducted by Wolf et al. (2016) explored the perceptions of Somali immigrants on mental illness. Symptoms such as screaming, hallucinations, erratic behaviour, or speaking in unknown voices are attributed to such possession. The community often turns to special religious healers who recite verses from the Quran and perform physical actions to expel the evil entity. If religious interventions fail, individuals are then encouraged to seek medical assistance (Wolf et al., 2016).

The role of faith and spirituality is not common in all ages of African communities, especially in migrant communities. For older adults, who may have been raised with strong religious values, faith and spirituality continue to shape their worldview and healthcare preferences

(Malone and Dadswell, 2018). Although young people are found to drift away from faith and spirituality, declining affiliation can create tensions and challenges in navigating the intersection of faith, spirituality, and healthcare (Shen, 2019). This indicates a strong need for research and healthcare providers to be cognizant of the diversity within African communities and avoid stereotyping while also recognising the profound influence religion and spirituality can have on health outcomes and patient experiences. Health practitioners working with African communities must know these spiritual dimensions and collaborate with faith leaders to provide holistic care that respects cultural values and practices. This is highlighted by several studies (Olivier et al., 2015, Levin, 2016, Codjoe et al., 2021) as being an approach that can improve the effectiveness of health interventions and ensure they are more acceptable to communities, thereby enhancing overall health outcomes.

2.7.4 Stigma and mental health

The concept of *stigma* can be traced back to before the nineteenth century when its Greek origins meant *to mark* or *to tattoo.* This mark may have been used for decorative purposes, but was often used to brand enslaved people and others as a signal of shame. Goffman defined stigma as a term that has meaning much like its literal Greek phrase, but is more about the disgrace the mark brings rather than the bodily evidence of it (Goffman, 1963). In other words, stigmatisation first identifies a characteristic deemed deviant to acceptable social norms; then, it perpetuates the devaluation of that individual or group (Arboleda-Florez, 2002). Though several authors wrote papers and books on stigma before Goffman, most had not explicitly defined the concept the way he did (Gaebel et al., 2016). Goffman not only defined the concept, but postulated the different types of stigma, how an individual copes with stigma and how the stigma affects the individuals associated to the stigmatised person. He argued that society has expectations of how people should look, behave, and live, and when they show any deviations from the norm, they are reduced or tainted individuals (Goffman, 1963). The assigning of these undesirable attributes results in a virtual social identity, whereas the person's actual social identity simply comprises a different reality to society's norms. He states that there are deviances that can be accepted and understood, but there are also ones that are not accepted, which results in stigmatisation (Goffman, 1963, Finzen, 2017). Erving Goffman's writings on stigma have provided the most common references in stigma and mental health.

Stigma is not just limited to mental health; Goffman discussed stigma as existing in tribal identities (race, ethnicities), physical abnormalities, and blemishes of individual character

(mental illness, addiction) (Goffman, 1963). The socio-cognitive model has contributed significantly to understanding stigma and mental health, which is relevant to this study. According to the socio-cognitive model, stereotypes, prejudice, and discrimination are all parts of stigma development. Sheehan et al. (2017) proposes a matrix for understanding stigma of mental illness which breaks it down to public stigma, self-stigma, label avoidance and structural stigma. This matrix relates to Goffman's theories on virtual social identities, which are driven by stereotypes, prejudice and discrimination. Simply defined, a stereotype is a generalised belief about the characteristics of a group and attributing those characteristics based on the individual's membership to the group (Finkel and Baumeister, 2019). *Prejudice,* conversely, is defined as dislike towards an individual or a group because of a generalisation of the attributes of that group or individual, which endorses the stereotype (Allport, 1954). Lastly, *discrimination* is defined as the differential treatment of an individual or group based on affiliation, often motivated by prejudice (Finkel and Baumeister, 2019).

There are several types of stigma that exist, but this section will focus on the six types most closely related to mental illness stigmatisation. These are public stigma, self-stigma, label avoidance, structural stigma, courtesy stigma and double stigma (Sheehan et al., 2017). Public stigma exists in multifaceted layers in an individual's life, with public prejudice and discrimination against the person or group. Well-informed individuals such as health professionals may also unknowingly perpetuate stigma through their language use, amongst other actions (Corrigan and Watson, 2002b). Self-stigma occurs when the individual internalises the misconceptions of their mental illness and believes they are less valuable as a result (Corrigan and Watson, 2002a). Label avoidance refers to individuals' decision to evade the stigmatic label due to public or self-stigma. Label avoidance is also one of the leading reasons for non-engagement with healthcare services because of individuals' desire to hide their illness from others (Sheehan et al., 2017). Structural stigma occurs when public and private institutions' policies restrict certain groups from opportunities based on their attributes. This may occur intentionally or unintentionally and manifest in employment, education, voting rights, or even holding public office (Sheehan et al., 2017). Courtesy or associative stigma refers to the stigma experienced by individuals close to the stigmatised individual or group. This includes friends, family, employers and service providers (Goffman, 1963, Sheehan et al., 2017). Lastly, double stigma occurs when someone may belong to or identify with more than one socially disadvantaged group, resulting in stigma from their multiple identities. According

to Sheehan et al. (2017), approximately half of all individuals with severe mental illness report discrimination arising from more than one of their attributes, such as ethnic or sexual minority status, substance abuse issues or physical disability, amongst others. This would mainly be true for migrants with mental ill-health, who might experience the double stigma because of their migration status.

Research on mental ill-health amongst African migrants has frequently explored stigma as a recurring theme amongst help-seeking barriers, with one of the most significant factors affecting timely help-seeking, diagnosis, and treatment being stigma (Clement et al., 2015, Mantovani et al., 2017, Nickerson et al., 2020, McCann et al., 2016). These perceptions of mental disorders are often culturally shaped, which influences how they are dealt with (Grupp et al., 2019). Understanding and addressing these cultural factors and stigma is crucial for research and practices.

2.7.5 Migrant engagement with mental health services

Socio-cultural factors impacting healthcare engagement

Western psychiatry and psychology have tended to be rooted in a Eurocentric approach to mental ill health, grounded in the racist and discriminatory notions that non-white people were barbaric and lacked psychological development (Fernando, 2010, Allen and Sharples, 2017). This is evident in the proven ethnically based prejudice and discrimination existing in mental healthcare to this day (Mantovani et al., 2017). Though discrimination and racism in mental healthcare have been overt in other countries, such as the US, it has been institutionalised in cultural and socio-economic exclusion in healthcare in the UK (Adams et al., 2014). This results in disproportionately higher diagnoses of psychotic disorders and poor social and health indicators amongst African groups in the UK. Compounded by the reported lack of mental health awareness in ethnic minorities, stigma, restricted legal entitlements to services, unfamiliarity with rights, administrative obstacles, language barriers, mistrust and direct and indirect discrimination, and poorer experiences and outcomes (Macioce, 2019), this leads to lower rates of engagement with healthcare services. As a result, there are higher rates of unattended mental health needs and poorer prognosis in minority groups as compared to other majority groups in the UK (Afuwape et al., 2010, Rechel et al., 2013, Macioce, 2019). Consequently there is an over-representation of African and Caribbean groups in in-patient psychiatric services and forced detention under the Mental Health Act (Mantovani et al., 2017).

The mental healthcare services in the National Health Service (NHS) are accessed through primary care, via general practitioners and nurses. In some cases, accident and emergency departments, social and housing agencies, the police, prisons and the courts are also possible referral points (Morgan et al., 2004, National Health Service, 2022). Thereafter, using the standards of diagnosis from the International Classification of Diseases (ICD), secondary care can diagnose an individual, if necessary (Fernando, 2010). The majority of contact with mental health services is accessed voluntarily. However, the Mental Health Act allows for compulsory detention in hospitals for people who pose a threat to themselves or others (Barnett et al., 2019). Primary care practitioners are responsible for assessing and treating common mental problems; referrals are made to specialist services if necessary. Though referrals to mental health services are available for all that need it, this does not always translate to equal access to that care. This is especially evident in research that asserts that ethnic minorities are less likely to access mental health services, more likely to experience difficulties accessing high-quality primary care, have higher rates of dropout from services, and are less satisfied with professional mental health services (Kovandžić et al., 2012, Maura and de Mamani, 2017, Carpenter-Song et al., 2011, Dobalian and Rivers, 2008, Olfson et al., 2009). Similarly, African migrants in the UK are often met with several barriers affecting engagement, such as the lack of knowledge on healthcare entitlements, lack of cultural sensitivity in mental healthcare and language barriers (Devonport et al., 2023, Barnett et al., 2019, Close et al., 2016, Mantovani et al., 2017) which will be discussed.

Cultural sensitivity in mental healthcare

There is a strong need for transcultural mental healthcare for minority ethnic groups in the UK, as concepts of normality and abnormality differ between communities (Allen and Sharples, 2017). Loewenthal et al. (2012) and other authors have found that the lack of cultural understanding shown by mental health professionals has a significant impact on the service users' experience with the system (Fernando, 2010). This includes professionals' intentional and unintentional attitudes towards minority groups, whether negative or neutral, which have a lasting impact on an individual's attitude towards primary care. This has been proven in research on culture-bound syndromes, defined as disorders or illnesses unique to a particular culture. Culture-bound syndromes have symptoms and changes in behaviour, which are accompanied by the treatment for those symptoms, which may be seen as different amongst other cultures (Aina and Morakinyo, 2011, Ventriglio et al., 2016). Though Western ideas of

mental health may be seen as the standardised way of categorising disorders, they, too, are culturally bound in themselves. For example, eating disorders, such as anorexia nervosa, have been considered as Western or European culture-bound syndromes and may be regarded as different to other cultures. The perception of thinness being equated to beauty is a reason for these eating disorders, historically based on Western ideology and cultural expectations of beauty (Allen and Sharples, 2017). Amongst the Southern African Nguni tribes, 'ufufunyana' is a syndrome described as a hysterical condition characterised by individuals speaking in a strange voice that cannot be understood whilst displaying unpredictable behaviour. These symptoms are seen as self-contained and usually last hours to days. However, this condition is often incorrectly diagnosed as schizophrenia (Ngubane et al., 2024, Keikelame and Swartz, 2016) Though an argument can be made that culture-bound syndromes hold little relevance in the present times of globalisation and interconnectedness, culture still has a notable impact on the meaning-making of mental health and how it is treated (Ventriglio et al., 2016).

Another aspect to consider in relation to cultural sensitivity in mental healthcare is the suitability of mental health services. The suitability of mental health services is among the most significant factors impacting service engagement for minority ethnic groups (Bhattacharyya and Benbow, 2013). Evidence suggests that suitable services should include access to specialised psychological care that utilises assessments and treatment programmes that are culturally competent (George, 2015). This extends beyond language translations and interpreting services, but also includes understanding beliefs associated with life, death, health and the expected clinical relationship (Macioce, 2019). The categorisation of communities and ethnicity in the UK also poses a challenge in identifying nuanced cultural, religious, and linguistic differences in various communities (Loewenthal et al., 2012). For example, the South Asian community is categorised into individuals from India, Pakistan, Bangladesh, and Sri Lanka, all with unique linguistic, cultural, and religious characteristics. Likewise, the "Black/African/Caribbean categorisation encompasses Black people from all fifty-four African countries and the Caribbean region, which are very different historically and culturally (Aspinall, 2011). Though the NHS has made provisions and funded third-sector organisations for culturally specific services, there is still a question on the appropriateness of these provisions. Salway et al. (2016) and Saunders et al. (2020) further state that whilst the effort on healthcare equality in the UK is apparent, there is still a poor execution in mental health and maternity care particularly. There also seems to be a disconnect between the nationwide

policies and the local ethnocultural implementations. One of the most apparent reasons is that the foundation of these provisions is not driven by the minority ethnic groups that they are designed for. These provisions are pointless without the prominent role of these groups in decision-making in policy forming and implementation (Macioce, 2019).

Closely linked to cultural barriers are the linguistic barriers some service users encounter in mental healthcare. Good healthcare provision largely depends on communication between the healthcare professional and the service user. Particularly where somatic symptoms are not present, the verbal communication of symptoms and indications is the basis of help-seeking and diagnosis of mental illness (Giacco et al., 2014, Priebe et al., 2016). Language barriers were found to be the significant barrier to assessing symptoms and establishing diagnosis and rapport with migrant patients, according to a study conducted in sixteen major European cities (Sandhu et al., 2013). Linguistic barriers affect not only diagnosis and symptom communication but also therapeutic treatments. In a study in Denmark, general practitioners reported reluctance in referring migrants to psychotherapeutic therapies because of the lack of bilingual therapists (Giacco et al., 2014). Likewise, migrant preference for bilingual therapists is often not addressed, which results in low engagement (Kaltman et al., 2014). A study conducted by Ochieng (2013) explored barriers to accessing and utilising health promotion services experienced by Black African migrants in the UK. Findings showed that the inability to communicate was the most significant barrier to seeking health promotion advice. Proficiency in English and the lack of adequate translated services are profound barriers as they also affect preventative help-seeking behaviours. The inability to communicate health concerns adequately, ask questions and fully understand health workers' advice further perpetuates the low engagement and mistrust in services.

The UK has been described as a super diverse country, which according to Pemberton et al. (2019) creates a melting pot of new migrants from different cultural backgrounds, which pose new challenges to service provision for the NHS in the context of an already overstretched system. This may mean some of the newly arrived migrants may not be able to navigate the healthcare system and healthcare providers who are not adequately equipped to deal with migrants' health concerns. Furthermore, the nature of a super diverse community influences individuals' identities and may introduce other forms of healthcare provision that seem more readily available. In the UK, where there is a diversity of minority ethnic populations, it might be challenging to curate culture-specific services for each group (Bhui and Sashidharan, 2003).

There are two particular weaknesses to the engagement with services: one is the poor detection and treatment of disorders, and the second is the aversive experiences of mental healthcare by ethnic minority people (Afuwape et al., 2010, Mantovani et al., 2017, Yorke et al., 2016). The poor detection and treatment of mental health disorders among African migrants can be attributed to several factors. Healthcare providers may lack cultural competence, leading to misdiagnosis or underdiagnosis of mental health conditions. Furthermore, language barriers and a lack of culturally appropriate services contribute to the ineffective treatment of mental disorders in this population (Ali et al., 2017). Aversive experiences with mental healthcare services also discourage engagement. Ethnic minority individuals often report experiences of discrimination, cultural insensitivity, and a lack of understanding from healthcare providers. These negative encounters foster distrust and apprehension toward Western mental healthcare systems (Henderson et al., 2015, Mantovani et al., 2017, Prajapati and Liebling, 2021). Consequently, many African migrants turn to traditional medicines and religious practices, which they find more respectful and congruent with their cultural values. These methods include herbal remedies, spiritual healing, and consultation with traditional healers who are perceived as more empathetic and understanding of their cultural background (Akyeampong et al., 2015).

Cultural sensitivity in mental healthcare is crucial in the UK due to the nation's diverse population, which includes a wide range of ethnicities, religions, and cultural backgrounds. This diversity necessitates an intersectional approach to mental health care that acknowledges the complex interplay between various identity factors, such as race, gender, socioeconomic status, and immigration status, which all contribute to an individual's mental health experience. This means understanding that the experiences and needs of individuals cannot be fully comprehended through a colour-blind lens but rather through an integrated perspective that accounts for their multifaceted identities. Cultural sensitivity can significantly impact the effectiveness of mental health services. When healthcare providers are culturally competent, they are better equipped to build trust with patients from diverse backgrounds, leading to more accurate diagnoses and effective treatment plans (Linney et al., 2020). Moreover, integrating an intersectional approach ensures that mental health care addresses the broader context of patients' lives. This can help create a more inclusive mental health care system that is responsive to the diverse needs of the UK's population, ultimately improving mental health outcomes and equity in care access and quality.

Conclusion

This chapter has reviewed the existing evidence on migrant experiences of immigration and the factors impacting their mental health and engagement. While numerous studies have investigated migrant healthcare engagement for various health-related issues in Scotland, there is a notable lack of recent research specifically focusing on the provision and engagement of migrants with mental health support. Several studies have examined health experiences among African populations in England, often extending their findings to the rest of the UK. However, a significant gap remains in the literature concerning African migrants in Scotland. The literature review indicates that migrant groups face numerous obstacles from pre-migration to post-migration conditions, exacerbated by the adjustment process in the UK. These challenges adversely affect their mental health and engagement with healthcare services due to various factors.

Moreover, structural barriers further complicate this adjustment process and make engagement significantly more challenging for migrants than for the majority population. As African migration to the UK continues to rise, a clear need exists to explore and understand the factors influencing mental healthcare service engagement in Scotland. Understanding the experiences and perspectives of African migrants can contribute to developing more appropriate and effective mental health services tailored to their specific needs.

Therefore focusing on these key gaps in mental health research in Scotland, this thesis has explored factors influencing mental health support amongst African migrants living in Scotland. This research has formulated the following research questions that are addressed in the following chapters:

1. What are African migrants' perceptions and experiences of mental health and healthcare in Scotland?
2. What factors influence help-seeking for mental health amongst African migrants?
3. How does immigration play a role in mental health behaviours and experiences?

The following chapter will build on this review by presenting the theoretical framework which has informed my approach to addressing these gaps. I will discuss the usefulness of analysing the dynamics of migration and mental health in relation to Bell's (1980) conceptualisation of the Critical Race Theory (CRT). By drawing from the tenets of CRT, I outline my research

approach to analyse African migrants' perceptions and experiences in relation to their dynamic social, cultural and structural conditions.

Chapter 3

Theoretical Framework

3.1 Overview

Help-seeking behaviours for self-diagnosed mental health problems have often been explored and understood using behavioural, cultural and social capital theories (Baskin et al., 2021). Though these play a significant role in understanding engagement with mental health support, a critical discourse analysis of the contextual factors that impact the lives of African migrants is required to understand the help-seeking among the African communities living in the Global North. In seeking to understand the undertones of structural factors, this research draws on ideas from Critical Race Theory (CRT) and Intersectionality as its tenet to explore the circumstances that contribute to the othering of African migrant communities and how that has an impact on engagement with mental health support. By using this framework, I explore how mental health and support are rooted in an intersection of racism and power dynamics embedded in lived experiences and policy.

This chapter begins with an overview of the CRT and its application in the UK. I then discuss the fundamental tenets that will be used in this thesis to situate mental health support engagement in the context that it exists, emphasising the power dynamics controlling the perspectives and experiences with self-diagnosed mental health issues. I then address some of the critiques of CRT and their implications in this study. In doing that, I explore how some key tenets of CRT will be used in this research.

3.2 Critical Race Theory

Critical race theory, developed initially in the 1970-1980s by legal scholars, sought to challenge the role of race and racism in the American legal system and the existing critical legal studies (West, 1995). The term was proposed 80 years after W.E.B. Du Bois discussed the issues of race and racism in his book “The Souls of Black Folk”. The main interest of the early Critical Race Theory was in how racism and racial injustice are constructed and represented not only in the legal culture but, more generally, in American culture as a whole (Treviño et al., 2008). Legal scholars further wanted to challenge the concepts of racism and discrimination as terms defined by white elites rather than the lived experiences of individuals and groups positioned on different levels (West, 1995, Graham et al., 2011). CRT differed from previous critical

studies as it centred the discussion on racialised power dynamics and aimed to implement change through activism. By using storytelling to challenge the narrative, the tenets of CRT provide an interpretive perspective of marginalised communities affected by their position in society as defined by their race, sexuality, gender, class or an intersection of these (Graham et al., 2011). Through activism, CRT empowered communities to critique their lived experiences and change the narrative (Crenshaw, 1990, Graham et al., 2011). To carry out its goals, CRT has five main principles, some of which apply to this thesis: (1) ordinariness of racism, (2) interest convergence, (3) social construction of race, (4) intersectionality and anti-essentialism and (5) the unique voice of colour (Crenshaw, 1990, Bell Jr, 1980, Bell, 1992, Delgado and Stefancic, 2017). The influence of CRT has expanded to other disciplines, such as education and health, where the theory has been used to challenge and transform the relationship between race, racism and power.

Though CRT originated in the study of law, its approach to understanding mental health perspectives and experiences helps challenge the biases engrained in mental health policies and practices that would otherwise not be considered. It offers a nuanced perspective of the sociology of mental health by highlighting the role of social structures, power dynamics, and systemic racism in shaping individuals' experiences, including their mental health. This is particularly valuable in the study of mental health as it is often theorised as a function of internal, individual factors which ignore the racial stratification that exists in society. In Brown's(2003) articulation of CRT in mental health, he suggests that there are three approaches that a CRT researcher might take to investigate the meaning of race in relationship to mental health and mental health issues. 1) a study of the social conditions (e.g. poverty, unemployment, crime) or risk factors (e.g. perceived experiences of discrimination) associated with racial stratification that might be linked to poor mental health, 2) a critique of standard indicators of mental health status and the construction of psychiatric disorders and 3) an examination of unique manifestations of mental health problems produced by racial stratification. By looking at these three approaches to the sociology of mental health, CRT is grounded in the pursuit of interrogating systems with the aim of reducing mental health disparities and promoting health equity (Rogers and Pilgrim, 2021).

3.3 Critical Race Theory in the UK

Critical Race Theory has a much longer history in the US than in the UK. However, in the early 2000s, a significant group of anti-racist scholars and activists started to apply the concept of CRT in the sociology of Education (Warmington, 2020, Cole, 2009, Bhopal and Pitkin, 2020). Inequalities in primary and secondary schools in Britain have been examined through a CRT lens (Bansal et al., 2014). Using this framework to understand how racism has continued to be perpetuated through education systems and continues to disempower students in minority groups has opened discussions on how racism and discrimination have persisted through institutions (Bhopal and Pitkin, 2020, Ladson-Billings and Tate, 1995, Gillborn, 2015). Recent attention on racial inequalities in the UK have resulted in initiatives such as the Race Disparity Audit (2017), The Lammy Review (2017) and initiatives such as Decolonising the Curriculum (UUK/NUS 2019) and 'Why isn't my professor Black? (2017)' which has renewed focus on race in higher education. Although it is more than 14 years since the first international CRT seminar was held in England in 2006, CRT remains underutilised in research outside of education in the UK. Questioned for its applicability to the UK, CRT is challenged to provide a dimension that affirms its credentials in the UK academic context (Meghji, 2021).

Among some of these critiques, there seems to be a perception that there is something different about racial oppression in the US from other countries (Kaufman, 2005). However, numerous scholars such as Paul Warmington, Kevin Hylton, Nicola Rolock and Shirin Housee have demonstrated the wide-ranging differences and similarities in US and UK contexts, showing ways in which the theory can be and has been applied beyond the US. For example, Warmington(2020) has written on the comparative histories of race, racism and the differences and similarities between the US and the UK and how that positions CRT in the intellectual space. On the other hand, Kevin Hylton focuses on CRT methodology and its ontological positions in research as more than an application of theory or method but rather a political positioning that involves the researcher taking a stance for transformational work (Hylton, 2012). Other authors such as Gilborn, Rollock, Vincent and Ball demonstrate an intersectional approach to CRT that critiques the focus of UK educational policy on the white working class, which ignores the intersecting 'raced, classed and gendered inequalities that shape the experiences of too many parents and children'. For a while, examples of CRT in the UK were set in the context of education in the UK.

More recently, Meghji and Niang (2022) analysed the British government's handling of the first wave of the COVID-19 pandemic using CRT from a decolonial perspective. They analysed/reported on the disproportionate number of COVID-related deaths among minority groups in the UK and highlighted the role that structural racism plays in poor health outcomes. They reference earlier arguments by Phelan and Link (2015) and Laster Pirtle (2020), emphasising that the root cause of disease is intricately tied to socioeconomic status, with racial inequality closely linked to socioeconomic inequalities. Consequently, minority populations, found to be overrepresented in poor quality housing, unemployment, underemployment, and poverty, face heightened susceptibility to health disparities. In the context of COVID-19 in Britain, BAME groups were more disproportionately financially affected by the consequences of the lockdown. These inequalities were present prior to the pandemic which made this group unprepared to cope with the economic consequences they were exposed to. Meghji and Niang (2022) argue that CRT and decolonial thought should be used to highlight the role of structural racism in exacerbated health inequalities. The authors also highlight that health outcomes are often rationalised and the role of racial inequality is not considered. For example, the higher numbers of COVID-19 deaths in minority groups were explained by state institutions as a result of a biological disposition rather than a result of systemic racism (Meghji and Niang, 2022).

Systemic racism in health in the UK is often placed as a thing of the past where institutions highlight the racially equitable landscape that has been created through various policies. However, Meghji and Niang (2022) make an example by highlighting the statements in the report from Public Health England on the disproportionate COVID-19 BAME death rates. The report that the authors refer to emphasises the historical existence of racism in healthcare that impacts help-seeking behaviour. This report does not discuss current racial inequality that may exist, and this shifts the blame to some past occurrence, not considering the current racial environment. One of the statements says:

> *Historic racism and poorer experiences of healthcare or at work may mean that BAME individuals are less likely to seek care when needed or as NHS staff less likely to speak up when they have concerns about PPE or testing.* (2020a: 23).

Meghji's (2021) argument highlights the current realities where a Black woman died after medical professionals continuously dismissed the severity of their COVID-19 symptoms. Supporting the assertion of historical racism and ignoring the current racial tensions that Black

and ethnic minority people live under undermines their experiences and makes it harder to address issues with help-seeking behaviours adequately.

Notwithstanding, CRT continues to receive its fair share of critique in the public, scholarly and political spheres. In the UK, it has been condemned and labelled as a left-wing attempt to promote biased political views by some of the Conservative MPs and right-wing media (Trilling, 2020, Shand-Baptiste, 2020, Wood, 2020). The equalities minister for the UK government at the time, Kemi Badenoch, was also quoted in 2020 as saying, "We do not want teachers to teach their white pupils about white privilege and inherited racial guilt" (Trilling, 2020). This statement is an example of the political challenges facing the use of CRT, which reinforce one of the key CRT assertions that racism and discrimination are defined by the elites, who are predominantly white and not by the lived experience of minorities. Furthermore, asserting that CRT merely serves as a political instrument to bring discomfort among white students during discussions on race undermines the potential for genuine dialogue regarding racial injustices and hampers the progress toward resolution.

Expectedly, CRT continues to be seen as an unwelcome guest by some sociology scholars in the UK because it highlights the contradictions existing in post-imperial society. These contradictions are demonstrated by the political struggle to satisfy the white working class while heeding the capital's demands (Carby, 1982). Warmington (2020) suggests that to resolve the contradiction in interests, the idea of a 'national interest' and 'we're all-in-it-together' perspective on education, work and economy has been adopted. However, in this resolve, the place of ethnic minority groups has been unclear and shifted around to serve their interest. Consequently, the reluctance to accept CRT theory in the UK can be seen as a reflection of the national interest ideology and the need to control the anti-racism discourse (Meghji, 2021).

Despite the criticism that CRT has endured, I will outline how the concepts of CRT can facilitate a more nuanced understanding of African migrants' perceptions and experiences with mental health in Scotland. I will provide an overview of the following tenets: the ordinariness of racism, interest convergence and intersectionality.

The tenets of Critical Race Theory

The ordinariness of racism and the conceptualisation of racism is an essential step before detailing the complexity of its implications. Paradies (2006, p144) states that "Racism can be thought of as one of many types of oppression which, along with its dialectical opposite

privilege, can be based on a range of social characteristics including gender (sexism), sexuality (heterosexism), physical and mental able-ness (ableism), age (ageism), class (classism), nationality, body size/shape, criminality, religion, and language/accent among others". This definition Paradies (2006) brings forward the relationship between racism and oppression based on socially constructed identities in which we are categorised. The characteristics of these identities are often based on phenotypical differences and employed as a societal power tool to be deployed and retired when convenient (Warmington, 2020, Paradies, 2006). Whilst Paradies (2006) definition of racism is detailed, CRT emphasises that racism is an entirely social relationship that permeates the social and political formation of institutions in society, which goes beyond overt racial prejudice (Warmington, 2020).

Critical theorists argue that by reducing racism to overt racial violence and hatred, we ignore the structural and institutional oppression embedded in society (Warmington, 2020). This theory emphasises the permanence of racism and states that it is so 'ordinary' that its existence can be denied (Bell, 1992, Ford and Airhihenbuwa, 2010). This denial is carried out as a deliberate depiction of race-neutral institutions, rules and practices and the ideology of liberalism. For example, the idea of race-neutrality in healthcare has been evident, especially with regards to mental health in the UK's health system. Disproportionate rates of admission of Black African and Black Caribbean groups in mental health wards in the NHS have persisted through the years (Barnett et al., 2019, Bradby, 2010). Not only were these groups most likely to be admitted to hospital, but those in hospital were highly likely admitted involuntarily and would have the most extended stay (Barnett et al., 2019). Yet, the reasons for these disparities have not been addressed.

Factors such as socioeconomic disparities and institutional and overt racism are also known risk factors for poor mental health outcomes. Though high admission rates persist amongst Black people, this is not reflected in the diagnoses of severe mental illnesses (Bansal et al., 2014), which could account for the admissions. This means that Black people are first diagnosed during admission and not during their primary care visits before admission. Furthermore, the stark differences in the treatment of mental diseases in Black people show that they are less likely to be offered psychotherapy and more likely to receive drugs or be treated under coercion (Nazroo et al., 2020, McKenzie and Bhui, 2007, Qassem et al., 2015). Though these disparities have been documented numerous times and have often been attributed to socioeconomic disadvantages, there is a lack of attention drawn to the role of institutional

racism in the creation of these disadvantages and how they are managed (Nazroo et al., 2020, Fernando, 2017a, Barnett et al., 2019) This suggests that research on mental health disparities could benefit from using the CRT as a theoretical framework to understand and better address these disparities (Meghji and Niang, 2022).

Issues of the ordinariness of racism and colour-blindness resonate with the experiences of Black patients in healthcare. Research has shown that in general hospital settings, Black patients' pain is often underestimated and undertreated because of false beliefs that Black patients have higher pain tolerance (Sim et al., 2021). This leads to the mistrust of services and perpetuates poor health outcomes. Furthermore, research carried out on practitioners' constructions of minority groups in Europe has shown that these preconceived constructions have influenced their attitudes, beliefs and biases. Without adequate cultural competency training and interracial understanding, these preconceived constructions can hinder positive health outcomes (Dune et al., 2018, Sim et al., 2021). Through denouncing liberalism, CRT argues that such experiences, prejudices and biases are not addressed and, therefore, will not cease to exist simply because liberal policies are put in place. Instead, colour-blind policies are put in place to enforce a patient and carer Race Equality Framework without addressing the underlying systemic oppression existing in these communities (Sim et al., 2021).

Interest convergence is concerned with the issues faced by minority groups that are often unaddressed unless the changes in policy and practice benefit the white majority. CRT scholar Bell Jr (1980) brought forward the term 'interest convergence' to emphasise this point and stated that gains made in Black communities to improve on racial injustices were only possible because they served the interests of the whites. In his writing, he acknowledged that those in power do not gain from the eradication of racism because racism advances the interests of the white working class (Bell Jr, 1980). Any civil rights victory would not make a substantive difference in the lives of Black people because it has been done in a way that upholds the foundation of white privilege. This tenet of the CRT proposes that the best way to advance race relations or racial justice efforts is for joint gains rather than one-sided improvements (Graham et al., 2011). Bell Jr.'s pessimism regarding racial justice in the US was due to the fact he knew that although progress would be made by Black people when their interests converged with white people's interests, all that would be lost when interests diverged (Crossley, 2016, Bell Jr, 1980).

When it comes to the improvement of mental health outcomes for minority groups, CRT's tenet of interest convergence suggests that the promotion of mental health and wellbeing and prevention of mental illness would only occur if the interests of both groups converged. This has been a longstanding issue for developing programmes that advocate for minorities. Programmes aimed at minority groups are often poorly funded and lack leverage to influence mainstream services (Rai-Atkins, 2002, Baskin et al., 2021). In 2002, the death of a Black man, Michael Bennett, whilst being restrained during a mental health crisis, raised questions about the structural failure of the mental health system. The findings of an inquiry found that attitudes and practices amongst those delivering mental health services to minority groups needed a significant shift. One of the results was creating the national Delivering Race Equality (DRE) programme to employ several hundred community development workers to deliver more appropriate and accessible mental health services to minorities (Craig and Walker, 2012, Wilson, 2009). The core of the DRE was to work with and support communities, including BME voluntary and community sectors, to help build capacity within them and ensure that views of minority communities were taken into account by the statutory sector in the planning and delivery of services (Wilson, 2009, Truswell and Bryant-Jefferies, 2010). Though the programme was allocated funding and a plan of implementation was carried out, it ultimately did not achieve the objectives it had set out to (Craig and Walker, 2012). The main factors that contributed to its failure were the lack of employment of Community Development Workers (CDWs) to carry out the work in the communities and subsequent budget cuts. Underlying these two factors was the lack of engagement by some stakeholders, lack of ownership of the DRE agenda and lack of understanding of the CDW role and its potential benefits. There was also the perception that race and ethnicity were not a priority in some areas because the ethnic minority groups were relatively small and invisible (Craig and Walker, 2012).

The hurdles faced by the DRE programme certainly indicated some of the deep-rooted issues of institutional racism. It was evident that for some stakeholders, the interest in improving minority mental health services did not converge with the interests of the programme and communities involved. This example shows how CRT's tenets are applicable in interrogating systems in which institutional racism is embedded in mental health provision for ethnic minorities. Firstly, the DRE shortcomings in employing Community Development Workers (CDWs) and sustaining community involvement reflect broader issues of tokenism and performative inclusion, which CRT helps to identify and critique. Moreover, by acknowledging

that interests converge only when it serves dominant groups, CRT highlights how systemic racism perpetuates disparities in mental health care. It also encourages a deeper analysis of how institutionalised racism influences resource allocation, policy implementation, and service delivery, as evidenced by the underfunding and subsequent failure of programs like DRE.

Intersectionality's role in CRT was introduced through scholars recognising that the complexities of the lives of Black people involve multiple aspects of oppression that are layered in their racialised experiences. Through integrating intersection with CRT, scholars could better understand the role of gender, class, sexuality, disability and other dimensions of their social identity in their daily lives (Collins and Bilge, 2020). In this thesis, intersectionality was not used as a standalone theory. Still, as a tenet of CRT, although some tensions exist in using both theories, further, in this chapter, I argue the importance of intersectionality in this research (see section 3.5).

Black feminist and critical scholars introduced the concept of *intersectionality* to understand the complicated role of social categorisations such as race and gender in the experiences of African American women. Scholars were particularly interested in how the intersection of these categorisations conferred the systems of oppression and privilege. Kimberlé Crenshaw has been often cited as the author who introduced the term. However, intersectionality has a long history in Black feminist thought in the West (Hull et al., 1982). The need to distinguish the Black feminist way of thought stemmed from the call to understand and expose the intertwined systems of oppression unique to Black women that were prevalent in American society. It sheds light on the microlevel (horizontal) and macrolevel (vertical) processes of stratification that affect individuals at the multiple axes of social identities (Collins and Bilge, 2020). This emerged within the wave of the American civil rights movement and the second-wave feminist activism (Collective, 1983). Since its development, intersectionality has gained popularity as a qualitative analytic framework in sociology.

At its core, intersectionality recognises that individuals do not experience oppression or privilege solely based on one aspect of their identity but rather due to the complex interactions between multiple social identities. For example, a Black woman's experience of discrimination cannot be fully understood by examining race and gender separately, as she may face unique forms of marginalisation that arise from the intersection of her race and gender. Intersectionality challenges traditional approaches to understanding social inequality, which often focus on single dimensions of identity in isolation (Billups et al., 2022). Instead, it

emphasises the need to analyse how various social categories intersect and interact to produce different forms of privilege and disadvantage. This approach highlights the complexity of individuals' lived experiences and underscores the importance of considering multiple dimensions of identity in efforts to address social injustice (Collins and Bilge, 2020). The concept of intersectionality has some similarity to the concept of *structural vulnerability* which refers to the risks or disadvantages individuals face due to their social position in relation to broader systems of power, such as political, economic, and social institutions. These vulnerabilities arise not from individual behaviours, but from larger social structures that limit access to resources, safety, and well-being (Bourgois et al., 2017, Quesada et al., 2011). While structural vulnerability recognizes the ways people are marginalized by systems, intersectionality deepens the analysis by showing how multiple marginalised identities shape the specific ways that vulnerability manifests. Although structural vulnerability has been used by some authors (Isaacs et al., 2022, Carruth et al., 2021) to examine health experiences of migrant groups, intersectionality as a tenet of CRT was more suitable for this research.

The concept of intersectionality not only proposes a lens through which social issues should be viewed but also facilitates a practical application to carry out advocacy through its premise. There is a growth in research on health inequalities using an intersectional lens. Using an intersectional framework to understand population health improves understanding of the relationship between multiple social positions and health (Collins and Bilge, 2020). It also helps shed some light on the consequences of the distribution of resources and exposes the mechanisms that maintain disproportionate health privileges amongst various groups. Despite the increased popularity of intersectionality across multiple research domains, the use of intersectional health inequalities is at a primary/early stage in Europe (Collins and Bilge, 2020). Although intersectionality has been commonly used as a standalone theory, some studies have discussed intersectionality as a tenet of CRT and for example, Freeman et al. (2017) used critical race theory and intersectionality tenet to understand poor engagement in HIV care amongst African American/Black and Hispanic persons living with HIV in the US. The findings showed that experiences and attitudes towards healthcare institutions were primarily influenced by aspects of structural racism, such as social segregation, concentrated poverty and unequal resources (Freeman et al., 2017). The intersectionality of service users' social positions according to race/ethnicity, class, and gender impacted their experience in a subordinate position to healthcare workers, which influenced engagement with services.

These tenets of CRT can inform the exploration of how African migrants perceive and experience mental health by understanding the racialised environment in which they exist.

3.4 Critiques of Critical Race Theory

Despite its breakthrough in critical studies since its initial articulation in the 1980s, Critical Race Theory has critics. To begin with, CRT has been commended for having several concise concepts to carry out the objectives of its framework. However, if it were to be recognised as a social theory, it lacks the systemic structure and intellectual architecture that constitutes a social theory (Treviño et al., 2008). The core tenets are explicitly defined, but have not been unified enough to explain their relationship. Which leads to the issues of fundamentalism displayed by the theory. Though the tenets of CRT are stipulated clearly, these are not always agreed upon by its critics. This gives a sense that CRT cannot be considered a social theory, as we know the word's meaning, but rather as a collective of analytic tools (Treviño et al., 2008). However, this critique could be seen as a strength rather than a limitation in this research because this study's aims do not fit a positivist way of thought. Exploring nuanced perspectives and experiences of African migrants requires a flexible framework. A rigid framework would go against the fundamental tenet of CRT, which argues that the elimination of racism is not an objective process but rather highly subjective. The subjective nature of its core tenets reflects the nuanced perspectives and experiences of African migrants on mental health.

Secondly, CRT has been criticised for making race the only explanation for understanding disparities in the modern world. Class is argued as being an essential consideration in seeking to understand the continued existence of racism (Cole, 2009, Delgado and Stefancic, 2017). Cole (2009) disproves the idea that the political system of white supremacy solely creates social inequalities. He states that instead, production and capitalism have made the inequalities which are based on class rather than race. His critique goes on to say that CRT ignores the white working class and xenophobia or racism experienced by other cultures. Based on this, Cole rejects the focus on race that CRT places and believes that eliminating socioeconomic classes would eliminate racism. Darder and Torres (2004) Make a similar argument. Some authors deny the argument made Cole (2009) that CRT ignores class in analysing racism. Mills (2009) disagrees and highlights the fact that CRT is a theory that takes broader political discourse and the intersectionality of social identities into consideration. This includes discourse on class, gender, and migration status as being operational in the oppression of "others". He argues that

though these identities are important, it is also important to consider race and racism. He maintains that though some white people live in poverty and are marginalised, there is still a disproportionately higher number of Black people living below the poverty line. The disparities are the crux of CRT, which is why race is an essential concept in understanding and eliminating racism and other oppressive structures in society. Whilst capitalism and production are essential, it is the white population that benefits from the success of that system (Crenshaw, 1990, Solórzano and Yosso, 2002).

The focus in CRT on social structure and not addressing agency has also been seen as a limitation (Parsons & Thompson, 2017). Bonilla-Silva (2019) introduced the concept of "racialised emotions" that best explains the complexity of agency in a racialised world. Racialised emotions are stimulated emotions that are a product of the subjective social categories formed by race, class or gender. Bonilla-Silva (2019) explains that people feel these emotions as their realities, even if derived from distorted or partially distorted understandings of the world. Thus, the agency of the people living in these realities is guided by their racialised emotions. Similarly, racialised emotions on the suitability and trustworthiness of statutory mental health support can serve as barriers to help-seeking for African migrants. This is evident in numerous bodies of research similar to the exploratory study carried out in a Somali community which revealed the level of mistrust in statutory mental health services that were held by the community. The community's mistrust of services may or may not result from a 'real' threat. However, their perceptions are founded on historically produced positions in society (Said et al., 2021). They are subjectively rational and may not be understood by groups without the same context. This does not mean that critical perspectives do not consider human agency; it merely acknowledges that agency exists in a socially constructed reality shaped by the intersection of social hierarchies grounded in structural racism (Meghji, 2021).

One last critique of CRT is restricting racism to a specific skin colour. *Xenoracism* is a concept that rose to refer to a form of racism that is not necessarily colour-coded. In the 21st century, the UK encouraged thousands of Eastern European workers to resettle in the UK an abundance of labour through immigration. The structures of capitalism gain from allowing immigration to occur, but remain strong enough to keep workers vulnerable and, therefore, easy to exploit, further perpetuating social and economic inequalities. The overt and covert racism experienced by these migrants has all the hallmarks of traditional racism but is based on their immigration status rather than their skin colour (Cole, 2009). The robust anti-migrant discourse was

exacerbated by the Brexit Referendum, which reinforced the Xeno-racist sentiments (Abranches et al., 2021). For example Sime et al. (2022) highlight how Central and Eastern European young people in the UK navigate their racial and ethnic identities in the wake of Brexit. The study reveals that these individuals often experience a complex form of racialisation, where their experiences of xenophobia are shaped by the intersections of their whiteness and foreignness. This study emphasises the nuanced ways in which racial and ethnic identities are constructed and experienced within the broader context of political and social changes which is not exclusive to Black people. Though in this research, colour-based racism is the focus, xenoracism is pertinent in understanding the intersection of identities producing multiple points of racial oppression experienced by African migrants. These groups not only fight through systemic barriers associated with their skin colour, but also negotiate with anti-migratory and racial microaggressions in their daily lives.

3.5 Suitability of the Critical Race Theory to the current study

Critical Race theory enables us to understand the various ways in which racial injustices and discrimination affect the lives of minority groups, particularly Black people living in the Global North. Socio-economic inequalities have been acknowledged as being the fundamental cause of illness. It is also known that racial inequality is essentially socio-economic, where ethnic minorities are disproportionately represented in poor housing, underemployment, unemployment and poverty. Phelan and Link (2015) and Laster Pirtle (2020) make the argument that racial inequality, too, is a fundamental cause of disease and should be treated as such. Using CRT in this thesis allows for more in-depth analysis and understanding of how racist systems have had an impact on African migrants and their perspectives on mental health support in Scotland. CRT aligns with the thesis in that it aims to understand social, political and structural features that perpetuate the process of racialisation. In understanding the interwoven racialised structures they exist in; we can understand how these experiences shape African migrants' help-seeking behaviours. A growing body of literature across social sciences, public health and natural science highlights the link between racism and health. More specifically, there is a clear association of discrimination being a social determinant of mental health (Compton and Shim, 2015). With discrimination and racism also extending to the institutions that individuals engage in, this affects their employment, education, health and housing. As a result, the intersectionality of disadvantaged social positions, institutional racism

and discrimination all exacerbate poor health outcomes (Compton and Shim, 2015, Hynie, 2018, Fernando, 2010).

Although this study utilises CRT, it is important for me to highlight the role of intersectionality as not only a tenet of CRT but as an analytical tool. While intersectionality and Critical Race Theory (CRT) share common goals in challenging systems of oppression and advocating for social justice, tensions can arise between the two frameworks due to differences in emphasis, scope, and methodology. Intersectionality seeks to examine how various social identities intersect to shape individuals' experiences of privilege and oppression, encompassing a wide range of dimensions such as race, gender, class, sexuality, and disability. In contrast, CRT primarily focuses on race and racism as central organising principles of social inequality. This narrower focus may lead to tensions as intersectional scholars advocate for a more comprehensive analysis that includes other dimensions of identity.

Intersectionality strongly emphasises centring the voices and experiences of marginalised individuals, particularly those with multiple marginalised identities. This approach aims to highlight the complexity of lived experiences and challenge dominant narratives of oppression. However, the broad applicability of intersectionality has also been a source of tension, as some scholars argue that it risks diluting the central focus on race, which is the hallmark of critical race theory (Saletti-Cuesta and Aizenberg, 2019). Proponents of critical race theory contend that race must remain the primary analytic lens, as it is the fundamental axis around which other systems of oppression are structured. Bell's (1992) articulation of CRT prioritises the perspectives of marginalised communities; however, its focus on race and racism may sometimes overshadow other dimensions of identity, leading to tensions over whose experiences are centred in analyses of social inequity.

Intersectionality and CRT may also have different strategic priorities and goals for social change. Intersectionality advocates may prioritise coalition-building and solidarity across different marginalised groups to simultaneously address multiple forms of oppression. In contrast, CRT scholars may prioritise a more focused approach to combating racial injustice within specific legal and institutional contexts. These differing strategic priorities can lead to tensions over the most effective strategies for achieving social justice. Despite these tensions, intersectionality and CRT also have complementary aspects that can enrich each other's analyses and perspectives. These provide a valuable tool for Critical Race Theorists to explore the multidimensional nature of racial oppression.

By bridging CRT and Intersectionality, research can adopt a more holistic approach to understanding and challenging the complex web of systemic inequalities. Therefore, the approach throughout this thesis was to examine the experiences and perceptions of mental health with the following CRT tenets in mind: the ordinariness of racism, interest convergence and intersectionality. I used these tenets in the following way: highlighting the ordinariness of racism I explored how historical contexts and systemic racism shaped the experiences of African migrants and influenced their mental health over time. I also explored the counter-narratives and resistance strategies used by African migrants and this included understanding how my participants coped with systemic racism. Intersectionality helped unpack how overlapping identities—such as race, ethnicity, gender, immigration status, and socioeconomic class—affected the mental health of my participants. This allowed me to explore how the compounded effects of being a migrant, a member of a marginalised racial group and either male or female created unique stressors and vulnerabilities. Intersectionality also allowed me to illuminate how local contexts, such as community support systems or cultural stigmas, affect the mental health of African migrants and their help-seeking behaviours.

3.6 Conclusion

In this chapter, Critical Race Theory (CRT) and Intersectionality as a tenet are outlined as analytic frameworks, examining their application in analysing African migrants' perspectives and experiences regarding mental health and support engagement. CRT prompts reflections on the intricate power dynamics influencing their racialised daily experiences and their help-seeking behaviours for self-identified mental health issues. It also provides a unique approach to challenging the exploration of mental health disparities among ethnic minorities in the UK, pushing beyond regulated anti-racism discourse. Various societal institutions such as healthcare facilities, schools, governments, businesses, entertainment, and community-based organisations adopt a one-size-fits-all approach, promoting a false sense of equality that masks structural racism (Kolivoski et al., 2014). Policies promoting equality, diversity, and inclusion often fail to challenge systemic issues, instead becoming mere checkbox exercises.

The relevance of CRT's principles is argued in providing insights into specific narratives and their influence on health behaviours within a racialised society. The chapter highlights the prevalence of racism in institutions, such as the handling of COVID-19 and ethnic minority groups, the use of interest convergence as a tool to preserve white interests, and

intersectionality as a means to explore the nuanced experiences of African migrants. By contextualising these experiences and behaviours, relevant concepts are applied to address the research questions. The subsequent chapter details the operationalisation of these concepts in the fieldwork and analysis conducted for the study.

Chapter 4

Methodology

4.1 Overview

The purpose of this chapter is to present the methodological approach used to address the research questions given at the end of Chapter 1. This qualitative study explored help-seeking/engagement with mental health support in Scotland using online focus groups and in-depth interviews with African migrants. The chapter begins by outlining and discussing the theoretical and philosophical assumptions and how they influenced the study, the research paradigm underpinning this study and the research design. This is followed by a critical discussion of the methods used in this study, including the steps taken in data collection, analysis, and presentation of the findings. I then conclude with a discussion of how I ensured the rigour and quality of the data and the ethical considerations of the study.

4.2 Theoretical, philosophical assumptions and research design

Any research process is underpinned by a set of ontological, epistemological, and methodological assumptions, often understood through the concept of paradigm. Research paradigms describe the general philosophical orientation to which the researcher and research researcher subscribe (Cohen et al., 2013, Thomas, 1962). According to Guba and Lincoln (1994), a paradigm is *"a set of basic beliefs that deals with ultimates or first principles. It represents a worldview that defines, for its holder, the nature of the world, the individual's place in it, and the range of possible relationships to that world and its parts…"* (pg.104). Furthermore, a research paradigm also describes the assumptions on the nature of reality (ontology), the type of knowledge (epistemology) and how knowledge is attained (methodology) (Guba and Lincoln, 1994, Cohen et al., 2013). As a systematic investigation, research involves understanding, describing and predicting phenomena in a specific context, and the researcher's philosophical worldview guides the research.

4.2.1 Ontology: a way of being in social reality

Crotty (1998) defines ontology as the study of being. Ontological claims define what constitutes social reality, how it is conceived, what it looks like and how the different units that make up that social reality interact (Blaikie and Priest, 2019, Grix, 2004). The ontology of the

research determines how the researcher makes assumptions about the phenomena they will be studying and how the phenomena are situated in the world. This is often the starting point in the systematic investigation the researcher intends to carry out (Mack, 2010). Naturally, ontological assumptions differ between researchers and may hold diverging opinions on the same phenomena. Through time, ontological positions have evolved and have been categorised in various ways by different scholars. However, two umbrella ontologies will be mentioned, and one will be discussed in the study. The two basic ontological positions are objectivism and subjectivism (Grix, 2004). Objectivism asserts that social reality exists independent of the influence of social actors. Conversely, subjectivism contends that social actors shape their reality and actively construct social phenomena (Grix, 2004). Subjectivism assumes that our personal experiences and cultural beliefs influence how we interpret the world. Our interpretation happens involuntarily and cannot be removed from our experiences (Crotty, 1998, Cohen et al., 2013).

Therefore, this study takes on the ontological position that African migrants' perceptions and understandings of mental health and mental health support are embedded in their experiences and beliefs in their social reality. This ontological assumption recognises how help-seeking behaviours are created by their reality based on subjective perceptions and experiences of mental health and support. Although subjective ontology has been critiqued as perpetuating the idea of a false dichotomy in understanding individuals' experiences, this ontology was relevant to understanding African migrants' social reality. A growing body of research argues for a critical realist approach to migrant research, which considers objective and subjective ontologies (Iosifides, 2018). However, contrary to the critique, the power dynamics and social inequalities existing in migrant contexts have not been ignored by this study. Instead, they have been considered as part of their subjective experience rather than an objective reality. This provides the experiences depicted in the study a level of autonomy on how their social reality influences them. Thus, the participants and the researcher have input on creating the experiences' narrative without dictating the inequality conditions as an objective fact. The ontology is directly linked to epistemology, and together, they direct research in understanding what knowledge is and how we justify this knowledge (Neuman, 2014).

4.2.2 Epistemology

The term epistemology originates from the Greek word *episteme,* which means knowledge (Trochim, 2015). Epistemology, as defined by Hamlyn (1995) as "the nature of knowledge, its

possibility, scope and general basis" (p.242), provides a philosophical grounding for the kinds of knowledge the researcher chooses and how they ensure that they are both legitimate and adequate for the research (Crotty, 1998). Worldviews are often assumed to exist in two ways: objective and subjective. However, Pring (2015) and other authors argue that the dualism of the two worldviews should not bind research. Instead, they see reality as complex and claim that research can exist in a continuum, ranging from the objective to the subjective worldviews, with variations between fields (Pring, 2015, Creswell, 2014). For this study, the two worldviews will be described.

The positivist worldview assumes a more scientific approach and it asserts that one objective reality exists independent of human subjectivity. It regards research as a process in which causes determine the effects or outcomes in a manner that is observable through replicable processes (Crotty, 1998, Cohen et al., 2013). It also takes an approach that reduces ideas into variables to test a hypothesis and answer research questions in a controlled environment. Through observation and measurement, the objective reality is quantified. Naturally, this worldview is often examined in quantitative research. In practical terms, positivist research often involves the use of quantitative methods, such as surveys, experiments, and statistical analyses, to collect and analyse data. These methods enable researchers to measure variables precisely, test hypotheses, and draw generalisable conclusions based on empirical evidence. The emphasis on observation and measurement aligns with the positivist commitment to uncovering universal truths about the objective reality that can be applied broadly across various settings (Creswell, 2014).

The interpretivist (or constructivist) worldview argues against the objective way of obtaining knowledge. Interpretivists believe that the world is understood through the subjective meaning of human experiences. These experiences are understood as complex and multidimensional rather than discrete variables. Researchers adopting this approach are typically qualitative, focusing on individuals' beliefs, feelings and interpretations, and contextual experiences negotiated between participants and the researcher (Cohen et al., 2013). Interpretivist research often involves methods such as in-depth interviews, focus groups, and participant observations. These methods allow researchers to gain a deeper understanding of how individuals make sense of their world and how they construct meanings within their specific contexts. The interpretivist approach prioritizes the subjective nature of these experiences and seeks to capture the complexity of human understanding as it is negotiated between participants and researchers

Moreover, interpretivist researchers acknowledge that their own backgrounds, perspectives, and biases play a role in shaping their interpretation of the data. This self-awareness is crucial, as researchers recognize that their own stance influences how they interpret and make sense of participants' meanings. This reflexivity is an integral part of the interpretivist approach, as it highlights the interplay between the researcher's perspective and the participants' experiences in the process of knowledge creation (Crotty, 1998, Creswell, 2014).

The central focus of this research is on subjective experiences and health beliefs. The positivist approach was not considered suitable, given it seeks an objective worldview to explain relationships between phenomena (Shah and Al-Bargi, 2013, Creswell, 2014). Given the interpretivist approach explores phenomena through culturally derived and historically situated interpretations, I considered it more suitable given my interest and focus on individuals' experiences. This paradigm is focused on the subjective meanings of phenomena (Shah and Al-Bargi, 2013, Crotty, 1998). Therefore, this study takes on a subjective interpretivist philosophical worldview as it seeks to understand the processes that lead to the construction of African migrants' reality (Cohen et al., 2013, Neuman, 2014). The experiences of African migrants are examined by analysing their reality through their context, which is seen as a product of an intersection of social identities. The choice of this paradigm influenced my choice of methodology, which will be discussed in detail next.

4.3 The study design

The choice of paradigm for this study thus informs the qualitative research design. By its nature, qualitative research centres its knowledge on a subjective worldview and aligns with the subjective interpretivism held by the aim of this research. Lewis-Beck *et al.* (2003) define qualitative research as "an umbrella term for an array of attitudes toward and strategies for conducting an inquiry aimed at discerning how human beings understand, experience, interpret and produce the social world". Since this study looked at participants' subjective experiences, adopting a qualitative research design was suitable to address the research aim and objectives. A qualitative design was considered more suitable because it examines the social processes and their realities in their contextual setting (Neuman, 2014); this research design is most helpful in understanding human experiences through a subjective lens. Qualitative research designs have been historically used in anthropology, sociology, and the humanities, and all are interested in human experience (Creswell, 2014, Neuman, 2014). This design was considered

as most suited for a study which seeks to explore and understand the meaning that African migrants make towards mental health and healthcare engagement in Scotland. According to Creswell (2014) the qualitative research process, emerging research questions are typically used to collect data in the participants' setting, data analysis is built from themes, and the researcher interprets the meaning of the data.

This research used thus focus groups and interviews to address the research questions with African migrants. The choice to combine both methods was driven by my desire to extend the breadth of the data to develop a more comprehensive understanding of the research topic. Focus groups allowed participants to engage in the topic and share varying perspectives, while the interviews allowed for individual experiences and perspectives to be explored in more depth, providing a nuanced understanding of the research topic. The use of these methods in the study is discussed next.

4.3.1 Focus group discussions

Focus group discussions (FGD) explore views on a subject matter with participants and a moderator to guide the discussion. The process allows participants to present their views and the group to listen, ask questions, and engage in meaningful dialogue (Ritchie et al., 2013). The moderator may have a more or less directive role in guiding the discussion, which often depends on the intent of the research and the dynamics within the group. Some scholars argue that FGDs follow a more natural communication environment than interviews because they allow individuals to influence and be influenced by those around them. This also allows for additional information to be revealed through engagement with the group discussion and may provide insight that the researcher had not anticipated (Ritchie et al., 2013). A typical FGD occurs between 8 to 12 participants and often occurs face to face. However, due to the ongoing COVID-19 pandemic, FGDs in this study were carried out online with 3-5 participants at a time. The literature varies in advice on the appropriate number of participants in an online FG. However, the group sizes were kept small to minimise challenges associated with larger groups, such as extraneous noises. According to Murray (1997), group size does not determine the level of group participation. However, individuals in the smaller group were more likely to contribute more freely. The use of the FGD method in the first phase of this study was beneficial as it provided diversity in opinions and led dialogue based on subjective experiences and perceptions.

Focus group discussions are suitable for research on discussions about attitudes and beliefs on mental health, especially in populations such as African migrants in the Global North. Several studies have opted to use FGDs and this is due to several key advantages that align with the complexities and sensitivities in this field of study (Saechao et al., 2012, Seven et al., 2021, McCann et al., 2018, Hollander, 2013). My decision to utilise FGDs was due to the value of creating a supportive and interactive environment where participants can share their experiences and perspectives, fostering a sense of community and mutual understanding. This is particularly important in migrant mental health research, where individuals may feel isolated or marginalised due to their migration experiences. The collective nature of focus groups can help participants feel more comfortable discussing sensitive topics, such as mental health challenges and the impact of migration on their well-being (Stewart, 2015). This was also timely as all participants were isolated due to the COVID-19 pandemic. Although focus groups are sometimes seen as inappropriate for sensitive topics, this can also help remove the cultural constructions that can often cause stigma around topics such as mental health and post-migratory difficulties (Kitzinger, 1994). I found that participants were more open to share their experiences as newly arrived migrants in a space where there was a sense of commonality in experiences. This also opened up a space to share various support networks that participants could join which cultivated peer support and community.

Focus groups also allowed for the exploration of diverse viewpoints and the capture of rich, qualitative data. Because migrants' mental health experiences are shaped by a multitude of factors, including cultural background, migration journey, socio-economic status, and encounters with host country systems, this can result in varied experiences and viewpoints. Through the interactions and discussions, participants in this study had complementary and argumentative interactions, which sparked important discussions that did not need to be facilitated by the researcher. The culturally and nationally diverse sample allowed participants to have varied opinions, for example, on the availability of support in the African community. Participants expressed their views and experiences on seeking support in communities with the same nationality, which some found to be more difficult due to stigma. This facilitated the identification of common themes and unique experiences, providing a nuanced understanding of the needs and challenges faced by these participants.

A crucial element in employing focus groups in this study is the participants' ability to freely express themselves when discussing stigmatising language prevalent in their cultures.

Participants were not only able to discuss cultural norms concerning mental health, but also engage in candid conversations about their experiences with racism, healthcare encounters, and political issues. This approach was essential in enhancing the validity and relevance of the research findings.

4.3.2 In-depth interviews

In-depth interviews are a powerful method for exploring subjective perceptions and experiences, offering a nuanced approach to understanding how individuals make sense of their social worlds. This method employs a conversational and participant-centred style, where the interaction is designed to uncover the meanings and interpretations participants attach to their experiences. While the format resembles a casual conversation, it is driven by a clear research purpose, with both the researcher and participant playing distinct roles in the dialogue. The primary objective of in-depth interviews is to delve into the unique interpretations and subjective experiences of participants, providing insight into their personal views and emotional responses. This makes the method particularly suitable for research focused on personal experiences, such as those involving sensitive topics like migrants' experiences, self-identified health issues, and perceptions of mental health (Hennink et al., 2020, Legard et al., 2003). By allowing participants to express their thoughts and feelings in their own words, in-depth interviews offer a rich and detailed understanding of their social realities.

Within an interpretive methodology, in-depth interviews offer a wealth of opportunities for data analysis and interpretation. The open-ended nature of the interviews facilitates the emergence of unexpected themes and insights, which can be further explored in data analysis. This flexibility allows researchers to adapt their focus based on the evolving data, thereby capturing the full complexity of participants' experiences. Interpretive approaches to data analysis emphasize the meanings and interpretations that participants attach to their experiences. In-depth interviews align well with this approach, as they enable researchers to delve deeply into the subjective and often hidden dimensions of human experience (Della Porta, 2014). The iterative nature of the interview process supports reflexivity, allowing researchers to continuously reflect on and refine their data collection strategies. This ongoing reflection helps to better capture the complexities of participants' experiences and ensures that the research remains responsive to the data.

The decision to use in-depth interviews for this research was driven by the need to capture and understand individual experiences in depth. In-depth interviews are particularly suited for this

purpose because they allow for detailed exploration of participants' personal narratives with migration and experience with mental health. The COVID-19 pandemic introduced significant challenges to traditional face-to-face interactions and restrictions on travel made in-person interviews impossible. As a result, adapting the interview process to an online format became a necessity. Gruber et al. (2021) reflects on the experience of conducting interviews with undocumented migrants during the pandemic and argued that this highlighted the possibility of research in conventionally inaccessible spaces such as wars zones. They emphasised that the need for flexibility for 'hard-to reach' participants was made possible through data collection online and through text. Similarly the use of online interviews in this research exemplified the possibility of collecting rich qualitative data remotely in a community typically considered 'hard-to-reach'. The effectiveness of online interviews in capturing individual experiences demonstrates that, with the right approach, the virtual format can be as effective as in-person interactions.

4.4 Recruitment and sampling strategy

4.4.1 Sample size and saturation

The fundamental nature of an interpretive-informed qualitative study is to focus on the meanings that individuals or groups attribute to social phenomena without seeking generalizability (Morrow, 2007, Guba and Lincoln, 1994). This means the sample size is informed by meaning-making rather than hypothesis-testing using variables (Malterud et al., 2016). My selection needed to focus on the depth of experiences rather than the number of participants included. Polkinghorne (2005) argued that the misleading nature of the word 'sample' in qualitative research has inference that the data will yield generalisable results. Instead, he suggested the word 'selection' would be more compatible with its nature of choosing the sources of nuanced data. However, this selection is only deemed sufficient once the data is analysed and data saturation is reached (Hennink and Kaiser, 2022) (see Section 4.7). This commitment to in-depth information justifies smaller sample sizes rather than representative sample sizes, which guided the number of participants in this study.

Inclusion and exclusion criteria

The criteria for the sample of this study were driven by the need to recruit participants who could provide rich data to address the research questions. This meant that individuals selected had to have direct experience of immigration from an African country and experience with the

engagement of healthcare services in Scotland, as this research was not only focused on looking at mental health support through a cultural lens, but the nationalities of participants were also not the focus. However, I was conscious of the dangers of stereotyping all African migrants as being the same and not paying attention to the diversity of experiences and perceptions that exist on the continent. With that in mind, informed by the statistics on African nationalities in Scotland (covered in section 2.2), I tried to recruit participants from diverse backgrounds through organisations/groups and snowballing.

The research objectives determined the inclusion and exclusion criteria for this study. Participants were adults over the age of 18 years, born in any one of the African countries and living in Scotland at the time of the study. Inclusion criteria also limited the participants to first-generation migrants born in Africa settled in the UK. They also needed to be able to communicate in English. It was also imperative that participants volunteered and could provide informed consent to participate in the study.

Participant sampling

Following engagement with the literature on sampling approaches, I considered the two primary sampling techniques in social science research: probability and non-probability sampling. Probability sampling is based on randomly selecting a representative sample of the population of interest. This type of sampling aims to give each potential participant an equal chance to be selected and is often used in quantitative research (Creswell, 2014, Hennink et al., 2020). At the same time, non-probability sampling uses non-random means to sample participants. This sampling is helpful to target specific participants and is often used in qualitative research (Walliman, 2006, Neuman, 2014). Considering the qualitative nature of the study, non-probability sampling was used to purposely recruit participants who reflect the characteristics and experiences of the Black African migrant population. The population of African migrants in Scotland has reached 30,000 (Office of National Statistics, 2023). It encompasses a number of African countries which were all eligible for this study (discussed further in inclusion and exclusion criteria). This allowed me to recruit from a population with a certain degree of commonality of settlement experiences yet enough diversity to present subjective perceptions and experiences.

Recruiting participants

The purposive sampling approach is often used in exploratory research to recruit distinctive participants that may not be readily available. Purposive sampling involves the researcher using local informants to locate potential participants (Neuman, 2014, Walliman, 2006). Black African migrants were purposively recruited through various existing migrant organisations and groups which served as gatekeepers. Following initial contact with the gatekeepers via email, a virtual meeting was set up to introduce myself to the potential participants. All participation was voluntarily, and each participant chose the slot (time and date) most suitable for them for either the focus group discussion or an individual interview.

A database of 15 organisations and groups that work with migrant communities in Scotland was compiled. Each was contacted by email, introducing myself and the purpose of the study. They were also asked if they could serve as gatekeepers and assist with accessing their organisation/group members that fit the inclusion criteria. Six of the fifteen organisations contacted responded and agreed to help with recruitment. Their diverse services helped reach a broad range of groups. The organisations were as follows:

- Organisation A is a UK-based charity founded in 2010 dedicated to amplifying the voices of migrants and challenging negative stereotypes in public and political discourse. The organisation provides platforms, training, and advocacy opportunities for migrants to tell their own stories and influence the narratives that shape migration policy and public perception. They had a large mailing list where my research was distributed to. Through this organisation I met an individual who had their own organisation who invited me to join a meeting.
- Organisation B was a small online based group that provides a platform for people from ethnic minority groups to express their views through blog writing. This group was small but I was able to meet two participants and a contact from Organisation C.
- Organisation C is a small charity founded in the 2018 led by females from an ethnic minority background. The organisation is committed to addressing inequalities affecting African and African diaspora communities in Scotland. This organisation focuses providing services on education, mentoring, mental health support and a food banks during the pandemic. They had a small pool of women who were keen to participate in the research when I came into contact with them.

- Organisation D is a human rights charity established in 1995 and the organisation is dedicated to supporting refugees, asylum seekers and migrants across the UK in rebuilding their lives with dignity and security. The contact from the organisation approached a few potential participants who reached out and took part in the research.
- Organisation E was a small Christian church that had predominantly African congregants. The leader of the church circulated my pamphlet and poster to the mailing list and WhatsApp group.
- Organisation F was contacted through social media (facebook) where they were active during the pandemic. This charity is dedicated to promoting economic and social inclusion among migrant and minority ethnic communities across Scotland. Established in 2011, they focus on supporting individuals particularly those from African and Eastern European backgrounds who may face challenges adapting to the UK environment due to language barriers, cultural differences, or systemic disadvantages.

Initial online meetings and email introductions were arranged with the gatekeepers, who decided to allow me to introduce myself and explain the purpose of my study. Gatekeepers were given information to inform potential participants and help them decide to participate. The information included details on their participation should they choose to participate in the FGD and/or the individual interviews. They were also provided copies of the Participant Information Sheet (PIS) and consent form to read themselves and ask questions thereafter. The timing of the recruitment phase of this study was significant because a lot of this took place during the COVID-19 pandemic lockdown in July 2021 (see section 4.6.2 for details). This meant that most of the organisations contacted were inundated with emails and online meetings, which led to delays in responses and some declining to assist with recruitment.

Additional recruitment measures

The convenience sampling strategy was additionally used to ease the practical constraints of the research (i.e. time) and minimise the limitations of recruiting participants from the same networks through snowballing. Convenience sampling allowed me to reach potential participants who may be easily accessible, in close geographical proximity, and who might be willing to participate (Etikan et al., 2016, Robinson, 2014). This sampling approach was used to recruit African migrants through poster advertisements and social media (see Appendix D). Using convenience sampling not only addressed time constraints, but also provided a diversity of participants. Kuan et al. (2020) utilised convenience sampling as a way to maximise the

number of study participants in focus group discussions on migrant accessibility to health services. This increased the range of the topics to be discussed and mitigated any limitations that came with the first method of recruitment, which was sending out invitations to relevant stakeholders.

Convenience sampling in this study was done by putting up of social media advertisements. This was done to open the recruitment pool beyond the organisations and groups identified in the previous strategy. One participant reached out through social media, and once interest was shown, they were contacted and given the PIS and Consent Form to fill out prior to participation. This method was less efficient, which may be due to the number of people the advertisements could reach. Using social media to put up advertisements had its limitations because it excluded those who did not use the social media platforms that I used for this study (facebook, twitter and Instagram). Additionally there was a reliance on the social media algorithm to suggest my research pages to users who met the eligibility criteria for the study.

Demographic characteristics of the participants

In total, 32 participants participated in the research, of which 15 took part in the focus group and 17 in individual interviews. The majority of participants in the study were either currently enrolled in postgraduate programmes or had initially arrived in the UK as international students. As a result, a significant proportion of the sample possessed at least a university-level education, with many holding undergraduate or postgraduate degrees. This educational background suggests that participants were likely to have a relatively high level of academic literacy. The table below provides demographic information on all participants.

Codes	Pseudonym	Age group	Gender	Country of origin
P01	Chifundo	40-49	Female	Malawi
P02	Tunde	30-39	Male	Nigeria
P03	Abidemi	40-49	Male	Ghana
P04	Zandi	30-39	Female	South Africa
P05	Segun	18-29	Male	Nigeria
P06	Debare	18-29	Male	Nigeria
P07	Mohammed	30-39	Male	Eritrea
P08	Ekoche	40-49	Female	Nigeria
P09	Zuri	40-49	Female	Kenya
P10	Nasha	30-39	Male	Nigeria
P11	Darweshi	40-49	Male	Tanzania
P12	Tinashe	40-49	Female	Zimbabwe
P13	Adedayo	30-39	Male	Nigeria
P14	Kelechi	30-39	Male	Nigeria
P15	Neema	30-39	Female	Tanzania
P16	Mansa	30-39	Female	Ghana
P17	Ijeoma	30-39	Female	Nigeria

Table 4. 1: The demographic information of participants in interviews

Focus group 1

Pseudonyms	Age group	Gender	Country of origin
Akin	20-29	Male	Nigeria
Tola	20-29	Female	Nigeria
Kalu	20-29	Male	Nigeria
Chukwu	30-39	Male	Nigeria
Onyi	30-39	Female	Nigeria

Focus group 2

Enita	40-49	Female	Nigeria
Nnenna	40-49	Female	Nigeria
Olufemi	30-39	Female	Nigeria
Ibrahim	40-49	Male	Ghana
Fola	50-59	Female	Nigeria
Fathima	40-49	Female	Cameroon
Adanna	40-49	Female	Nigeria
Obi	50-59	Male	Nigeria
Monifa	40-49	Female	Nigeria
Chinua	40-49	Male	Nigeria

Table 4. 2: The demographic information of the participants in focus groups

4.5 Ethical considerations

Research with historically marginalised populations and research on sensitive topics require the researcher to be cognisant of intersecting issues such as power, consent, trust and harm (Court et al., 2018). Therefore, this section discusses my understanding of and approach to the key ethical considerations in my research on mental health support with African migrants. This section outlines my positionality and reflexivity, risks and benefits of the research, informed consent, anonymity and confidentiality. This study followed the ethical guidelines set by the University of Strathclyde, and ethical approval (see Appendix E) was sought prior to data collection.

4.5.1 Informed consent

Informed consent is a key ethical standard to consider when carrying out research on human beings. The principle of informed consent aims to safeguard people's freedom to participate in research and is founded on trust and integrity (Klykken, 2021). Potential participants should be given detailed information about what the research participation entails, why it is being carried out, who is funding it, what will happen to the data collected and how it will be disseminated, what the potential risks and benefits of their participation might be, and how anonymity and confidentiality will be managed. Informed consent should be seen as an ongoing process where the researcher states the consequences or lack thereof if the participants decide to withdraw from the study (Wiles, 2012). Consent for this research was obtained for audio and/or video recording because data was collected online via Zoom.

Research on migrant populations poses additional ethical considerations regarding informed consent because language and cultural differences could overwhelm the consent forms. Therefore, informed consent not only means telling the individual about the study but also requires further consideration of how your information is provided. It is crucial that information is provided in a user-friendly manner with limited research jargon and ambiguity. It is also important to choose the right font, size of text and graphics in the information to ensure it is accessible (Wiles, 2012).

In my research, I ensured that the research details were accessible by designing an information leaflet in English to accompany the Participant Information Sheet (PIS) and consent form (see Appendix A). This also allowed gatekeepers to share the leaflet through their networks with potential participants. Once individuals expressed interest in the study, I then emailed the PIS and consent form and set up an informal telephone conversation to allow potential participants to ask any questions and to explain in-depth what participation and consent entailed. In addition to explaining what was on the PIS, I provided contact details for myself and the ethics committee in case the individual had further questions regarding the study. Participants were asked to read the PIS thoroughly, sign the consent form and return it via email. Consent is not a rigid one-size-fits-all process; in fact, Iphofen (2011) argues that obtaining consent should be gained in the most convenient way, so for participants who could not sign the form and email it back, oral consent was obtained, voice-recorded.

Consent was treated as an ongoing process where I observed participants' body language and emotions as we went through the interview and asked frequently if they wanted to stop if I noticed individuals being upset. None of the participants wanted to stop the interviews, and none showed distress that was of concern. Ongoing consent was particularly important because we discussed past experiences that may have been unpleasant, also mental health and experiences of racism and xenophobia. All participants were also only included if they showed the capacity to converse in English through pre-interview conversations, and if I felt they did not, the data collection process did not begin (see section 4.4.1 on inclusion and exclusion criteria). For example, one participant was not fluent in English, which meant they did not meet the inclusion criteria and could not participate. An interpreter could not be provided in this instance due to financial constraints.

4.5.2 Positionality and reflexivity as an African migrant living in Scotland

Davies (2007) suggests that the selection of research topic and the subjects are almost always influenced by personal stories, disciplinary culture, and external forces in the broader political, social and economic climate. It is, therefore, not a complete surprise that the underlying reasons for this research have stemmed from my identity as an African migrant living in Scotland. Though my personal story may vary from that of my participants, there exists some commonality of experiences. The intersection of my identity and my research interests in health disparities amongst minority groups led to the formation of my research. This meant that it was important that I acknowledge my positionality and understand how my views, values and beliefs influence my research process. This process of self-reflection is referred to as reflexivity (Manohar et al., 2017).

One of the most important considerations in researcher positionality in migrant health research is the way participants "place" the researcher, which is influenced by a number of factors such as gender, age, culture ethnicity and social class amongst others (Milner, 2007). The majority of my participants were older than me, some identified with a different gender than I do, and they had a varied cultural backgrounds, which Manohar et al. (2017) considers influential in the research process. Through reading literature, accessing government census information and interacting with migrant organisations, I was aware of the likely demographics of participants that I would encounter. I knew that I would likely recruit individuals with different identities than I did as a young female doctoral student from South Africa. This made me aware of my position as an 'outsider within' which was a term coined by Collins (1998) to explain Black female intellectuals' position rooted in their multiple identities in their communities (ethnic) and in their professional roles (academic). This intersection of identities provided me with a level of understanding of perceptions and experiences that existed in African migrant communities in relation to mental health. It also provided me with somewhat easier access to groups with potential participants. On the other hand, my identity as a researcher provided the 'outsider within' status where, to a certain level, I had to engage with my study and participants as a researcher, and this shifted back and forth as I engaged with the study.

It was, therefore, important that I practised self-reflection as I designed the research, collected the data and analysed it. Self-reflection held me accountable for how I framed my questions and encouraged me to be open to unexpected or varying findings to avoid any personal bias. Unexpected findings, such as participants who did not have any difficult experiences since their

arrival in the UK, challenged me to revisit how I engaged in the discussion of African migrant experiences. I was also challenged to question my position of privilege as a doctoral student from the most economically and constitutionally progressive African country, in contrast to some of my participants who may have endured challenging pre and post-migratory experiences. Ongoing issues of xenophobic attacks taking place in South Africa against other African migrants (Tella, 2016) also encouraged me to reflect on the role my identity played in my data collection process.

Mitigating the effects of researcher positionality is one that requires active reflexivity throughout the research process. Finlay and Gough (2008) suggests four strategies and practices that they used to practice reflexivity during his research: asking difficult questions, writing a research diary, presenting work to different audiences and reflecting on difficulties and unexpected findings. Throughout the process of designing my research, carrying out the data collection, and beginning the analysis, I went through processes of questioning my choices and comparing them to other research that had been done before me. Once data collection began, I kept a personal diary in the form of voice recordings where I spoke about how I felt about the interview I had completed. I also reflected on some aspects of personal bias that may have been challenged in the interview and how I would address them moving forward.

4.5.3 Risks and benefits

A number of factors can contribute to migrant groups being considered vulnerable in health research. Factors such as language barriers, cultural differences and legal status can all have an impact on effective communication (Loue, 2012). Though participants included in this research were not displaced migrants (see Section 4.4.1 on 'Inclusion and exclusion criteria'), there was a need for a level of consideration of risks of harm to the participants because of the nature of the study. Participants were asked questions about their pre and post-migration experiences, perceptions and experiences with mental health and perceptions and experiences with racism and xenophobia. This meant that these conversations led to sensitive topics, which may have posed some emotional risks for the participants. Though no visible distress was shown by participants, I had to have a level of preparation in the case that it did occur. The preparation included reading extensively on the literature surrounding my chosen topic, gaining volunteer work with a migrant organisation giving me experience to deal with potentially stressful or emotional key issues and familiarising myself with organisations and contact details that I suggested to individuals if they needed further support.

In trying to minimise the risk of harm to my participants, I made it clear during focus group discussions and interviews that individuals were not forced to share any personal experiences that they were not comfortable sharing. I also offered pre-interview conversations with participants to build rapport and answer any concerns that may lead to unanticipated distress during data collection. Most participants were comfortable sharing personal stories of their migration difficulties, mental health issues, and some experiences of severe racist acts perpetrated against them. During these accounts, I ensured that I was attentive and provided words of comfort and gratitude for sharing. I also continually asked that participants let me know if they were feeling uncomfortable at any point. A number of participants were quite interested in finding out how they could access the research findings upon completion, and I provided information on how the research would be disseminated and assured them that they would receive a report once available at the end of the study. Participants also expressed gratitude for being a part of the research, and most stated that this topic was of importance in their communities.

4.5.4 Anonymity and confidentiality

Anonymity and confidentiality are two concepts of ethical consideration, and they refer to the protection of participants' privacy and respect for autonomy (Oliver, 2010, Gregory, 2003). In research, confidentiality is maintained in order to keep identifiable participant information private and that any information given will not be repeated without their consent (Ritchie et al., 2013). Anonymity is how confidentiality is mobilised and ensures that any personal information such as names, locations and organisations are anonymised to maintain the participants' privacy (Ritchie et al., 2013). Confidentiality in research is always maintained by the researcher, unless the participant expresses that they pose a threat to themselves or others. In that case, the researcher is liable to break confidentiality and act accordingly (notify supervisor, authorities etc.) to ensure everyone is safe. They are also liable to alert the participant of this potential need to breach confidentiality as part of the informed consent process (Ritchie et al., 2013, Gregory, 2003). These two concepts are also closely related to informed consent because participants need to be informed about how their information will be managed and what the implications of that will be.

For the focus group discussions, I collaborated with organisations and groups with existing networks of African communities which meant participants knew each other and had formed a rapport. I clarified to the participants that I could not ensure complete confidentiality in group

discussions; however, I emphasised the need for participants to respect the privacy of shared experiences. In the individual interviews, I allowed participants to select a time that was most suitable for them and encouraged them to be in a space where they could talk unreservedly for the duration of our interview. Confidentiality was also ensured throughout the data collection and data storage process. I carried out data collection in a private space, names of participants were replaced with participant IDs (i.e. P01, P02, FG01), and data was stored in a secure folder on the University server. Because of the sensitive nature of this study, I reminded each participant that if they expressed any distress or disclosed plans for self-harm or harming others during the interview process, I would have to breach confidentiality and notify my academic supervisor to ensure that the participants received assistance. However, none of the participants showed distress or expressed any risk of harm to others or themselves.

4.6 Data collection

The objectives informed the data collection methods of this research. I utilised online focus group discussions and in-depth interviews with African migrants. Figure 1 shows the data collection process followed.

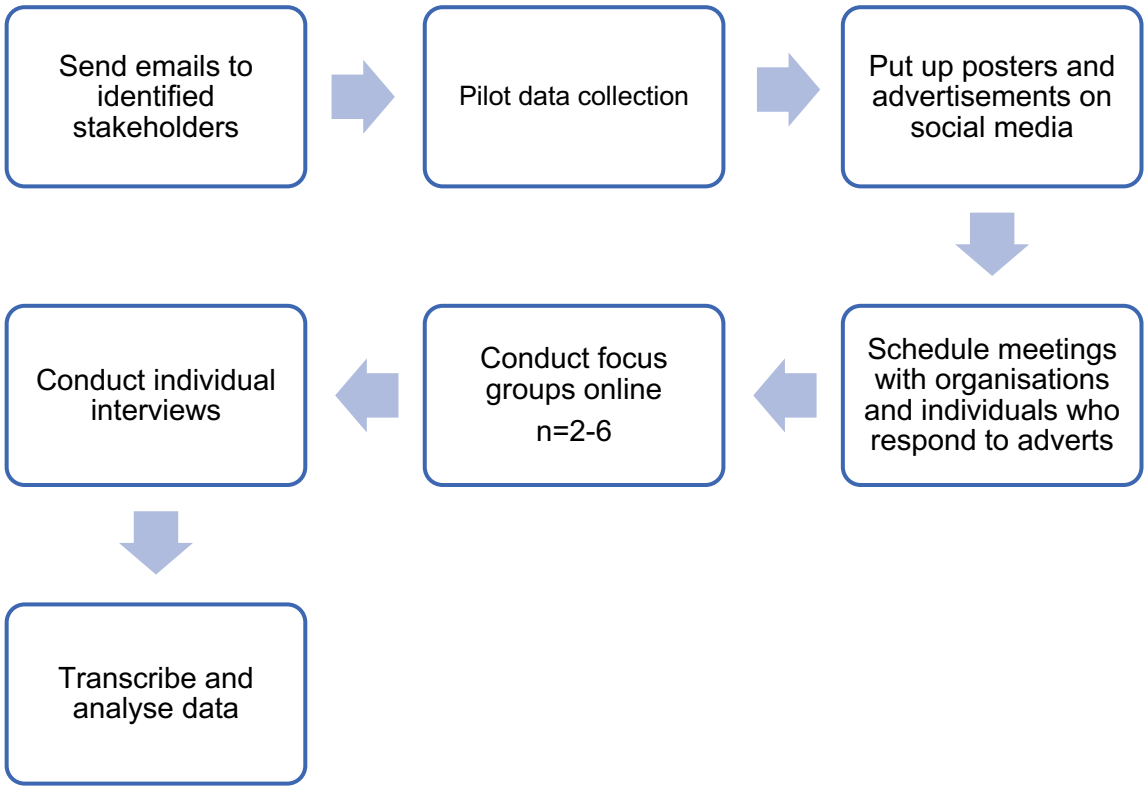

Figure 4. 1: The data collection process

4.6.1 COVID-19 related data collection adjustments

The beginning of the year 2020 came with major worldwide transformation when the World Health Organization (WHO) declared the Corona virus disease (COVID-19) a global public-health emergency. The rapid transmission and high mortality rates during the pandemic not only disrupted common systems of society, economy, health and education but also disrupted the practices of research data collection. This particularly impacts research that relies on gathering people in close proximity as a data collection method (Torrentira, 2020). Because the virus was transmitted through close contact via touching or contact with small, infected droplets or aerosols (from coughing, sneezing, speaking), it become unstoppable. The only preventative measures or attempts to lessen the spread were possible through social distancing, wearing of face coverings and other protective gear, quarantines, and lockdowns (Torrentira, 2020, Remuzzi and Remuzzi, 2020). Although containment measures have proven successful, most governments continued to place restrictive measures for months, which researchers had to work around.

At the onset, I had planned to conduct data collection face-to-face. However, these plans had to be revisited as a result of the pandemic-related restrictions. Albeit focus groups and in-depth interviews rely mainly on face-to face human interaction in a 'real world' setting, this was not possible (Walliman, 2006, Hennink et al., 2020). Nonetheless, technology has allowed for videoconferencing through platforms such as Zoom, which became the platform used for data collection in this study. Videoconferencing tools may be a solution to mitigate the distance between interviewer and interviewee, as well as time constraints, costs, or, in this case, a pandemic (Gillham, 2005, Cohen et al., 2013). Online interviewing has become more of a common practice. Firstly, during the current climate of a global pandemic, face-to-face interviews may have posed a health risk to the interviewer and interviewee alike. Even in instances where social distancing measures were adhered to, exposing both parties to unnecessary travel to a secure venue would have exposed them to the possibility of infection. Furthermore, online interviews could be carried out more quickly by eliminating travel times and other logistical issues, which would be suitable for participants with work or personal commitments (Torrentira, 2020, Dodds and Hess, 2020).

Online interviews also give the interviewee more confidence as they are not in a formal interview setting with a researcher, which may be intimidating for most, especially when

sensitive topics are discussed (Dodds and Hess, 2020). Participants were given the option to switch their cameras off. This was noted in my data collection, where some participants preferred to keep their cameras off. In my data collection process, I kept in mind that interviewing is relational and interactional, which can prove challenging online, so I kept my camera on throughout. This also allowed me to demonstrate active listening by nodding, making eye contact (if their camera was on), and using verbal affirmations such as "I understand" or "That's a good point." I strived to facilitate an open and flexible interaction, allowing participants to share as much as they were comfortable. I also started each session with a friendly and personal introduction whilst asking about their day to create a sociable environment before I started recording. This helped establish trust and reduced any apprehension that participants might have had. Lastly, there is a cost-benefit for online interviews where no costs are associated with travelling to the venue (Walliman, 2006, Cohen et al., 2013). This was particularly advantageous as my research had a limited budget.

Although it may be argued that there are limitations to the online data collection methods, there are strengths in this method, especially when researching sensitive topics and hard-to-reach groups. Dodds and Hess (2020) conducted a qualitative study with young people and their families on youth alcohol consumption and family communication. The authors also used this study as a tool to assess the online research methods and reflect on their strengths and limitations. The benefits of online group interviews were that they were comfortable, non-intrusive and safe, engaging and convenient, easy to set up, and had clear communication. The limitations were that communication may have flowed better face-to-face, participants had concerns about online privacy, and there were some set-up issues where more than one participant were on the same device (Dodds and Hess, 2020). Online interviews may be the 'new normal' in research post-pandemic , and with the continued development and usage of virtual meeting platforms, distant research methods are slowly becoming an option (Farooq and De Villiers, 2017). Work by Dodds and Hess (2020) in conjunction with literature from Lijadi and Van Schalkwyk (2015), Abrams et al. (2015), and Ienca and Vayena (2020) amongst others, was used to guide online data collection in this research.

4.6.2 Piloting the study

The first step in my data collection was to carry out a pilot study. Pilot studies are commonly associated with quantitative research. However, a number of major qualitative studies use pilot studies in preparation for the full-scale data collection (Aziz and Khan, 2020) and identify the

best approaches to how the participants should be recruited, data collected and findings analysed (Malmqvist et al., 2019, Gill et al., 2008). The significance of the pilot study was that it allowed for the interview schedules to be tested on a small methodological scale. This also allowed for testing the recruitment strategy and online data collection methods. According to Malmqvist et al. (2019), pilot studies also allow the researcher to improve the research quality and should be seen as a crucial part of the research process.

Lessons learnt from the pilot study

The recruitment process for the pilot study followed the same steps as was intended for the main data collection. Participants for the pilot were recruited through snowballing and convenience sampling. A potential participant was first approached and asked if they would like to participate in the study. They stated that they had a group of international students willing to participate in the pilot study. The group was contacted via email, and the PIS and informed consent forms were sent. Some participants did not agree to participate, although ultimately, four agreed, and we arranged a date and time for the group discussion. Each participant was allowed to ask questions and sign the Consent Form before the discussion. For the in-depth interviews with African migrants, I contacted a potential participant from a third-sector organisation that I was an active member of. This individual fits the inclusion criteria for this study. I emailed the individual, introduced the study, and asked if they would like to participate. They responded and suggested two more participants who had also agreed to participate. I reached out to the two potential participants via email, and they responded positively. Each participant responded and agreed to participate and sent back a signed consent form. I then invited the participants to a pre-interview telephone conversation. I spoke to each participant over the phone, which assisted me in establishing their fluency in conversing in English and allowed each individual to ask any additional questions. Though brief, this telephone conversation allowed the researcher and the participant to build a rapport and converse in an informal setting before the interview. Thereafter, a date and time were arranged for a Zoom interview between the participants and me. A similar process was followed for the rest of the participants in this study.

The recruitment of the participants was straightforward. However, online communication did present some other various issues. The signing of informed consent forms posed a challenge for participants as some had no access to and/or knowledge of technology. This challenge was mitigated with verbal consent, which was recorded and documented for participants who could

not digitally sign the form. The next issue was connectivity, and although it did not pose a major obstacle during the study, it was anticipated to be an issue. There was no direct solution to this issue, participants experiencing connectivity issues were allowed to re-join the Zoom meeting once the issue was solved. This did not pose a major obstacle, as connectivity was generally good during the data collection process. Overall, the pilot study achieved what it sought to do; feedback was received from participants, and this provided insight into the data collection on a smaller scale. No significant changes were made to the data collection instruments apart from refining the wording of some of the questions, and the data collected during the pilot was used in the main study.

Focus group discussions and in-depth interviews with participants

Following the piloting phase of the study's interview schedules, the first phase of the data collection was initiated. Various migrant organisations and groups (gatekeepers) were contacted through email, social media (private message on Facebook) and telephone, where I introduced myself and detailed the purpose of the contact (see section on participant recruitment strategy). A follow-up online meeting was arranged where gatekeepers introduced me to potential participants to answer any questions that they might have. We then discussed possible dates and times for the focus group discussions (FGs). All time slots were allocated for a minimum of two and a maximum of six participants, and each slot was filled up on a first-come, first-served basis. Prior to the FG, participants were encouraged to read the information leaflet, sign the Informed Consent Form, and return it to me via email. All participants in the study signed the Consent Form, and those who could not do so gave verbal consent (further detailed later in the chapter). Participants were also notified that all FGs would be conducted online and the software (Zoom) would be used. Any connectivity issues were addressed prior to the FG to ensure that the FG started promptly.

Participants joined the secured online room on Zoom at the agreed date and time. I then introduced myself again and set ground rules for the discussion. Participants were reminded that the conversation would be recorded and were given the opportunity to switch their cameras off if they preferred. The first part of the discussion was the ice breaker, where the participants and the researcher introduced themselves to the group and shared a bit about where they come from and what they love about it. The following themes were explored during the discussion (see also Appendix C): general thoughts on the life of African migrants living in Scotland (adjustment, challenges, pre & post migration life), perceptions on mental health (attitudes,

beliefs, & stigma), and thoughts on mental healthcare, support and treatment (types of support, help-seeking behaviours, barriers to hep-seeking and solutions). In closing, participants were briefed on other ongoing data collection activities they may want to participate in. I also encouraged participants to ask any follow-up questions at the end of the discussion. Each FG was recorded, and recordings were transferred to the University's password-protected cloud storage.

Interpersonal characteristics were a particularly important consideration in the FG. Stewart (2015) highlights the importance of interpersonal characteristics and how they influence group behaviour and performance. Individual characteristics (demographic, physical, personality, etc.) influence a participant's behaviour and how they interact in the group. A combination of personal characteristics may lead to an unsuccessful or successful discussion. Especially in sensitive discussions, the group formation needs to be carefully led/managed. In this study, focus groups were formed of individuals with a homogenous background in the sense that they were all first-generation African migrants currently living in Scotland and had a common association with a migrant organisation, community group or church.

The semi-structured interviews were held with volunteers from the two FGs, gatekeeper invites, and responses from advertisements (see section 4.4 on participant recruitment strategy). Each participant was required to read the PIS and sign the Informed Consent prior to the interview. In line with the local COVID-19 restrictions, participants were invited to an online interview with me. Once a time and date were agreed upon, the meeting was set. The interview began with a brief introduction and a reminder of the details of the PIS. The following themes were discussed (see Appendix C): a general warm-up discussion (pre and post-migration experiences, adjustment), general perceptions on immigration (public & media attitudes towards migrants, racism and/or xenophobia, impact negative attitudes have on migrants wellbeing, political climate towards migration), perceptions on mental health (attitudes, beliefs, experiences before and after the pandemic), thoughts on mental healthcare, support and treatment (help-seeking behaviours, experiences with help-seeking, perception on health professionals' relationships with migrants, challenges seeking support, cultural differences), and thoughts on future initiatives (suggestions on overcoming barriers to mental health support). Participants were then thanked and given an opportunity to ask any additional questions and give feedback on their experience.

4.8 Data management and analysis

4.8.1 The process of transcribing

Each audio recording was transcribed using the recorded interview data from the focus groups and individual interviews. Transcribing raw data is vital in data analysis as it involves the reduction, interpretation and presentation of data in written form. The process of transcription is often treated as a behind-the-scenes task. This step plays an important role which has the responsibility to represent the participant's account through a meaningful dialogue. Oliver et al. (2005) encourage a process of reflection throughout the process of transcription and for researchers to critically interrogate their transcription decisions. This is particularly important because transcriptions do not merely convert spoken interviews into text; they represent a contextual interchange created by the participant and researcher (Widodo, 2014). Throughout this dialogue, the research data is already being analysed and interpreted by the researcher, which makes the transcript more than a behind-the-scenes action. Through using an online platform such as Zoom; automatic audio transcriptions of each recorded interview were generated. However, because of varying accents and pronunciations, these transcriptions did not provide an entirely accurate verbatim representation, which required me to go through all generated transcriptions and correct any errors. This also allowed me to reflect on the interview, make note of my interviewing technique, notice any unanticipated conversation and see the emerging themes arising from the interviews.

All transcription took place as soon as possible after the interview, whilst the interview was still vivid in my memory. On average, a session of between 45-60 minutes of recording took 2-5 hours of tidying up the transcript, depending on the accuracy of the transcription generated by the Zoom software. Interviews were transcribed verbatim; however, paralinguistic components such as cough, laughter, hesitations, etc. were left out of the transcripts.

4.8.2 Thematic analysis

Thematic analysis is an approach that identifies, analyses and reports the patterns presented in your data (Braun et al., 2019). Though thematic analysis is not bound by specific theoretic conditions, Braun and Clarke (2006) discuss a version of thematic analysis that is used primarily in qualitative research. This version encourages a process of coding and identifying patterns, with the researcher playing an active role in this process. The patterns are referred to as *themes* and are essential in making sense of the raw data collected. Though there are other

approaches to data analysis, thematic analysis was chosen for this study because it is considered to be suitable for examining patterns, commonalities and differences across data sets (Braun et al., 2019).

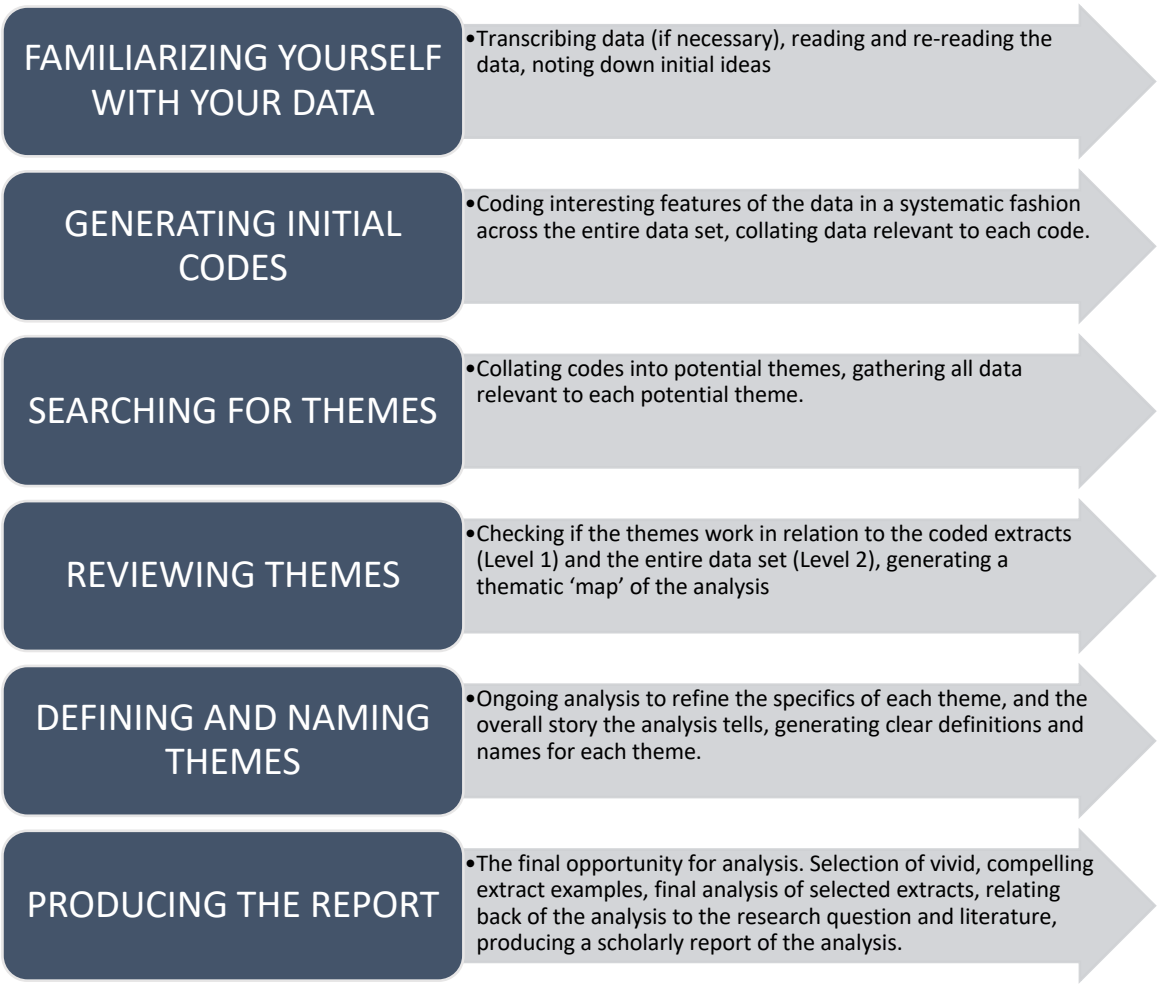

Figure 4. 2: The six stages of thematic analysis accordhing to Barun & Clarke (2006)

Following the process of thematic analysis as described by Braun and Clarke (2006), I familiarised myself with the data, generated initial codes guided by my research questions, searched for potential themes, reviewed the themes and defined each of them and then provided quotes necessary to answer my research questions. Though thematic analysis may be simplified in these six steps, it is, in fact, a process that develops over time and requires the researcher to immerse themselves in the data to find meaningful themes.

I initially tabulated the codes in a Word document to sort my data from the transcripts that I had completed. I combined these codes into sub-themes and then themes and placed the quotes that informed these themes in a column, as seen in Appendix F. This process was aided by the use of QSR NVivo software, which I used to read through each transcript and followed the

steps suggested by Braun and Clarke (2006) to ensure rigour through the data analysis process. I adopted and inductive approach to thematic analysis to provide a rich account of the participants' accounts. Through this process, I started recognising some shared African migrant experiences and how they impacted help-seeking behaviours for mental health. For example, most participants discussed the need to be strong and 'get on with it' in various difficult experiences in their lives. I was able to put together individuals' narratives and discussions from the FGD to progress the analysis and turn the data into themes.

The interpretivist approach recognises the interviewers role who's participation shapes the data. This approach emphasizes the importance of reflexivity, which involves the researcher's ongoing reflection on their own biases, perspectives, and influence throughout the research process (see section 4.5.2 for detailed discussion on reflexivity) (Duffy et al., 2021). During the analysis I acknowledged my subjectivity as being an integral part of the research process rather than a limitation and I reflected on my bias as an African migrant and as a researcher. I kept notes on my reflections which were important in not only documenting my thoughts but to be able to refer back throughout the analysis. Referring back to my notes helped me remember the context of the interviews it also helped me interrogate my perceptions and misconceptions at the time of the interview.

The practice of reflexivity is closely linked to CRT especially when examining issues of race, power and inequality. Reflexivity requires researchers to acknowledge how their own race, class, gender, and other social identities shape their perspectives and influence the research process (D'Cruz et al., 2006, Tang Yan et al., 2022). Within the framework of CRT, reflexivity pushes researchers to critically examine how their positionality interacts with the racial and social dynamics they are studying. For example, a researcher from a privileged racial background must reflect on how this privilege affects their interpretation of marginalized racial groups' experiences. One of CRT's central tenets is the importance of giving voice to those who have been marginalized by dominant racial structures. Reflexivity plays a crucial role here, as researchers must constantly reflect on how they are amplifying or potentially distorting these voices (Tang Yan et al., 2022). A reflexive CRT researcher ensures that the voices of marginalized communities are represented accurately and ethically, rather than being filtered through a biased or limited lens. Although I had a shared identity with my participants as an African migrant I still had to ensure that my findings reflected the accounts given by participants. This was done through summarising and paraphrasing to confirm that my

interpretation of the data aligns with their accounts during the interviews. Moreover I intend on sending summaries of findings to participants giving them an opportunity to provide feedback.

4.9 Conclusion

This chapter has established a justification for the chosen methodology of this research. The beginning of the chapter outlined the underlying theoretical assumptions, positioning the study within a framework of subjective ontology and epistemology that aligns with my research worldview. The chapter proceeded to present the research design and methods comprehensively, detailing each step of the data collection and analysis process.

Following this chapter, a thorough presentation of the findings will be provided and this will be accompanied by an extensive discussion that draws from existing literature to contextualise and elaborate on the primary themes identified in the research. The forthcoming findings chapters are structured to investigate the participants' pre-migratory and post-migratory experiences and how these experiences influence their perceptions and experiences of mental health in Scotland. By examining both past and present contexts, the research aims to shed light on the factors shaping participants' help-seeking behaviours and attitudes towards mental health. This analysis intended to identify critical opportunities to enhance mental health support and intervention strategies. The ultimate goal is to inform efforts aimed at improving help-seeking behaviours for mental health issues, thereby contributing to more effective and culturally sensitive mental health services.

Chapter 5

Pre and post-migratory experiences of African migrants in Scotland

5.1 Overview

This chapter presents the findings on participants' pre and post-migratory experiences drawn from the qualitative interviews and focus groups conducted with African migrants living in Scotland. It reflects their perceptions and experiences through their migration journeys from their home countries to the Global North. It begins by mapping out the pre- and post-migratory experiences of the participants, highlighting their reasons for migration and their experiences in adjusting to their new surroundings. This section emphasises the notion of resilience (discussed in 2.6.3), which emerges as a prominent theme in the participants' narratives. Their resilience sheds light on their ability to overcome adversity and navigate migration challenges. The chapter then moves on to the participants' experiences with racism in all forms.

I use the concept of the ordinariness of racism from the Critical Race Theory (CRT) to analyse participants' accounts. I argue that the normalisation of racism in the Global North, specifically in African migrants' lives, has complex implications for mental health and engagement, which are covered later in the chapter. To gain a deeper understanding of participants' experiences, an intersectional lens is then applied to explore the convergence of racism, gender norms, and social class. By recognising the interplay of these factors, the societal context in which mental health and engagement are situated is better understood. Furthermore, the chapter highlights the importance of addressing racism and its impact on mental health within the broader social justice and equity context. Throughout this chapter, I use CRT and Intersectionality to present a nuanced understanding of mental health engagement among African migrants.

5.2 "You know us Africans, we are very resilient": Adverse life conditions pre and post-migration

The in-depth interviews started with participants talking about themselves and their experience on their journey to Scotland, which is covered in the next three sections. Understanding pre and post-migratory experiences of African migrants uncovers the layered implications that these experiences have on their mental health and well-being in general. Other studies have

highlighted the association between adverse life conditions pre and post-migration and their negative implications on mental and physical health (Kandula et al., 2004, Castañeda et al., 2015, Alegría et al., 2017). Whilst evidence on mental health issues in migrant populations often places refugees, asylum seekers and undocumented migrants at a higher risk due to the higher prevalence of post-traumatic stress disorder (PTSD), depression and anxiety (Lindert et al., 2009, Sen et al., 2018), the hostile attitudes and political environments towards migrants place all groups at risk of distress. I show that although participants in this study consisted mainly of individuals moving for economic, spousal, and family reunification reasons, their experiences adjusting to their new environment posed various challenges.

Classical theoretical models covered in the literature review (see Chapter Two, Section 2.3) examine the various aspects of acculturation and integration and refer to some of these challenges in relation to migrants' socio-cultural and economic integration. Acculturation is one distinct factor that is associated with mental health outcomes, and when an individual experiences some levels of acculturative stress that threaten their well-being, this could lead to depression, anxiety or somatisation (Balidemaj and Small, 2019). All participants in this study were first-generation migrants, which makes them more vulnerable to acculturative stress according to Schwartz et al. (2007) and Fanfan and Stacciarini (2020). The challenges experienced by these participants contributed to a perceived sense of resilience to leverage these obstacles and live under adversity.

5.2.1 Pre-migration: reasons for migration to Scotland

Africa is often seen as a continent of mass displacement and emigration due to poverty, conflict, warfare and environmental degradation (Flahaux and De Haas, 2016, Castles et al., 2014). Though poverty, conflict, warfare, and environmental degradation can be cited for many migratory reasons, a large portion of migration is due to family reunification, work, or study (Schoumaker et al., 2013). According to the Migratory Observation (Vargas-Silva and Rienzo, 2019) , 46% of the foreign-born population in the UK are non-EU citizens who migrate for family reunification reasons, and work and study reasons account for 23% and 17%, respectively. Family reunification is a common reason for migration, as individuals may seek to reunite with family members who have migrated to other countries. Work and study opportunities in other regions can be enticing prospects for personal and professional growth, leading individuals to move in pursuit of their goals (Schoumaker et al., 2013).

The migration patterns of Africans to the United Kingdom have long been shaped by the legacy of colonialism. The historical relationship between the UK and its former colonies has created well-established social, cultural, and economic ties facilitating ongoing population movements. (Czaika and De Haas, 2011). This is covered in depth in chapter 2, section 2.2. The presence of racial minorities in Europe has often drawn connections between the diasporic experiences of contemporary migrants and the colonial histories that precede them. Scholars have also noted how the naming of Britain as postcolonial reflects an acknowledgement of the colonial past that has influenced emigration patterns from the empire and the racial dynamics that have emerged with the arrival of these(Sharpe, 1995). In my research, I acknowledge the racial dynamics and how these deeply entrenched colonial roots have a role in African migrants' lives today.

Participants spoke in-depth about their pre-migratory experiences and how those experiences had continued to influence their current choices and attitudes. Pre-migratory perceptions, attitudes and beliefs on mental health are covered in the next chapter (see Section 6.2). In this section, I discuss the reasons why participants moved away from their home countries, most often than not for a job and educational opportunities, perceived better quality of life and family reunification reasons.

> *The reason I'm here is because my partner, my husband got a position and he got a job opportunity and it was a really cool one, so of course we were going to move, you know.* (Zandi, South African female)

> *I entered Scotland and was granted indefinite leave status to be here because before I was in Tanzania, and I had a partner from this country (Scotland). So, I got married back there and went through the process (to get a visa) and then I came back here.* (Darweshi, Tanzanian male)

Migration theories (see section 2.3) propose various economic reasons behind individuals' migration. Labour supply and demand, wage differentials between countries and individual decisions based on a cost-benefit analysis are some of the motivations for migration. Though some of the underlying motivations for migration were economic in nature for my participants, their migration was more complex than just being driven by economic resources. Issues of security in various forms were discussed by participants as being a contributing factor in their decision to move from their home countries. The concept of human security was popularised in the 1994 United Nations Development Programme's (UNDP) Human Development Report

(Anand and Sen, 1994) and it broadens the understanding of security by encompassing various dimensions of well-being and freedom from threats. Human security emphasises the interconnectedness of different forms of insecurity and recognises that multiple factors can impact individuals' lives and safety. Similarly, Giménez-Gómez et al. (2019) argued that human security is a driver of international immigration. They refer to human security as freedom from fear (threats to the safety of people), freedom from want (threats to basic needs) and freedom to live in dignity (threats to human rights and, by extension, access to services and opportunities). Numerous participants discussed the need for security in various forms as being a driver for their immigration. For example, high violent crime rates in South Africa make it one of the most dangerous countries to live in, particularly for women and children (Sommer et al., 2017, Ward et al., 2018). Zandi reflected on her experiences and spoke about her difficulties regarding safety in her home country.

> *As a woman, it was extremely unsafe for me back home. You're constantly looking over your shoulder and locking your doors because the crime rates are just too high.* (Zandi, South African female)

Like Zandi, Neema and Kalu spoke about the security issues they faced at home which made their day-to-day activities stressful.

> *When you're here [in the UK] your anxiety level reduces, if I was in Nigeria, I would worry about security. I would worry about everything because I know the stress of trying to be safe.* (Neema, Nigerian female)

> *You know security here is good, basically we can walk at night the chances of people doing something bad are low. But the chances[of crime] are higher back home.* (Kalu, Nigerian male, FG 1)

Participants also discussed political situations in their home country and how that was also a source of insecurity. The ongoing crimes of abductions in Nigeria have been a national threat for decades. Reasons for abductions could be for political reasons, for rituals, or for financial gain (Ibrahim and Ibrahim Mukhtar, 2017, Oyewole, 2016). The widely publicised kidnapping of schoolgirls by the terrorist group Boko Haram gained international attention. However, participants said that this was a norm in Nigeria.

> *Everyone is always complaining that all the time you're not safe, even from traveling from one place to the other. You basically have to pray and do fasting before you travel,*

because you might get kidnapped. Looking at that, I prefer this place[Scotland]. (Tola, Nigerian female, FG 1)

Yes, kidnapping is very common, and if your family does not have the money, you are in trouble. It is scary to know you can leave your house and not come back. (Chukwu, Nigerian male, FG 1)

Some participants like Ekoche and Segun chose to move to Scotland for financial and educational reasons by finding a way to extend their study opportunities. Both participants had established careers in Nigeria, Ekoche working in a bank and Segun in a university, but they felt that to gain access to better educational and professional opportunities, they had to move abroad.

I came here in 2009 to do my Master's at the University of Glasgow. At the completion of my Masters, I got a studentship to study, to do a PhD project. (Ekoche, Nigerian female)

Before, I would say I was pretty comfortable before I came to the UK, it's not like I'm not comfortable now, but I was living a good life before coming here. But one thing I wanted to do is to study for my PhD, which is a good opportunity. Not everyone gets the opportunity to travel or even study this far. (Segun, Nigerian male)

In Nasha's case, he had previously moved to the UK for his master's degree, then moved back to Nigeria because he struggled to adjust to life in England. He said that after a few years of living in Nigeria and working as a lecturer, he decided to try again and move abroad, and this time he moved to Scotland because he felt that there was an opportunity for the career he wanted:

That's why I had to come back to say this is my vision, I want to get that expertise. Because I guess they have the manpower and the platform for the industry that I want, so I made my decision to come back here. (Nasha, Nigerian male)

Educational opportunities are a significant factor driving the migration of African people, with many individuals seeking higher education abroad to access quality educational institutions, advanced research facilities, and diverse academic programs (Ke et al., 2022, Flahaux and De Haas, 2016). In the case of Ekoche and Segun, the desire to extend their study opportunities in Scotland reflected the aspiration for personal and professional growth through education, a common theme in migration stories. Individuals may perceive that other countries offer better

healthcare, education, social services and career prospects, motivating them to seek a better quality of life for themselves and their families.

Three participants also spoke about the lack of adequate healthcare in Nigeria and that it was worse in the rural areas, which is important because Nigeria is predominantly rural. This means that most of the population has limited access to quality healthcare (Janssens et al., 2016). Tola spoke about access to healthcare for the poor and said that receiving healthcare was easier for those who had the finances:

> *So that's why most Africans come here, because you're not getting the health facilities you need because you can't just go into an hospital, you need to be financially buoyant to get help.* (Tola, Nigerian female, FG 1)

Segun spoke about how, because of inadequate healthcare, people did not get medical care unless they were physically unable to do anything due to their health:

> *Primary care is not readily available in Nigeria. It is also not appropriate to go to the doctor when you've got a headache, you go to the doctor when you've gotten to the point where you can no longer walk.* (Segun, Nigerian male)

Human security, as defined by the United Nations as a reason for migration, agency when it comes to African migration to the global North. It brings forward the individual contexts that influence migration rather than giving a broad reason, like certain migration theories have previously done. It also emphasises the structural issues that lead to migration beyond economic gain. Participants spoke about the insecurities that affected their lives, specifically their context. These insecurities reflected their experiences as people of a particular gender, ethnicity, and background at a particular time. By understanding the insecurities that influenced their lives, participants in the study could provide valuable insights into the real-life experiences of African migrants. This approach acknowledges that migration decisions are not solely driven by economic factors but can be shaped by the need for safety, dignity, access to services and better opportunities. Each individual's migration experience responded to their specific context and challenges.

Critical Race Theory (CRT) provides a powerful lens to analyse the complex relationship between historical colonialism, imperialism, and contemporary migration patterns. This perspective emphasises how historical legacies of power, exploitation, and inequality continue to resonate and explain why people migrate today. The legacy of exploitation and displacement

continues to impact human security in the Global South. The exploitation of resources, land and labour during colonial and current times disrupts existing social and economic structures, leaving communities vulnerable to poverty and instability (Mayblin and Turner, 2020, Midgley and Piachaud, 2011). These conditions have been key drivers of migration, as individuals and families seek better opportunities and escape economic hardships that stem in part from the historical exploitation of their regions. The dominance of colonial powers further reinforced racial hierarchies, where certain racial groups were positioned as superior and others as inferior. This dynamic has far-reaching implications for migration, as individuals from the former colonies may migrate to countries associated with former colonisers, seeking opportunities, education and refuge (Fechter and Walsh, 2013, Flahaux and De Haas, 2016). The inequalities and injustices ingrained in colonial and imperial systems have continued to shape societies long after formal colonisation ended. The socio-economic disparities that originated from colonial exploitation continue to influence access to education, employment, health and social resources. As a result, individuals and communities that have historically been marginalised are often more likely to migrate in pursuit of better prospects and improved living conditions.

However, it is crucial to recognise that while migration may address certain insecurities, it can also bring new types of insecurities post-migration. The process of settling in a new country, dealing with cultural differences, navigating statutory systems and facing potential discrimination can create new challenges for African migrants. Some may argue that migration governance is a mode through which contemporary racial and class hierarchies are reinforced (Mayblin, 2017, Bhambra, 2017). Understanding these post-migration insecurities is essential for providing appropriate support and services to help migrants adjust and thrive in their new environments. Adopting a human security perspective in understanding African migration allows for a more comprehensive analysis of the factors influencing migration decisions. It places human agency and real-life experiences at the centre of the discussion, leading to a more informed and contextually sensitive understanding of migration.

5.2.2 Post-migration experiences and the quality of life

After migration, participants in this study hoped to improve their lives in various ways. Beyond economic and educational pursuits, most sought an overall improved quality of life. This encompassed factors such as access to better healthcare, a safer environment, and better public services. The aspiration for an enhanced quality of life highlighted their desire to improve their well-being. Some participants settled in other countries before coming to Scotland, and some

arrived directly from their home country to Scotland. When they discussed their experiences and quality of life post-migration, participants often referenced other countries they had been to besides Scotland. The accounts in this thesis are based on experiences in Scotland, with some comparisons made to other countries where they lived.

Drawing on their experiences, most participants felt that though adjustments were not easy, settling in Scotland had been easier than other countries they had lived in previously. Participants often mentioned the warmth and kindness of people in Scotland as something that made their adjustment easier. Feeling welcomed and accepted by the local community can foster a sense of belonging and reduce feelings of isolation or alienation that migrants may experience in a new environment:

> *I found it very friendly, and I think that just being in Scotland, made it a little bit easier because the people are different it's almost like being in Africa in a different country because people are quite laid back here and they're very accepting.* (Zuri, Kenyan female)

Mohammed, Tinashe and Zandi spoke about their experience in Germany, where they did not feel as welcomed and had issues adjusting.

> *So there are outcasts or people who might not be happy by our presence here[in Scotland] but all in all, people are good. I mean comparing to people I met in Germany; Scottish people are quite humble and congenial.* (Mohammed, Eritrean male)

Tinashe also spoke about the difficult work culture she had to adjust to, which affected her mental wellbeing:

> *Adjusting to a very toxic work culture in Berlin, specifically. We were so overworked!* (Tinashe, Zimbabwean female)

Zandi further spoke about the feeling of belonging or lack thereof in other countries she has lived in:.

> *I just find them [Scottish people] generally so nice, and I think it's probably because I am comparing it to all the other places that I've been. From living in Cape Town, to living in Berlin then living in Switzerland. I know the varying degrees of being in spaces where you belong, but you kind of don't [belong]. It's a sense of you can play with us, but you can't sit with us.* (Zandi, South African female)

Positive social interactions and a welcoming society can provide a safety net for migrants, allowing them to build social networks, access valuable resources, and better understand the local culture. These connections can be essential for navigating the practical aspects of daily life, such as finding housing, employment and educational opportunities (Phillimore, 2021, Kirkwood et al., 2015). The friendliness of the people encountered might also counteract any potential experiences of discrimination or prejudice that some migrants may face. Furthermore, migrants often face isolation and loneliness due to the unfamiliarity of their surroundings and the absence of familiar support systems. Positive social interactions counteract this isolation by creating a sense of belonging and companionship. Meaningful interactions contribute to mental and emotional well-being, helping migrants combat feelings of loneliness. The participants' experiences align with their rebuilding of social capital, which will discussed in depth in Section 6.3.4.

The Scottish weather and climate, in general, were the most mentioned when talking about aspects they had to adapt to. Most African countries experience extremely warm weather throughout the year, in contrast to Scotland's climate, which was a difficult adjustment for many participants. When asked about their post-migratory experiences of settling, immediately Zandi and Kelechi spoke about their experience with the Scottish weather:

> *Did I have expectations or knowledge about Scotland or anything like that, not really. About the United Kingdom, in general, yes, probably knew a lot more about England than Scotland. This is where the low expectations come in, I just knew it was this country somewhere in the north, that's super grim and angry.* (Zandi, South African female)

> *It took me a long time to get used to the darkness and the constant rain. Even now when I have to leave the house, I wear lots of clothes to make sure I am covered.* (Kelechi, Nigerian man)

Adjusting to the Scottish weather is a practical and tangible aspect of the post-migration process that directly impacts daily life. Participants' experiences with the climate can influence various aspects of their lives, from clothing choices to daily routines and overall well-being. Adapting to colder temperatures, rain and limited sunlight during certain seasons can be challenging, especially for those not accustomed to such weather conditions (Shor and Roelfs, 2019). The participants' experiences with the Scottish weather reflect the sentiment shared by many migrants settling in Scotland. The change in weather patterns can affect migrants'

physical and mental well-being, as it may contribute to feelings of discomfort, isolation or homesickness (Shor and Roelfs, 2019, Martinez-Callaghan and Gil-Lacruz, 2017).

In FG 1 Akin also spoke about environmental factors and concerns about the consequences of poor air quality in Glasgow:

> *The environment you live in is very polluted, the pollution is bad. I lived here for over four years, and I started having lots of respiratory problems, I was feeling sick because of how polluted it is.* (Akin, Nigerian male, FG 1)

Though participants expressed that the friendly nature of Scottish people made it easier to settle in, aspects of their post-migratory life that related to the socio-cultural adjustments as an indication of their quality of life were not as positive. Negative experiences often referred to the lack of social connection of family support and the culture shock relating to language and a different way of life.

Socio-cultural adjustments are complex and largely influenced by pre-migratory factors, where the differences between the home country and the host country can make it harder for migrants to adapt. Theories of acculturation and assimilation (covered in Section 2.3) have been critiqued and tend to overlook the difficulties of identity negotiation and its influence on adjustment (Ventriglio and Bhugra, 2019). Ventriglio and Bhugra (2019) argue that people have micro-identities which may form a part of their broader identity. For example, participants in this study not only identified as African but had various other identities related to their gender, religion, sexual identity, or their profession. With each of these micro-identities, individuals may hide some parts and present different identities, depending on the circumstances. Ventriglio and Bhugra (2019) make the example of sexuality, where individuals may decide to present themselves in a certain way to hide their sexuality to avoid stigma in their communities. Social acclimatisation and adjustment may differ for different individuals within this identity management process. Furthermore, migrants may face dilemmas in maintaining aspects of their original cultural identity while integrating into the host culture. This may cause a sense of internal conflict and identity confusion.

The process of identity negotiation can be complex and emotionally challenging as individuals try to reconcile their heritage and values from their home country with the cultural norms and expectations of the host society (Asante et al., 2016, Cook and Waite, 2016). Theories of acculturation and assimilation often suggest a linear progression towards adopting the host

culture or completely assimilating, overlooking the diverse ways individuals adapt to the host culture while also retaining elements of their original cultural identity. In reality, many migrants find themselves in a state of cultural hybridity, maintaining certain aspects of their heritage while embracing elements of the host culture. This cultural negotiation and blending process can lead to feelings of uncertainty and isolation as they tackle the questions of belonging and acceptance (Arthur, 2016). Moreover, external factors, such as discrimination or hostility towards migrants, can further complicate the process of identity negotiation, which will be covered in depth in the next section on the 'Ordinariness of racism'. Negative encounters in the host society may reinforce feelings of marginalisation and hinder a sense of integration and acceptance.

One of the most mentioned socio-cultural difficulties was the language barrier, which, as a marker of culture, is an important integration tool and without it, adjustment can be extremely hard. Language barriers can affect many aspects of migrant life such as education, employment and healthcare. In educational settings, limited language proficiency may impede academic progress; in the job market, language skills are often essential for securing employment and advancing in a career. This is a well-cited barrier to adjustment and can be a tool for othering (Eren and Çavuşoğlu, 2021, Claeys et al., 2023, Parveen et al., 2017). As discussed in this chapter, the lack of understanding of local languages reminds the individual of their belonging in society, which perpetuates multiple vulnerabilities. Although all participants in this study were fluent in English, they struggled to understand Scottish accents. Regional accents and dialects can differ significantly from standard English, making it difficult for migrants to fully comprehend spoken language in everyday interactions with people with various Scottish accents:

> *For me, the first thing is the language barrier, because when I got here, it was so hard for me to pick up the Glaswegian accent. That's something that took me a long time. Even now [after living in Scotland for years], I still struggle.* (Tola, Nigerian female, FG 1)

> *Wow, it was tough for me, I studied here, I did my Masters, and it was a bit of an uphill task. The accent of some of my lecturers made it very challenging.* (Adanna, Nigerian female, FG 2)

Nnenna (Nigerian female, FG 2) said that she had not got used to the accent and that her children helped her understand sometimes, even though she had lived in Scotland for over 10 years:

> *I moved to Scotland in 2010, but the language is so difficult because I feel like they don't even speak [local] English. The funny thing is, I just keep saying yes, yes about everything, that has been very difficult for me. Now things are getting better because my children are born here and sometimes, they correct me if there is something that I don't understand.*

Social and organisational networks post-migration were important for participants, where many cited the difficulties of integrating into Scottish society despite the friendliness of the people they encountered. Most participants felt that the onus was on the individual to find ways to make friends because there was a lack of support for finding social groups for newly arrived migrants. Darweshi felt that there was no sympathy or understanding of the changes and adjustments that newly arrived migrants experience:

> *The lack of sympathy, lack of understanding that these are people that have come into this this new environment, new culture, new language, new way of doing things they need to have a helping hand to get through the process. That helping hand does not exist, you know, whether it's at a structure level, or at a friendship level.* (Darweshi, Tanzanian male)

Participants also often referred to the difficulties of starting afresh with friends and careers, which are common experiences for many migrants. Relocating to a new country often means leaving behind established social networks and professional connections, which can significantly impact migrants' overall well-being and sense of belonging. Migrants may initially feel lonely and isolated as they navigate their way into an unfamiliar social environment. The absence of familiar support systems, such as close friends and family, can be emotionally challenging, particularly during the early stages of settlement. Fola and Fathima spoke about this:

> *Coming from a different culture, a different mentality to another setting, one of the most difficult things was actually leaving family behind and come restart all over again.* (Fola, Nigerian female, FG 2)

> *It's totally different from what you are familiar with in Africa, a new way of life, leaving family and friends behind, as human beings, we tend to function well amongst the people who we are familiar with. So you come to a new culture, you are not familiar with anybody, you start to learn the culture, you start to learn the language, to understand the accent.* (Fathima, Cameroonian female, FG 2)

Monifa spoke about the difficulties of being unable to work the same job. This difficulty was often related to various factors, including differences in professional qualifications, certifications, and credentials recognition between countries. The inability to work in the same job as before migration can significantly affect migrants' economic well-being and professional identity. For individuals like Monifa and many other participants who had established careers in their home country, not being able to continue in their previous occupations can be disheartening and frustrating, as shown in other studies (Meraj, 2015, Ogbemudia, 2021). One of the main barriers migrants encounter in accessing the job market is the recognition of their qualifications and work experience in the host country. Some professional licenses and certifications obtained in one country may not be automatically recognised or transferable to another, leading to additional training or education needed to meet local requirements (Ogbemudia, 2021). In some cases, migrants may face deskilling, where they are forced to take lower-skill jobs or pay than their qualifications and experience would suggest. This can lead to a sense of underutilisation of skills and talents, affecting job satisfaction and overall well-being, as reflected in Monifa's experience:

> *What actually gets to me is when you're in Africa, you think you are a career woman. You are this, you are that and then you come to this side of the world and it's like you don't really matter. Your qualification doesn't really matter here. Your qualification doesn't stand a chance.* (Monifa, Nigerian female, FG 2)

Deskilling can also be seen as a manifestation of structural racism. This can occur due to biases in hiring practices, which can be influenced by racial stereotypes and discriminatory policies. Deskilling also restricts upward mobility for skilled migrants, perpetuating their marginalisation that occurs at various levels concurrently. This resonates with claims from Critical Race Theory that systemic barriers prevent racial minorities from accessing opportunities and achieving success. Furthermore, colour-blind policies may fail to address the racial biases that lead to skilled migrants being disproportionately deskilled.

Enita spoke about how she relied on her phone to keep her connected to family at home because she was/felt often isolated. This hinted at the value of transnational connections as a way to maintain a sense of belonging and connectedness with one's home country and family. For many migrants, maintaining transnational connections through their phones and social media is essential to staying in touch with loved ones and preserving cultural ties (Waite and Cook, 2011, Flahaux and De Haas, 2016).

> *You just stay on your own. You don't have any family member like back home. People will come together, sit together and discuss everything [in her own country]. But here, you have to be on the phone. Sometimes, some of the family members will think that you talk too much, and they will not even pick up your call.* (Enita, Nigerian female, FG 2)

While transnational connections offer many benefits, they can also present challenges like in Enita's case, as a heavy reliance on technology for communication may not fully substitute the need for physical presence and face-to-face interactions.

One other participant said that she had no issues adjusting to Scottish culture because she moved into a diverse community with Scottish people who were more open to interacting with other ethnicities:

> *The Scottish community are so good at it [getting to know you], even if they don't understand what you're trying to say, they take all the time to sit down, watch you, listen to you say whatever you want to say, and this is good.* (Zuri, Kenyan female)

The bi-dimensional model of acculturation (explored in depth in Section 2.3) proposed by Ward et al. (2020) explains the process of socio-cultural adjustment of migrants, as also demonstrated by the post-migratory experiences of participants in this study. The first dimension refers to the behavioural adjustments migrants must make through culture learning (Searle and Ward, 1990, Ward et al., 2020). Some of the obstacles faced by participants included culture-specific skills, languages, and norms necessary for everyday life. Participants discussed their difficulties adjusting to the language, different accents and the weather. Though some of these difficulties may be anticipated prior to arrival, the adjustment process requires the individual to experience these differences first-hand. Navigating learning about the culture can be a daunting task, and in cases where individuals do not feel welcome or supported, this can be a difficult transition, which could lead to psychological stress, as mentioned by the second dimension in Ward's model (Ward et al., 2020, Searle and Ward, 1990). This second

dimension refers to psychological adjustments, which refer to one's mental well-being within the new culture, and as with any coping process, this is determined by the availability of one's coping resources. In instances where coping resources are not available, as mentioned by a participant (Darweshi), this can lead to psychological distress.

Overall, participants felt that once they overcame the initial culture shock and found a sense of community, their quality of life was better than pre-migration. Moreover, participants' perceptions of a better quality of life varied according to the different aspects of their lives. For example, most participants felt that they had more financial freedom post-migration, despite the initial financial challenges that come with visa processes and settling:

> *I would say that quality of life has improved, like the earning power (average income) here. The same number of hours you can put to work here and the same amount of hours to do the same work in Malawi, you earn more here.* (Chifundo, Malawian female)

> *Financially, I'm kind of stable now compared to when I was back home because the sponsorship (scholarship) is OK, to take care of me or my basic needs, so I'm comfortable in that area.* (Nasha, Nigerian male)

> *I found that settling in Scotland was better than England for several reasons. Once I was settled, I was happy with the life I had with my children, but it definitely has not been easy.* (Zuri, Kenyan female)

Many participants spoke about their struggles with the financial burdens that come with being an economic migrant in the UK, such as visa fees, student fees and ineligibility of public funds:

> *When you move into a new country, you might have financial issues, maybe you're not coming from a well-funded place. It can be quite expensive to move to a new country from Africa.* (Kalu, Nigerian male, FG 1)

> *It was hard work because obviously when you come, you're not allowed like any benefit, so you have to work and for us who came to study you have to pay international fees, which is not cheap. So me and my husband, we both had several jobs to pay our fees, which wasn't easy.* (Chifundo, Malawian female)

The struggles with financial burdens migrants face are common challenges that can significantly impact their settlement and integration process. Individuals often move to a new

country for better economic opportunities but must contend with various expenses and financial barriers. Visa fees and other immigration-related costs can be substantial and are often necessary for a stay in the host country (Fernandez-Reino and Sumption, 2020). These fees can significantly burden migrants, mainly from economically disadvantaged backgrounds. Paying for visa applications and processing fees can deplete their savings and financial resources, making it challenging to meet other essential needs (Walsh, 2019, Fernandez-Reino and Sumption, 2020).

In a situation like the one Chifundo found herself in, being an international student meant that she and her husband had to have multiple jobs to afford tuition fees and related educational expenses, which can pose significant challenges. Additionally, ineligibility for public funds or social welfare benefits can leave economic migrants without access to crucial financial support systems in their host country (Odumade and Graham, 2019). This lack of financial assistance can exacerbate their difficulties covering essential living expenses, such as housing and food. The financial burdens that economic migrants experience can lead to stress, anxiety, and feelings of insecurity (Webber, 2019). This financial strain may force migrants to make difficult choices between meeting basic needs and pursuing other personal and professional development opportunities.

Critical Race Theory emphasises the concept of intersectionality, which acknowledges that various aspects, such as race, gender, discrimination and socioeconomic status, intersect to create unique experiences of oppression and privilege (Grosfoguel et al., 2015). This perspective goes beyond examining identities in isolation, acknowledging that they interact and compound to shape the lived realities of individuals within complex social structures. For example, Chifundo's position as an international student and a migrant intersected with structural inequalities in education and economic systems. Disparities in wages, employment opportunities, and social safety nets hindered her ability to achieve financial stability. This was a similar experience for most participants. Participants reported experiencing financial burdens leading to stress, anxiety, and insecurity, which shaped their experiences of migration, aligned with CRT's examination of how structural inequalities contribute to emotional and psychological distress among marginalised communities. The financial strain faced by many was compounded by systemic factors that restricted their access to financial support. This limitation, embedded within institutional policies and power dynamics, reinforces CRT's

central assertion that structural factors contribute to perpetuating the struggles experienced by marginalised communities.

5.2.3 Resilience and the African identity despite difficulties post-migration

Following discussions on the difficulties faced pre and post-migration by African migrants, participants emphasised that their resilience had carried them through these times. Participants often asserted that even through adversity, they remained strong because that was part of their African culture, and this led to a recurring theme in the analysis: resilience. Resilience has been used to define the process by which people endure hardships and sustain lives that have meaning and contribute positively to those around them (Van Hook, 2019); this has been covered in the literature review (see Section 2.7). Regardless of the reason for migration, participants said adjusting to their new lives in a different country was mainly a stressful experience. As mentioned in their pre-and post-migratory experiences, significant lifestyle changes such as economic and social conditions, language and weather can be challenging. Though the study participants narrated numerous challenges they continued to face, their resilience and their will to keep going were evident. Some also stated that adversity was a good exchange for a better life in the long term. They saw the adjustment as necessary to get the life they have always wanted, away from the various insecurities in their home country.

Many participants brought up the notion of resilience in various narratives concerning the obstacles they faced. Post-migratory stressors were dealt with by adopting a deliberately positive outlook on their new life's possibilities. This may not have solved their problems, but it was used as a coping mechanism. Chifundo, for example, said she had found ways to adapt and live through her new surroundings. Compared to her pre-migratory life, she felt solutions had always been possible in Scotland. Similarly, Tunde had always had the desire to leave Nigeria, so any challenges that he encountered matter less because he had achieved his goal of moving:

> *It hasn't been easy, but it has always been possible, there's always opportunities, where you are able to explore and be able like to adapt and be able to find your way through society in that way.* (Chifundo, Malawian female)

> *I just moved on, I wasn't challenged in terms of adjustments or missing home or any of that kind of stuff. I certainly wasn't missing home because, you know, I'd always wanted to kind of come over, so you know, I just got on with it.* (Tunde, Nigerian male)

Zuri, who had lived in Scotland for 22 years, said that she and her family arrived when there was not much diversity in Scotland, which made her adjustment more difficult. However, like other participants, she showed a level of resilience, and she had to continue with her life:

> *When I first came actually it was those early days I could walk through Sauchiehall street and not see a Black person at all. But it was okay, I mean we didn't suffer a lot, there was a few kids here and there, who you know were a bit funny, but generally, it was OK.* (Zuri, Kenyan female)

The participants saw resilience as a largely positive attribute; however, some believed it was a tool to overcome adversity. Most participants normalised their adversity and said that as an African, a man or woman, they had to stay strong and keep going. This can especially be problematic when engaging in help-seeking behaviours, which will be discussed in the next chapter.

> *Don't you know that's what men do when they go through a tough situation? Especially coming from an African background where you know, you don't really cry, you don't really show your emotions. You're expected to be seen as very strong. But you're really suffering. You're really struggling, but you can't say, so you keep it, because what would people say about you?* (Abidemi, Ghanaian male)

> *Then I remember going back home and then sharing this story (racist attack) with the family (he was staying with in Scotland), no one took me seriously. This is where I realised that this is not a joke. I need to step out and find the strength within myself to man up because whatever you do, wherever you are, you're going to be on your own.* (Darweshi, Tanzanian male)

In the case of women, there were certain expected gender roles highlighted by participants which required them to be strong through adversities. Ekoche (Nigerian female) recalled having to deal with her children reporting experiences of racial microaggressions and how she had to be strong and encouraging:

> *As a mother, you cannot show that you are worried or sad because your children will see that, and it will make them sad. That's why in those cases where they told me these things (experiences with racial microaggressions), I would just encourage them to be strong and ignore them.*

Similarly, Zuri (Kenyan female) recalls her experiences when she newly arrived in the UK and had to decide on where to settle as a single mother with two children:

> *We first lived in England, but I did not like it and felt it wasn't suitable for me and my kids. I then had to move to Scotland, which did not have many Black families at the time, so it was hard. But I had to make it happen for me and my kids.*

The way participants spoke about resilience was varied and multifaceted, which showed the complexity of the adjustment process in migrant groups. The above statements show that their resilience has been a combination of their lifelong experiences and social conditioning.

The concept of resilience has received more significant interest in stress and trauma research to understand health implications (Ciaramella et al., 2021). In mental health, research on resilience has highlighted the ability of people and communities to possess capacities, skills, knowledge, and potential for self-reliance or to become co-producers of their support system rather than passive recipients (Pattoni, 2012). The resilience of African migrants in this study can also be seen as a legacy of some of the economic and political strife the participants had to endure in their pre-migratory lives. The strife has given them the tools to devise individual coping strategies rather than rely on external support systems. This is evident in some of the quotes where participants viewed their struggles as an individual experience they had to deal with on their own. Bell's (1992) articulation of CRT explains how historical and structural inequalities, often rooted in colonialism and imperialism, influence migration patterns and experiences. The resilience observed among African migrants in this study can be seen as a legacy of the challenges they faced before migration. CRT also emphasises how racialised groups develop coping strategies in response to systemic oppression. Moreover, the participants' reliance on individual coping mechanisms instead of external support systems reflects the limitations of available resources and the need to rely on their own strengths, echoing CRT's analysis of systemic barriers.

Though post-migratory adjustments are not unique to individuals, the participants here showed that their coping mechanisms relied on personal initiative rather than on seeking external support. However, there is a thin line between healthy coping mechanisms and counter-productive approaches brought on by stigma (Boardman et al., 2011). Participants often stated that showing signs of struggle or not being able to cope was not acceptable in their culture, which gave them little to no choice but to be resilient. Especially in instances of post-migratory adjustments and struggles, the stigma associated with not being able to cope carried the risk of

being labelled as ‘weak’, which has negative connotations in many African communities. Moreover, the idea of failing after relocating to a new country due to the inability to cope made them develop resilience to the issues they faced. Cultural norms and gender roles intersect to shape individuals' experiences, and the stigma associated with not being able to cope is rooted in cultural norms and can be amplified when intersecting with gender expectations. Undoubtedly, this can impact help-seeking and mental well-being and may lead to poor health outcomes, as discussed in the next chapter.

5.3 The ordinariness of racism in the UK and its impact on African migrants’ wellbeing

While speaking about issues surrounding adjustment and post-migratory experiences, participants discussed their experiences with racism. In this section, I use concepts from Critical Race Theory (the ordinariness of racism) to analyse experiences of overt and covert racism and how its ordinariness has been embedded in the Scottish society and institutions the participants in this study engaged with. I argue that politics and media serve as facilitators of racism by perpetuating prejudicial narratives about African migrants. As a result, the combination of the permanence of racism, social class and gender norms presents conducive environments for mental health issues to thrive in these communities.

Most of the participants in this study spoke about instances where they had experienced racism in either covert or overt manners. Drawing on the concepts of racism and ethnic identity covered in section 2.6 and bringing concepts from the Critical Race Theory (CRT) discussed in more depth in Chapter 4, such as the ordinariness of racism and interest convergence, I analyse how racism played a significant role in participants’ lives. In many contexts, the adjustment and resilience of African migrants are further influenced by experiences with racism in the new environment. Research on acculturation and adjustment of migrants in the UK has continuously shown evidence of experiences of overt racism, whilst anti-racism policies are not addressing the racism that exists in the institutions many migrants engage with and rely on (Fernando, 2010, Scott-Jones and Kamara, 2020). The intersecting layers of overt and covert racism have been known to have a sustained impact on individuals’ quality of life through reinforcing socioeconomic disparities and reduced access to educational resources and employment opportunities (Williams et al., 2019). Though there has been less focus put in most literature to distinguish between racism experienced in Scotland and racism in other parts of

the country, the findings of this thesis focus/report on experiences in Scotland. To further situate participants' experiences with mental health and engagement with services, participants' experiences were explored and analysed through the lens of Critical Race Theory's overarching concept of the 'ordinariness of racism'.

5.3.1 Experiences of overt racism

Whilst all participants acknowledged that their experiences in Scotland had been more positive than in other countries they had lived in, such as Germany and England, they detailed instances where they had experienced overt racism and the impact this had on them. Almost every participant had at least one incident to share where they experienced an overtly racist encounter. Darweshi and Chifundo narrated experiences where they were physically attacked. Their experiences described severe attacks which occurred in public whilst they went on about their regular lives:

> *One day, on a rainy day, I was attacked by four people when I was going to work. These four gentlemen, you know, when you look at white people, they look like decent people. They jumped on my neck, and the other one knocked my legs, so I fell down.* (Darweshi, Tanzanian male)

> *I have experienced [racism], where people have thrown eggs at me because of being an immigrant. Of course, I didn't take that to heart, I can't come to the level of people who are like that, I just stood up for myself and moved on.* (Chifundo, Malawian female)

In both cases, Darweshi and Chifundo described how people who witnessed the attacks did nothing to assist them during or after the attacks, which added to the hurt that they felt:

> *But you know what traumatised me was not the action of those four people; it was the passiveness and the inaction of the people who were standing by. Nobody did anything, nobody. You can imagine the trauma that this has created.* (Darweshi, Tanzanian male)

The inaction of bystanders during racist attacks has been extensively explored in literature, and various reasons, such as fear, learned helplessness, and the bystander effect, have been given to understand this phenomenon. However, some scholars have explored the lack of action towards racist attacks as being a result of racial biases and discrimination; this has been labelled as aversive racism (Murrell, 2020, Dovidio and Gaertner, 2000). Drawing on a Critical Race Theory perspective, this concept could explain how unconscious racial biases influence how people react to racist attacks around them. This inaction is embedded in the covert racism that

exists in Western societies with subtle nuances, as will be discussed next. The statements made by the two participants above were that these occurrences reminded them that they did not belong. These feelings were exacerbated when they did not receive support from other people who witnessed the attacks, which contradicted the perceived notion of Scottish people being friendly.

The concept of belonging can be linked with migrant social identities, which can be multifaceted due to transnational influences on one's sense of belonging. Transnationalism (see section 2.3) not only refers to the transfer of tangible objects but can also be a source of connection to social identity. For first-generation African migrants living in the UK, the experience of transnationalism can be particularly distinct. They often carry their African identities with them after moving to the UK, and these identities continue to play a significant role in shaping their sense of self and belonging. Waite and Cook (2011) discuss the notion of "straddling lives" and what this implies for first-generation African migrants living in the UK. This notion highlights the duality and complexity of social identities for migrants as they navigate between their African identity, rooted in their cultural heritage, and their British identity, shaped by their experiences in the UK. Balancing these two identities can create a sense of being stretched between two worlds, with conflicting expectations and cultural norms.

Waite and Cook (2011) also highlight how, in some social spaces, individuals' African identity can be prominent, and this may not be congruent with the whiteness portrayed in British identity, which can lead to the feeling of not belonging. Being caught between African and British identities can lead to personal questions of belonging and integration. Migrants may contend with questions about where they truly belong and how to reconcile their dual identities. This process of identity negotiation can be emotionally challenging and may impact migrants' self-perception and mental well-being. I found some similarities in the participants' stories, where they all identified with their African identity and engaged in practices and norms native to their background. They were, however, still aware that living in a different country required them to adjust, which became problematic when faced with racism that reminded them of their "otherness". Given these feelings of otherness, the associated emotions of distress and sadness that develop did affect mental well-being.

5.3.2 Experiencing microaggressions

Not all participants reported cases of overt racism. However, many participants made mention of instances that can be seen as covert racism in the form of racial microaggressions and

experiences of systemic racism. Some authors have questioned the concept of racial microaggression, which has been labelled as non-existent and not worth studying (Harris Jr, 2008, Campbell and Manning, 2014, Lilienfeld, 2017). Denying that racial microaggressions can be perpetuated through politics, social media and the news, which can create and reinforce hostile and invalidating the societal climate experienced by Black people. One common covert racist act that one participant mentioned was the treatment of Black people in supermarkets or shopping centres. Research has documented the discriminatory treatment experienced by Black people whilst shopping and how that impacts access to goods and services and consumer experiences (Bennett et al., 2015). Of interest is the reason behind the racial profiling in settings such as retail, which could result in the constant, regular microaggressions experienced by the participants. Chifundo (Malawian female) narrates how she experienced being followed while shopping and how it impacted her:

> *I've also experienced like in shops the security people following you around, like you're there to steal. Like if I've come in the shop, I have a purpose I'm here to buy I can't be taking things for free. So those are some of the experiences that affect your mental health.*

With covert racism, mundane tasks such as shopping at a supermarket and travelling to work or university can unexpectedly expose Black people to racial microaggressions, which in their nature are not explicit but can have profound harm. Segun narrated an incident where he was on his way home from university, and he encountered a stranger who engaged in what he perceived as a racial microaggression. To an outsider, the exchange may not seem harmful, which is what makes microaggressions hard to identify and address:

> *I was on my way home from uni and I was sitting in the bus and this drunk guy was just making noise and he said something like oh, where you from? So I told him, then he said very confidently that he was very sure that he is the first white person that I was talking to since I got here.* (Segun, Nigerian man)

In Segun's story, the microaggression involved firstly questioning his nationality based on the colour of his skin. His interlocutor then assumed Segun had never spoken to a white person before, which further alienated him as someone who did not belong. Some participants detailed experiences of microaggressions that were experienced by their children in school and the impact it had on them.

> *I remember in my children's school there just two African families and to be fair to the kids, they saw people who were different from them. And with all the social conditioning if you like, that has gone into training children here, they wanted to know; 'Oh do you live in a tree? How does it look in Africa? Why do you have thick lips? Why is your hair like this? Oh, your hair texture'... Now that my children are grown, they would tell me that they would say my name is Sarah because they don't want to use the Ekoche name because it is different to what other people would use.* (Ekoche, Nigerian woman)

These accounts reflect how micro-aggressions may be ambiguous and may or may not have clear hallmarks of racism, which makes it hard to identify. Literature supports the fact that most people find it hard to define racist behaviours that come in the form of microaggressions because racism is often perceived in extremes and may be mistaken as everyday incivilities (Torino et al., 2018, Karlsen and Nazroo, 2002). However, the difference between overt and covert racism is that racial microaggressions are based on someone's race, which results in an interaction that would not have happened otherwise. This is evident in that in some of their accounts, participants spoke about racism in extremes and gave examples of the overt racism experienced by public figures or the injustices that led to the Black Lives Matter (BLM) movement. Debare mentioned the likelihood of him experiencing racism in the UK and said he had been particularly concerned because of the injustices that the BLM movement had brought to light but had not experienced anything extreme. He mentioned incidents with colleagues at work who mocked him because he could not understand customers' accents. Though he did not recognise these as racially charged incidences, these could be, in fact, classified as microaggressions. These incidences were based on racial prejudices that would not have occurred if Debare did not have language barriers.

> *When I started work at McDonald's, I obviously had to interact with people, it was a bit difficult to understand what they were saying and how to slow it down in my head. They go over the order and you're like please can you come again, and they've said it like three times and some of my colleagues found this amusing and instead of helping, they talked amongst themselves.* (Debare, Nigerian male)

Some literature argues that experiences of constant microaggressions can cause more distress than overt racism because one may not know how to react to these instances, putting them in a state of continuous defence when dealing with others. Numerous qualitative studies by Black American scholars have found that long-term experiences with microaggressions and

discrimination have a detrimental impact on physical and mental well-being (Nadal et al., 2014, Loyd et al., 2022, Kogan et al., 2022). However, the challenge is that at the surface level, microaggressions can be seen to have a 'plausible' explanation, making it more difficult to distinguish between perceived and actual racism. For example, Chifundo's experience of being followed around the supermarket can be explained as being a part of regular security measures. However, it has been established through literature and various discourses that this is racial profiling and that white populations do not experience the same treatment. Racial profiling refers to the practice of singling out individuals based on their perceived race, ethnicity, or national origin for heightened security scrutiny or surveillance (Ngo et al., 2018, Gabbidon and Higgins, 2020). When members of certain racial or ethnic groups are disproportionately subjected to such scrutiny without concrete evidence of wrongdoing, it can lead to feelings of marginalisation, anxiety and a sense of being treated as suspicious solely based on their appearance (Gabbidon and Higgins, 2020).

The experience of racial microaggressions can also serve as a constant reminder of migrants' position in society, which is known to have an impact on adjustment and settling in a new environment (Torres-Harding and Turner, 2015). It can also reinforce the firm belief that one group's history, values and way of life is superior, a phenomenon known as ethnocentric monoculturalism (Barker and Ukpong, 2020). I observed this in some of the participants' accounts, which are covered in the next section, where there was a sense of rationalisation towards incidences of racial microaggressions. This points to the concept of "ordinariness of racism", (Delgado and Stefancic, 2017) which refers to the normalisation of racist attitudes and behaviours in society. When covert racism becomes so ingrained and accepted in everyday interactions, it can be challenging to recognise and challenge these harmful behaviours. This points to the ordinariness of racism that runs deep, producing a complacency for perpetuating covert racism in society. By ignoring covert racism, there is little to no space to understand how, under these circumstances, conditions such as poor educational attainment, unemployability and mental illness can continue to impact African migrant communities.

5.3.3 The role of media and political rhetoric on African migrants in the UK

When speaking about their experiences with racism, most participants mentioned the role of politics and media in how African migrants were portrayed in the British press. One of the most controversial relationships in the UK is between the media, politics, and immigration. As covered in Chapter 2, there is growing evidence of the influence of political discourse and

public opinion on immigration laws (Threadgold, 2009, Dempster and Hargrave, 2017). Most participants noted that the media and politics in the UK contributed to the overall negative perception of African migrants, which likely increased discrimination and racism in various forms. Some noted that there was both a positive and a negative influence, especially in Scotland. Anti-migrant sentiments that the UK government holds were discussed about the impact it has on how the public treats migrants. Participants gave examples of the misconceptions that they felt were driven by politics and the media, including misconceptions such as that migrants were "here to take their jobs" and abuse public services. These narratives made participants feel further ostracised and unwelcomed, which profoundly impacted their well-being (Musolff, 2015) and made it harder to adjust to their new environment. Segun spoke about the misconceptions he perceived perpetuated by legislation reinforcing the anti-migrant rhetoric.

> *I feel like some kind of legislation, some kind of laws that were passed on this issue [immigration] portrays… are not so good image about immigrants in the UK. It seems to be a major driving factor for people in the community, because when they see laws passed and when they see politicians talk about some things, they definitely begin to form their opinions about [migrants] oh they're here to take our jobs…* (Segun, Nigerian male)

Segun's point has been made in political discourse on how anti-migrant laws influence public perception. Though most of the reasons behind anti-migrant sentiments centre around the competition for resources, there is also an element of symbolic racism. Symbolic racism is defined as a form of covert racism that acknowledges the liberal movements that advocate for race equality but still maintain anti-migrant sentiment by placing the blame for ill societal issues onto ethnic minorities (Clair and Denis, 2015). Referring to Segun's quote as an example, misconceptions about migrant groups are perpetuated through the discussion of increased migration as a result of failed African conditions rather than through an in-depth discussion of the mechanisms that lead to this flow in the first place. Mechanisms such as political unrest and the lack of security in African countries can be traced back to colonialism and resource exploitation. McLaren and Johnson (2007) also highlight the possibility of British citizens feeling like their values and way of life are at risk due to the influence of migrant religions and cultures, which may be different to theirs.

The notion of immigration is racialised, and when negative opinions about migrants are brought up, they are often referring to non-white migrants, particularly those from specific racial or ethnic backgrounds. This phenomenon is rooted in historical and contemporary patterns of discrimination, prejudice and xenophobia, which have led to the racialisation of immigration issues (Wekker, 2016). Media portrayals, political rhetoric and social attitudes can influence racialised narratives about immigration. Media representations often disproportionately focus on certain racial or ethnic groups in the context of immigration, reinforcing stereotypes and biases. Politicians may also use immigration as a divisive issue to appeal to certain voter bases, contributing to the racialisation of the discourse (Lawlor and Tolley, 2017). CRT highlights how the ordinariness of racism extends to media representations, which perpetuate racial stereotypes and biases. The disproportionate focus on certain racial or ethnic groups in immigration stories can reinforce pre-existing stereotypes and shape public attitudes. Media powerfully shapes public consciousness (Garnham, 2020) and relies on pre-existing racial stereotypes and biases to tell stories. These portrayals reinforce harmful narratives and contribute to the perpetuation of discriminatory attitudes.

One other participant, however, felt that the government and politicians were doing their best to be inclusive and made an example where this was the case:

> *I think that the country is doing a lot to support migrants, for example during the Euro competition, there were racist comments to quite several players that missed the penalty. You have Boris Johnson coming out to rebuke such statements, you have other people in government coming to stand against racism and all of that.* (Debare, Nigerian male)

On the other hand, Darweshi made a critical comment and pointed out the readiness of the public to condemn racism but do nothing to address the systemic racism that exists.

> *Having been in this country for a while, I see that people are very quick to take matters into the public arena, but they're not quick and they're not willing to criticize the system.* (Darweshi, Tanzania male)

He also went on to say that racism is only highlighted when perpetuated on public figures and that the media is playing a somewhat vital role in telling these stories. He highlighted that the media plays a crucial role in shaping public perceptions and narratives around racism and discrimination. The stories covered by the media can influence public awareness and

understanding of these issues. When incidents of racism involving public figures are reported, it can spark national or even international conversations about the persistence of racism in society. However, he says the media makes no effort to interrogate the systems that perpetuate this racism:

> *...up until recently, the media was hostile. Right now, we can see the media projecting some issues of Black people, even though they choose to go for those who are footballers or sports experts, and they portray them as heroes. But the media, I don't know where they are heading with this, because most of the time they may be very good in chatting about things, but not good in criticizing the structure.* (Darweshi, Tanzanian male)

Akin and Abidemi also spoke about the role of media in the misrepresentation of life in Africa, which helps perpetuate prejudice and misinformation.

> *It's all stuck in their mind that we are always starving people, that there are no rich people in Africa, you always starve. We only run away from wars and all that, you know?* (Akin, Nigerian male, FG 1)

> *They [the media] control the world actually. You meet people who haven't gone outside this country, and they tell you what they've watched on TV. I was talking to my wife's friends; they tell me they heard this in the news that we live on trees in Africa and there are animals crawling all over. And I asked them, if animals and lions and snakes are crawling all over, will I be here?* (Abidemi, Ghanaian male)

The last decade has been one with a historic shift in immigration policy in the UK as the public has seen the build-up that has led to the 2016 Brexit Referendum in the UK. Polling has revealed that British citizens have grown increasingly concerned about migration (Smith and Deacon, 2018). This may or may not be the case for Scotland, which has maintained a politically opposing stance, which is covered in section 2.5.1. However, with a growth in internet media spaces, dehumanising metaphors of migrants have not been subdued. Musolff (2015) highlights the stigmatising labelling that online media perpetuates and argues that these are deliberate and based on historical discourse rooted in racism. Likewise, based on the evidence in this study, I say that challenging racism is not only confined to the public disapproval of racist behaviours, but it also should include questioning the systems that allow these behaviours to thrive.

A few participants expressed satisfaction with how racism was dealt with in Scotland. At the same time, they also shared personal experiences that indicated how the system has placed them at a disadvantage due to their nationality or race. For example, in Zuri's case, she felt that Scotland had done well in ensuring the integration of migrants compared to other countries. Participants' experiences with public services such as housing, education institutions, and healthcare have reminded them of their societal position and how services treat them. Zuri recalled working in a housing office where a colleague commented that they would not provide "nice" housing to a migrant applicant because they should "go back to their country". Another stated that they were asked to provide proof of address and some identification to register with a GP, which they thought was not mandatory for other new patients. As covered in section 2.4 of the literature review, in the past, hostile immigration laws allowed the Home Office to track down migrants using information shared with their GP. This means that African migrants being asked for proof of address and identification is not only applied to them but is instead a legacy of hostile laws designed for a specific purpose that might be triggering for people experiencing this. These examples show how politics can serve as a vessel to sustain anti-migrant sentiments, which are breeding grounds for racism.

5.3.4 Coping with racism

Coping with racism is a complex and individualised process, and the strategies used by African migrants to cope with these incidents can vary depending on their personal experiences, cultural background and support systems. Participants said that they were selective about the racist remarks they responded to, depending on the circumstances. Most of the participants said though they were aware of racism, they did not focus on it and that ignoring it was a form of self-preservation. Responding to every instance of racism can be emotionally exhausting. It may not always lead to a productive outcome or can put them at further risk, so participants choosing not to engage with every racist remark allows individuals to protect their mental and emotional well-being. Some participants, like Zuri, attributed racist comments to ignorance and said that she decided if and when to respond, depending on the situation:

> *Because they will always make a comment, I just think to myself, is this worth discussing with this person, is this person educated enough for me to have this conversation with them and if not, I don't waste my breath, but that's me. I've learned that from so many years of being here.* (Zuri, Kenyan female)

By understanding that racist attitudes may stem from a lack of knowledge or exposure to different cultures, individuals may be able to detach themselves emotionally from hurtful remarks. This perspective can help them approach the situation with more patience and empathy, choosing to respond or educate when appropriate and potentially effective.

Ekoche mentioned that challenging discriminatory behaviour in Scotland had been much easier than in other places because people were more aware of the inappropriateness of discriminatory behaviour and tried to avoid racist behaviours:

> *Coming here to Scotland, even though like I mentioned earlier, you see those kind of behaviours [racism], but they are not so obvious. So, if they were not asking other people (for identification) and they ask you and you challenge them, they could let you in, but not in England. But why are you asking for this document (identification) when you didn't ask anyone else?* (Ekoche, Nigerian female)

In one instance, a participant mentioned how he would notice that people would avoid the seat next to him when he was on a train. This made him wonder if it was because he was Black.

> *I don't know, but when I get on the train, I would ask myself why is it that nobody's trying to sit close to me, a Black person. But eventually I realised that maybe it's just that people don't want to get into your space. I know maybe it's because I'm Black, but I just started to not pay attention because I feel like I'm here to study, prove myself and advance my career, and those things should not weigh me down.* (Adedayo, Nigerian male)

Participants had different coping mechanisms with their experiences with racism; some said they ignored the events and carried on with their day, and some said they challenged the perpetrators, like Ekoche. Research has found that experiences or perceptions of racism are also influenced by a person's gender and social class, which also means that racism can affect individuals' health differently (Lewis and Grzanka, 2016, Karlsen and Nazroo, 2002). For example, using the interviews, there were patterns about experiences of racism in Scotland. Using gender and measures of social class, such as income level and occupation, incidents of racism seemed to be less severe for individuals in higher social classes. Little research explores the intersection of social class and experiences of racism. However, there appears to be less reporting of racism amongst people with lower socio-economic resources (Krieger, 2000, Karlsen and Nazroo, 2002, Lewis and Grzanka, 2016).

Women in this study were also more likely to report experiences with racism than men but were less likely to respond to or challenge racism. The difference in gender in this study may be because there were more female-identifying participants. However, there is evidence that the reporting of discrimination is less likely in women than in men. Women are said to be more likely to internalise their experiences and accept marginalisation, which may be a result of the intersectionality of being an African, being Black and being a woman (Karlsen and Nazroo, 2002, Armstead et al., 1989, Karlsen et al., 2020). For African and Black women, the combined impact of race, gender, and ethnicity creates a unique set of challenges that affect their willingness and ability to confront discriminatory practices. This internalisation and acceptance of marginalisation may stem from historical and societal patterns where African and Black women have been systematically silenced and marginalised, leading to a resigned acceptance of their circumstances (Karlsen et al., 2020). Furthermore, the internalisation of racist experiences among women may also be influenced by cultural and social expectations that discourage vocal opposition or confrontation. These expectations can manifest in various forms, such as familial and community pressures to maintain harmony or the perceived futility of challenging deeply entrenched systemic racism (Bletscher and Spiers, 2023). These findings show the importance of considering gender and intersectionality in understanding and addressing the complexities of racism and discrimination in diverse populations.

5.4 Conclusion

This chapter has provided an exploration of the pre-and post-migratory experiences of the participants in this study, drawing from quotes from the interviews and focus groups. By mapping out the participants' migration journeys, the chapter has highlighted the diverse motivations behind their migration and the complex process of adjusting to their new environment. The theme of resilience has emerged prominently, illustrating the migrants' capacity to overcome significant adversities and navigate the multifaceted challenges of migration.

The chapter highlighted the pervasive issue of racism, employing the Critical Race Theory (CRT) concept of the ordinariness of racism to dissect the participants' encounters with racism in the Global North. This analysis has revealed the deep-rooted normalisation of racism and its intricate implications for the mental health and societal engagement of African migrants. An intersectional approach further enriched the discussion by examining how racism intersects

with gender norms and social class, providing a more holistic understanding of the participants' lived experiences. Through the lenses of CRT and Intersectionality, the chapter has shown the critical need to address racism and its profound impact on mental health within a broader social justice realm. It has offered a nuanced perspective on mental health engagement among African migrants, emphasising the importance of contextualising their experiences within the larger societal context. This chapter sets the stage for subsequent discussions on the interventions and policies necessary to support African migrants, advocating for a more inclusive and equitable society.

Chapter 6

Mental health attitudes, beliefs and help-seeking among African migrants

6.1 Overview

This chapter begins with an overview of the perceptions of mental health, attitudes and beliefs shared by the participants of this study about mental health. With these accounts, I argue that these perceptions, attitudes and beliefs were based on pre-migratory cultures. The findings suggest that these deeply ingrained attitudes and beliefs influence migrants' understanding of psychological distress even after migration. By shedding light on these pre-migratory cultural influences, I set the context which may allow us to understand the unique challenges and perspectives African migrants face when dealing with mental health issues. Furthermore, stigma emerged as a recurring theme in the participants' accounts. I discuss here the various forms of stigma as a powerful social force that can hinder open discussions about mental health and create barriers to seeking help. By acknowledging and analysing stigma, I explore the contradictions it poses to African communities' collective way of life. I also look at stigma in healthcare and, lastly, the intersection of racism and stigma. Through these participants' stories, we can gain valuable insights into the factors that contribute to mental health challenges and the effects of post-migratory experiences on their psychological well-being.

This chapter draws connections between participants' experiences and the cultural contexts that shape their perceptions of mental health. By doing so, I hope to identify potential interventions and strategies that can be tailored to meet the specific needs of African migrants. I then explore participants' accounts of experiences with healthcare services and some of the implications these can have on their future help-seeking behaviours. The last section of the chapter presents a way forward, as suggested by participants, highlighting how they feel mental health matters can be improved in their communities. With the majority of the participants stating that they would not use statutory mental health services, I explored solutions that they felt would improve mental health outcomes for African migrants.

6.2 Perceptions, attitudes and beliefs about mental health

Perceptions, attitudes and beliefs about mental health have been well evidenced in migrant health research, and they play a vital role in understanding help-seeking behaviours (Andrade et al., 2014, Arday, 2018, Harwood et al., 2023). Consistent with this, theoretical frameworks (Andersen, 1995) have highlighted health beliefs as a critical factor influencing the perceived need and subsequent use of healthcare. Health beliefs have a crucial impact on how individuals recognise and manage symptoms and seek help, as well as perceived outcomes should they seek help. Though perceptions, attitudes and beliefs provide one means of explaining how culture and social norms influence health behaviours, they have the potential to explain behavioural variation in specific populations such as African migrants. The following three sections demonstrate how pre-migratory constructions of mental health continue to be expressed by participants post-migration. Several factors, such as cultural and religious stereotypes, media stories, and knowledge and access to information and services, influence social constructions of mental health (Choudhry et al., 2016). When asked about mental health, participants had an understanding of what the term meant to them, which was influenced by perceptions, attitudes and beliefs before coming to the UK. Participants discussed stigmatising labels associated with mental illness and what they thought the common causes were that could lead to mental illness. Though there was a diversity in the demographics of the participants, there were concurrent views on mental health and how their African upbringing and cultural beliefs had shaped these views.

6.2.1 Conceptualising mental health and mental illness

As first-generation migrants, many of the participants' belief systems were shaped by the cultural norms and beliefs that they lived in before migration. When asked what mental health meant to them, most participants felt that they were not able to put into words what mental health was adequately. Still, they defined it as a deviation from normal behaviour, referring thus to mental ill health rather than good mental health. All except a few participants used the words 'mental health' when referring to ill mental health. There was little to no differentiation between 'healthy' and ill mental health. Many accounts spoke about the difficulties in identifying mental ill health because they felt it is not as identifiable as physical health. The participants of this study held different meanings and perspectives on mental health that differ thus from Western psychology. In mental health research, cultural relativism is a term that is often used to discuss and advocate for understanding and evaluating mental health issues within

the cultural context in which they arise. It acknowledges that beliefs about mental health, attitudes toward treatment, and expressions of distress vary significantly across different cultures (Corin, 2017, Baghramian and Coliva, 2019) (see section 2.7.3 for further discussion). Many participants found it challenging to put into words what mental health means to them. They also stated that they would speak about their emotions rather than mental health because it is not a phrase they would use in their language. Some participants, like Tunde (Nigerian male), said that they never understood the concept of mental health, as it was a complex term to grasp for Nigerians:

> *I never quite understood the concept [mental health] and I wouldn't be the first person to say that because it's such a delicate area you know, even the professionals sometimes don't understand it themselves*.

Another participant felt that the words 'mental health' were not words they would necessarily use to describe the way they were feeling:

> *I don't think about mental health in those terms like mental health and sound so official. But just what is happening internally. How am I feeling? What am I thinking? Am I okay, with what I'm feeling and thinking?* (Tola, Nigerian female, FG 1)

Participants often referred to emotional wellbeing when discussing mental health; in a focus group discussion, Akin (Nigerian male, FG 1) said: "*I think emotional state of mind is the general definition".* Kalu (Nigerian male, FG 1) also argued that mental health was subjective; "*And again, what counts as good mental health is different for different people".*

Words used to describe mental health differed for everyone, and although all participants in this study were fluent in English, many were multilingual, and English was not their first language. This also meant they used other words and phrases to conceptualise mental health and its meaning. Many of the participants also spoke about specific conditions, such as anxiety and depression, rather than mental health as a whole. Using different words and phrases to describe mental health reflects the influence of cultural and linguistic factors on how people understand and communicate about their emotional well-being. Cultural concepts and expressions related to mental health may not always have direct equivalents in English, leading to variations in how individuals from different cultural backgrounds articulate their experiences.

Some participants said they did not pay attention or label mental health as something that needed to be taken seriously until they were faced with specific symptoms they felt was out of the ordinary. Some also stated that since arriving in the UK, they have had a different understanding of what mental health is, which indicates that mental health is culturally conceptualised and understood. The shift in understanding mental health after arriving in the UK further highlights the cultural conceptualisation of mental health. Exposure to a new cultural context can influence individuals' perceptions and attitudes towards mental health, as they may encounter different approaches to mental health care and destigmatisation efforts in their new country:

> *Back then [in Nigeria], I didn't know that it is a mental health crisis until when I got to the UK, you see that this thing is real…When I couldn't take an exam, they directed me to go to my GP, and when I talked to my GP, they recommended a counsellor. So that's when they now began to teach me about mental health.* (Nasha, Nigerian male)

> *Funny if you had asked me this question four years ago before my studies, I wouldn't really have anything to say. I would've probably never even heard of the word (mental health).* (Segun, Nigerian male)

One participant spoke about not associating mental health difficulties with someone who has a positive outlook on life. This perception is based on the assumption that a positive mindset can protect someone from mental health challenges:

> *I've experienced it first-hand, but before that I never thought I would be in that situation because I see myself as strong, I see myself as having a positive mentality*. (Debare, Nigerian male)

Similarly, Mansa felt that before migration she felt that stress and depression were considered just a difficult time in your life. She says that after migration, her understanding of mental health changed:

> *So when it comes to stress, depression and all those stuff, we see them as you are passing through a horrible time. So we don't really regard that as mental health, but coming here and then coming to understand their definition and classification of mental health. It changed my perception of what mental health is because they will treat even something mild and say it is mental health.* (Mansa, Ghanaian female)

These points made by participants draws on the longstanding debates on how mental health is conceptualised and whether experiences of stress and depression should be considered as mental health issues or typical phases in life. In his early work, Corey Keyes (2002) introduced the idea that mental health exists in a continuum and that people can have varying mental health based on their current situation. In his assertion, he states that mental health is not the absence of a mental disorder but rather the presence of sufficiently high levels of well-being (Keyes, 2002). Keyes statements can ring true from the participants' accounts of this study. As discussed in Chapter 5, participants spoke about various pre and post-migratory stressors that existed in their lives. However, most participants discussed that despite adversity, they remained resilient, which indicated their well-being.

Though mental well-being was something that was seen as necessary to participants, a few spoke about the difficulties in identifying mental health issues as opposed to physical health issues. These difficulties stemmed from the fact that symptoms were intangible and subjective, which meant that physical problems were more frequently considered rather than mental health. Zandi referred to how she has an internal dialogue on whether or not she is ill and says that usually refers to her physical health rather than mental:

> *I probably think about physical health a lot more than I think about mental health, maybe I'm just generally conditioned to think about physical health. Like in general I ask myself if I feel ill. Do I have any aches on my body? It's a little bit more immediate and more obvious.* (Zandi, South African female)

Likewise, Mohammed made the point that mental health is not like cancer, with physical symptoms, so he cannot identify/define it as clearly. However, he also acknowledged that sometimes he might need help with improving his emotional well-being or reducing stress, which indicates that although mental health is not tangible, he has felt signs of distress:

> *I don't have evidence on mental health problems for example like cancer or something. But yeah sometimes you need something to heighten your know emotions or to help you manage stress.* (Mohammed, Eritrean male)

The participants focus on physical health over mental health because it is more immediately identified as a phenomenon observed in many societies. This highlights the prevailing societal norms and attitudes that prioritise physical well-being and often overlook mental health concerns. Physical health issues are usually more visible and tangible, making them easier to

identify and address. In contrast, mental health issues can be internalised and less apparent, leading to challenges in recognising and understanding them. This disparity in identification can result in mental health issues being downplayed or neglected in comparison to physical health concerns. The perception that physical health is more immediately identified may also be influenced by cultural beliefs and how health is traditionally approached. In some cultures, there might be a greater emphasis on physical ailments and treating visible symptoms, while mental health concerns are viewed with less urgency or are associated with stigma.

Research has found a strong association between mental and physical health, where one is affected substantially by the other in times of distress (Scott et al., 2016, Launders et al., 2022). Adedayo (Nigerian male) spoke about how stress can lead not only to physical health issues but also to the inability to do anything at all. He likened it to being pushed against the wall:

> *I have realised now that your brain gets to you when you are having a tough time. It not only affects your physical and it's not you being weak, it's your health, but it's also your emotional health, it's your brain! You can take a walk and try to work through your emotions, but it just pushes you to the wall and you just can't do anything anymore.*

These accounts reflect how mental health is conceptualised in African culture, which can be different from Western culture. Symptoms attributable to mental illness in Western medicine may have different wording in African cultures (Ogutu, 2019, Spittel et al., 2019). Consequently, the terminology employed to discuss mental health might hold distinct significance for African individuals. As stated by some participants, they did not consider stress or depression as being associated with mental health; they treated that as temporary life stressors that they could deal with. Most participants did not distinguish the terms they used when referring to good or ill mental health. They perceived the words 'mental health' to mean illness that disturbed your emotions or spirit. There was no positive connotation to the words, and participants often used the words 'mental health' instead of mental illness. This led to discussions on the stigmatising labelling in African communities, a recurring theme.

6.2.2 Invisible chains: the stigmatising language of mental health

When discussing the language used when talking about mental health, there was a consensus that there were no positive connotations when talking about mental illness. As mentioned before, most participants used the term 'mental health' to refer to ill mental health, which gave some insight into the negative connotations that the term holds in many African cultures. There

was a significant stigma surrounding the conversations about mental health. As covered in the literature review in section 2.6.4, Goffman (1963) coined the term ‘stigma’ to describe a mark of undesirability that makes the bearer tainted or devalued by others. Others have since developed the concept over the decades, but the fundamental hallmark of stigma remains. Participants shared the different words and phrases that are used in African communities to describe someone with mental health issues. Individuals were considered ‘dangerous’, ‘mad’ or ‘unstable’ if they were known to have mental health issues, and participants felt there was little to no understanding that people can manage most disorders and live a ‘normal’ life. Most felt pressured to keep their issues to themselves to avoid the judgement and labelling that came with expressing difficulties to their loved ones. Although most of the participants stated that they had more knowledge and awareness surrounding mental health post-migration, they still felt that stigmatising labels held them back from being open about their mental health. Zandi (South African female) recalled how people with mental health issues were often made fun of, which showed the lack of understanding, which is associated with mental illness, which perpetuates stigma in the community:

> *Where I grew up, people made fun of others that were mentally ill and even now there's a culture to make fun of people that are mentally ill. I think, maybe it's this African thing, where we find humour in everything, maybe it's like a trauma response or something.*

Mental illness is often met with avoidance and emotional numbing within many African communities. These responses, while reflective of individual coping mechanisms, are also deeply embedded in cultural, historical, and societal contexts that shape how trauma and psychological distress are processed (Bovey et al., 2025, Backe et al., 2021). Avoidance and numbing not only manifest at the personal level but also influence communal attitudes toward mental health, contributing to stigma, underreporting, and reluctance to seek professional support. At the communal level, these coping responses often translate into widespread stigma around mental illness, where mental health struggles are either dismissed as spiritual or moral failings, or kept hidden due to fear of social ostracism. Emotional numbing such as detachment or denial becomes normalised, creating environments in which suffering is endured in isolation and psychological support is rarely sought (Ventevogel et al., 2013, Penxa-Matholeni, 2025). This not only contributes to significant underreporting of mental health issues but also creates barriers to early intervention and culturally appropriate care. Furthermore, the lack of language

around mental illness in many African languages limits the ability to articulate distress in ways that are legible to both the community and healthcare professionals, further reinforcing silence and stigma (Kaiser et al., 2015). Crucially, these patterns are not merely deficits but adaptations to structural conditions where mental health systems may be inaccessible, distrusted, or perceived as irrelevant due to their Western orientation.

Strongly tied to their opinions on resilience, the language participants used resulted in them avoiding the words 'mental health' to discuss their wellbeing. The negative connotations of mental illness made them feel they would be showing signs of weakness for experiencing difficulties and that it was unacceptable. Debare (Nigerian male) opened up about his experience with depression but had difficulties labelling it as depression.

> *Well, I've experienced uhh depression, well I don't want to use the word depression. I think the attitude that most people have towards mental health is they see it as really bad, they don't want to own up to it. Nobody wants to admit to it, it has a very bad outlook, it's negative.*

Ekoche (Nigerian female) spoke about the specific words that were frequently used to describe people with severe mental health issues. Like others, she said that there was little to no consideration for less severe illnesses such as depression and anxiety and that people were just considered '*mad*' and '*crazy*':

> *When you say that somebody is suffering from mental health issues, we think we are looking at a madman or a mad person. It's a bit different because mental health could be depression, which is different from just being outrightly mad. I don't know what they call mad people here. I don't think they use that term here? You know what I mean by mad people like on the street yeah, literally mad.*

Most participants said that they had not been exposed to people with mild or manageable mental illness; they would only see people with untreated or severe mental conditions, which reinforced the stigmatising labelling. Descriptive terms such as 'suffering' were used when talking about mental health, which indicated how some participants felt about mental health.

> *Because back home when you said you are suffering mentally, everyone will be like you lazy, mental laziness why do you say you're suffering mentally. But here, they'll say okay take your time.* (Chukwu, Nigerian male, FG 1)

Participants also noted that people with severe mental illness would often be labelled as dangerous in many cultures, and there was a fear associated with mental illness. As a result, some participants said they imagine a person roaming the streets when talking about mental illness:

> *When we think of mental health in Africa, we think of madness. When you've lost your mind and you roam the streets.* (Onyi, Nigerian female, FG 1)

> *Where my native home state we just make a distinction between mad people and that's when we say ohh, this is a psych case or a mental case and he's dangerous.* (Fola, Nigerian female, FG 2)

The association between severe mental illness and dangerousness is a stigma deeply ingrained in many societies, including African communities. Media portrayals, sensationalised stories and a lack of accurate information about mental health can fuel this misconception (Mantovani et al., 2017, Codjoe et al., 2021, McCann et al., 2016). When the community believes that individuals with mental illness are inherently dangerous, it creates a hostile environment that further isolates and marginalises those who are struggling. The imagery of people wandering the streets can be indicative of the general lack of understanding about mental health, particularly in severe cases. In reality, mental illness is a diverse spectrum of conditions that encompasses various symptoms and experiences. People with mental illness are also more often victims of violence rather than perpetrators (Thornicroft, 2020). However, the imagery of individuals aimlessly roaming the streets oversimplifies and stigmatises mental health challenges, perpetuating the misconception that individuals with mental illness are somehow disconnected from reality or pose a threat.

The reluctance to engage with mental health issues in African communities can also be linked to intergenerational trauma, a phenomenon in which the psychological effects of trauma are transmitted from one generation to the next (Ullah et al., 2023, Hoosain, 2013). Historical and ongoing experiences such as colonialism, political violence, economic disenfranchisement, apartheid, and forced migration have left deep psychological wounds that are rarely acknowledged or processed. These collective traumas have fostered a culture of silence, where emotional suffering is internalised and stoicism is valorised. For example, in post-apartheid South Africa, many older individuals who lived through the violence, racial oppression, and systemic dehumanisation of apartheid may avoid discussing their pain, either because they were never given the tools to process it or because they were conditioned to suppress it for

survival (Knight, 2019). Elders who have endured such hardship without acknowledging their trauma may, often unconsciously, model avoidant behaviours minimising distress, discouraging emotional expression, or dismissing mental illness as a Western construct. These patterns are absorbed by younger generations, who then replicate them in their own lives. As a result, mental illness in African communities is not approached with the sensitivity that it should be.

Intersecting social identities: gender norms and stigma

In many African cultures, there exists a set of gender norms that can significantly impact mental health experiences and outcomes for individuals (Weber et al., 2019, Yu, 2018). These gendered norms are social expectations, and roles can play a significant role in shaping how people perceive and cope with mental health challenges (Watson and Hunter, 2015). Embedded within the fabric of African societies, these gender norms delineate roles, behaviours and responsibilities considered appropriate for men and women. They often reflect deeply entrenched cultural values, historical traditions and perceptions of masculinity and femininity. These norms create a set of expectations for how individuals should interact with the world around them, and they inevitably intersect with the realm of mental health in several ways. Firstly, these gender norms dictate the acceptable emotional expressions and coping strategies for men and women. Men may be socialised to exhibit stoicism, emotional restraint, and an aversion to vulnerability, constraining their ability to openly discuss their emotions or seek help when faced with mental health challenges. On the other hand, women might be encouraged to be nurturing, empathetic caregivers, which, while fostering strong support networks, can also lead to emotional exhaustion and neglect of their mental well-being.

In many African cultures, a set of masculine norms places an expectation on men to suppress their emotional expressions (Ezeugwu and Ojedokun, 2020). Undoubtedly, this has an impact on their mental wellbeing (Griffith et al., 2016). This is compounded by the fact that in most African communities, being a migrant is often seen as being in a place of privilege and potentially having a better life than family and friends in one's country of origin (Okeke-Ihejirika et al., 2022). This gives little room for vulnerability because of the fear of appearing weak or ungrateful. The masculine norms within African cultures often emphasise traits such as emotional restraint, stoicism and toughness, discouraging men from openly expressing their feelings or seeking help for mental health issues (Ezeugwu and Ojedokun, 2020, Olawo, 2019).

The societal expectation that men should be strong and resilient can lead to suppressed emotions, making it difficult for them to address their mental health needs.

Moreover, the notion that migration is linked to improved circumstances adds complexity. Migrants are often regarded as having access to opportunities and resources that might be lacking in their home countries. This perception can create pressure on individuals to project an image of success and gratitude, discouraging them from admitting to struggles with mental health. The fear of being seen as weak or unappreciative can prevent individuals from seeking support and sharing their emotional challenges.

One striking statement was made by Nasha when he spoke about the difficulties of being a migrant struggling with their mental health. He talked about dealing with academic pressures as a student, the loss of his sister, and not being able to attend the funeral, which had an impact on his mental health. However, many participants, like Nasha, narrated the fear of letting their family down or being perceived as weak when it came to mental health. This demonstrates the intersecting social identities of being a migrant and an African man/woman, which comes with its pressures. This is evident in Nasha's experience as an African male who thought he was expected to be strong and show resilience under all circumstances:

> *You are even shy to complain to people because they will say, my friend what is wrong with you, can't you handle life. Up to the extent that when you lose a loved one and you complain, they say you are weak, can't you forget it, what's wrong with you. So, you become afraid of telling them.* (Nasha, Nigerian male)

Similarly, Segun (Nigerian male) spoke about the pressure of being strong in African communities.

> *There are some things that would happen in the past and you say you have to be strong. You know that's what men do when they go through tough situations, especially coming from an African background. You don't really show your emotions you're expected to be a very strong person, while you're really suffering, you're really struggling, but you can't say it. Because what would people say about you?* (Segun, Nigerian male)

Three of the women in this study discussed various difficulties of being caregivers and trying to take care of their mental health. Within African communities, traditional female gender roles often prioritise caregiving responsibilities over personal well-being (Heise et al., 2019, Mmari et al., 2017). Exhibiting the behaviour of a strong Black woman is normalised and encouraged,

where women are expected to sacrifice for the betterment of everyone else (Donovan and West, 2015). This can result in women being disproportionately focused on fulfilling their caregiving duties rather than prioritising their mental health. In many African cultures, women are often expected to fulfil multiple roles, including caregiving for children, elders, and other family members. This expectation can lead to a significant imbalance between their caregiving responsibilities and the time and energy available to care for themselves. As a result, women might neglect their own mental health needs as they prioritise the needs of their families and communities. The societal pressure to adhere to these gender roles can lead to feelings of guilt or inadequacy when women consider taking time for themselves or seeking support for their mental health. Self-care might be seen as a luxury or even a selfish act compared to the demands of caregiving and fulfilling familial duties.

In Zuri's case, she moved to Scotland as a single parent of two young children, which she says was a challenge. She disclosed the issues she faced with anxiety, which went untreated until she decided to seek help. As the sole carer of her children, she expressed that despite what she was dealing with on a personal level, she needed to ensure that her children were settled:

> *Yes, it was difficult as I moved here alone with my children, I had to make sure they were okay. Fortunately, I moved into a diverse community in the Southside [of Glasgow] with Asian people and other Black people, so I had support but I had to make sure I took care of them (her children).* (Zuri, Kenyan female)

Fathima mentioned her and her husband's difficulties in balancing work, family and education as newly arrived migrants. She spoke about being vital for her family and making it possible for them to earn a living:

> *My husband and I took extra shifts, but I still had to take care of my family. You know make sure everyone eats and gets to school on time. It wasn't easy.* (Fathima, Nigerian female)

In one focus group, participants spoke about the difficulties in maintaining confidentiality of their mental issues and how that can be difficult when you have children to take care of. Enita spoke about post-natal depression and the difficulties of having to take care of yourself and your new-born baby whilst not being able to reach out to anyone for support:

> *Everybody is mad when you go to through post-natal depression. You are not given any medication, but it goes away on its own because it's a natural thing. After birth you are*

> *breastfeeding and tears are coming down, whilst nobody has said anything to you. It's natural and at a point it fades out but it is hard, it is important to keep in touch with other women to talk about this because we all go through it.* (Enita, Nigerian female, FG 2)

Postnatal depression was an important topic to discuss as research indicates that antenatal and postnatal depression are more prevalent among migrant women compared to the general population (Anderson et al., 2017). This heightened prevalence can be attributed to an intersection of various factors that affect migrant women, such as a lack of support systems, including familial and social networks, leaving many migrant women without the necessary emotional and practical assistance during pregnancy and after childbirth. These issues create a challenging environment that increases the vulnerability of migrant women to antenatal and postnatal depression (Anderson et al., 2017, Giscombe et al., 2020).

The concept of stigma has been covered extensively in literature on African communities and mental health. Participants in this study spoke about stigma in its three levels: self, social and structural (as covered already in Section 5.4.6). The self and social stigma were prominent in this study, and examples of how these two elements/aspects overlap were shown. Out of fear of being labelled and discriminated against by their communities back home and around them in the UK, they did not feel confident in talking about their mental health. Though most participants were aware of the stigma as a social phenomenon and its detrimental effect, there was still discomfort when discussing personal struggles. Compounded by the pressures of resilience, there was an emphasis on keeping any struggles hidden. This phenomenon is reflective of a broader societal challenge: the need to challenge and dismantle the deeply ingrained stigmatisation of mental health issues. The participants' accounts underscore the importance of creating safe spaces and open dialogues where individuals can discuss their mental health without fear of judgment. It also highlights the significance of education in shifting cultural perceptions and fostering understanding and empathy for both women and men. This is also reflected in literature discussing the role of stigma in mental health and what this means for help-seeking behaviours, which will be covered in more depth in section 6.3.5 (Quinn and Knifton, 2014, Mantovani et al., 2017, Ogutu, 2019).

Stigma was a recurring theme in this study, though yet to be spoken about using the term. I argue that though it is a known barrier and there have been numerous interventions aimed at addressing it in the UK, there is a need to deconstruct further other root causes, such as harmful

social norms/identities held in African communities that perpetuate stigma. My findings emphasise the importance of cultural sensitivity in designing interventions. Approaches that fail to consider the unique dynamics of each community's gender norms might fall short of effectively dismantling stigma. By delving into the stigmatising labelling constructed by harmful social norms and identities, a more nuanced and culturally sensitive understanding of how mental health is perceived, discussed, and supported within African communities can be developed.

6.2.3 Participants' perceptions of the causes of mental illness

When exploring the topic of stigmatising labels tied to mental health, participants in the study also engaged in discussions about their perceptions of the underlying causes of mental health issues. These perceptions were notably shaped by cultural norms that influence how mental illness is defined and labelled within their communities. Drawing on pre- and post-migratory experiences highlighted earlier in this chapter, common risk factors for mental illness amongst migrants are multifaceted. Situations may include political conflicts, significant disasters, economic difficulties, and post-migratory stressors such as acculturation, racism, work-life balance, visa concerns and culture shock, amongst other factors (Amuyunzu-Nyamongo, 2013) (see section 2.7.2). Biomedical explanations for mental illnesses are predominant in Western cultures and have been used in a one-size-fits-all fashion for non-Western countries alike. However, most African cultures utilise spiritual, religious and psychosocial explanations, often neglected in Western medicine (Makanjuola et al., 2016, Ogutu, 2019). Participants had varying perceptions on what they thought were causes of mental health illnesses ranging from spiritual, biological, genetic and psychosocial, which has implications for their help-seeking decisions.

Spiritual explanations often hold deep significance within African cultures (Kpanake, 2018, Chaze et al., 2015). Mental health issues might be attributed to spiritual causes, ancestral influences, or supernatural forces. This belief system can lead individuals to seek guidance from religious leaders and traditional healers or engage in rituals to address these perceived spiritual origins of distress. Ekoche and Ijeoma shared that in their communities, mental health issues can be seen as being caused by a lack of faith. This is a widespread perception, especially in rural areas, where life is still guided by spirituality or religion, which can also co-exist with biological and psycho-social causes.

So Christians of African descent we see it as lack of faith, some will label it as spiritual weakness that the person suffers from. (Ekoche, Nigerian female)

Sometimes it can be that they are not close to God, this is why their mental health is suffering. I believe that prayer is a powerful force. (Ijeoma, Nigerian female)

These accounts match various literature which found that East and West African communities seek traditional and spiritual healing when faced with mental health issues (Gureje and Lasebikan, 2006, Nsereko et al., 2011, Quinn and Knifton, 2014). Spiritual explanations are intertwined with the belief that the spiritual realm profoundly impacts the material world, including one's mental well-being. Mental health challenges might be seen as manifestations of spiritual imbalances or disturbances. Individuals may believe that negative energies, malicious spirits, or ancestral influences contribute to distress (Chaze et al., 2015, Mantovani et al., 2017). This viewpoint can offer a sense of coherence in a world where the spiritual and material are interconnected. For example, the description of symptoms, as mentioned by Ekoche, does not see mental health issues as being a physical ailment but rather as being caused by supernatural forces that can only be addressed spiritually. This may also be influenced by the fact that mainstream psychiatric services may be viewed as foreign or alienating. Though spirituality provides explanations for 'supernatural forces' causing mental illness, they can also induce fear and paranoia, which perpetuates stigma (Salifu Yendork et al., 2016).

A few participants acknowledged that mental health issues could also stem from biological or genetic factors. Biological and genetic explanations for mental health are often rooted in Western scientific understanding. Genetic factors, brain chemistry imbalances and physiological anomalies are considered contributing factors to mental illnesses. While these explanations might resonate with some individuals, they may not fully capture the complex interplay of cultural and psychosocial factors intrinsic to non-Western perspectives. Chifundo and Adedayo spoke about the hereditary nature of some mental health issues, and both felt that in such cases, it was best to seek professional help, while Tola attributed mental health issues to chemical imbalances in the brain:

Sometimes mental health issues can come from your family line (Chifundo, Malawian female)

Some people don't understand that you can be born with that trait. There is nothing you can do except just take medication. (Adedayo, Nigerian male)

(mental health issues) could even be as a result of chemical imbalances. Some of them are clinical. (Tola, Nigerian female, FG 1)

Two participants cited alcohol and drug use as a cause of mental illness. The impact of alcohol and substance abuse has been associated with poor mental health and poor help-seeking behaviour for migrant groups (McCann et al., 2016, McCann et al., 2018). The intersection of alcohol and substance abuse with mental health issues has significant implications. Substance abuse can exacerbate existing mental health conditions, trigger new ones, or even serve as a form of self-medication for emotional distress. However, despite its association with mental health challenges, substance abuse can also be a source of stigma. Individuals struggling with alcohol or drug dependence may encounter heightened levels of ostracisation within their communities. This stigma can lead to a cycle of isolation, exacerbating mental health difficulties and hindering the willingness to seek help:

I remember I had this neighbour who was always drunk and maybe he was taking drugs I don't know, but he did not seem okay in the head I think he drank until he became mentally unwell. (Fola, Nigerian female, FG 2)

Sometimes drugs can lead to mental health (issues). You don't know what you put in your body and what it can do to your thinking. (Onyi, Nigerian female, FG 1)

One participant spoke about a combination of underlying conditions, not taking care of your physical health and abusing alcohol, which might be a cause of mental health issues. These echoed sentiments shared by other participants on the importance of physical health when taking care of your mental health:

Some sort of underlying condition, compounded with stresses, for sure. Maybe generally not looking after yourself, or too much alcohol and intoxication also not enough exercise and not enough rest might lead into that breakdown. (Tunde, Nigerian male)

Most participants thought that psychosocial factors faced by African migrants were a common cause of mental illness. It has been well established that social determinants of mental health include psychosocial factors influenced by broader social, political and economic factors (Hynie, 2018, Rousseau and Frounfelker, 2019). The experiences of African migrants encompass a range of psychosocial factors intertwined with broader societal and contextual influences. These factors include the stressors of adapting to a new cultural environment, facing

discrimination and racism, struggling with language barriers, navigating complex immigration systems, and contending with economic uncertainties (Rousseau and Frounfelker, 2019). Furthermore, participants shared their encounters with social isolation, a sense of displacement, and a feeling of being caught between two worlds. This was reflected in participants' accounts of their pre-and post-migratory experiences covered earlier in this chapter, where most experiences included social, political and economic difficulties. Prolonged exposure to these vulnerabilities can lead to a decline in mental health, as also reflected in participants' accounts in this section.

Some participants in this study were international students previously or currently enrolled, and they discussed how academic stress can cause a mental decline which they cannot open up about because of the fear of looking like a failure to their family and peers at home:

> *And the worst one is if you are in academia and you complain that you're suffering from anxiety and depression, they will say it is because you cannot do it, you are dumb, you are not intelligent.* (Nasha, Nigerian male)

> *Oh where do I even begin; of course academic stress was a lot. But there was no opportunity to stop and take a break because you have a limited time and limited funds.* (Ekoche, Nigerian female)

The journey of international students often involves unique challenges, such as adapting to a new academic system, cultural environment, and social context, which can generate considerable stress and pressure. Pursuing academic excellence while managing cultural adjustments and potential language barriers can create a demanding and sometimes overwhelming experience. This academic stress can manifest in various forms, including anxiety, depression, and burnout (Cantwell, 2019, Oppedal et al., 2004, Stein and De Andreotti, 2016). Despite these challenges, the fear of appearing unsuccessful can hinder seeking help. The cultural value placed on academic achievement can contribute to a perception that sharing struggles might tarnish one's image or reputation. This fear of disappointing family members and peers in their home countries can lead to a reluctance to communicate openly about mental health difficulties.

Olufemi (Nigerian female, FG 2) also discussed the difficulties in finding work with qualifications obtained from African higher education and how she had to study further to start her career.

No matter what you think you were doing before you came it's not recognised. It's like all of a sudden, the experience in Africa is quite inferior, your experiences don't count. If you are in the medical field or in some specialized field, you need to start doing their recertification so that you can validate your degree. It's quite tough and it can have a serious effect on your psyche if you're not strong.

Literature on the experiences of international students and the associated stressors has discussed the inequalities, immobility and stark differences. Studies also highlight the 'brain drain' that this causes where human capital is extracted from the Global South, leading to more disparities between countries (Stein and De Andreotti, 2016). Similarly, participants spoke about their careers and education before migration; as mentioned by Olufemi, in some cases, these are not valid in the UK. Moreover, students arrive at host institutions and face reality, leaving them disappointed, unfulfilled, and sometimes exploited (Stein and De Andreotti, 2016, Madge et al., 2015, Yang, 2022). This was reflected in participants' accounts, where they discussed their realities in Scotland. These realities become more challenging to deal with when there are multiple vulnerabilities to mental health deterioration and a lack of a safe space to discuss them.

Most of the participants were aware of the multiple vulnerabilities that could have led to a deterioration of their mental health. Akin (Nigerian male, FG 1) spoke about intersecting factors when asked what could contribute to poor mental health: "*Factors can be mental hardship or physical problems because of the way this society is structured, it is set to make it hard in many ways."* He then spoke about vulnerabilities he has experienced as a Black African immigrant male student in Scotland. Highlighting the intersection of post-migratory challenges and obstacles faced in their gender roles, male participants spoke about the additional pressures on their mental well-being. Akin also expressed that the pressure came from his desire to succeed and progress in his career.

When you find yourself in a pressured environment, the negative thoughts get to come in because of the anticipation. Imagine you have that fear of what if I fail and then I have to go back home. Then people will say oh this guy was one of the two people who was selected in the whole state, he has come back and did not even succeed. That's pressure on its own. You're thinking about family who feel like oh you are bringing a breakthrough in the family and then you are coming back, and you failed. Then you're thinking about your own self, oh prospect of building a career, if you don't make it now

that means you have a break in your career progress. All those things make you anticipate negativity that might happen rather than looking at the positivity of you getting it. (Akin, Nigerian male, FG 1)

The prolonged stressors of migrant life and how they can have a profound effect on an individual's mental health were discussed by the majority of the participants and served as a major stressor that had an impact on their mental health. These two accounts exemplify the broader reality that migrants often grapple with the conflict between immediate survival needs and the desire for personal well-being and fulfilment. The constant juggling of financial responsibilities, bureaucratic demands and personal aspirations can contribute to chronic stress that takes a toll on mental health over time.

Tunde's perspective exemplifies the trade-offs migrants often confront regarding their financial choices. He articulated the painful reality of prioritising practical concerns like visa application fees over other interests. This dynamic captures the emotional toll that economic constraints and administrative demands can exert on migrants' mental well-being. Tunde's account shows the intricate decisions migrants must navigate, where immediate practical needs can overshadow the pursuit of personal well-being.

You know spending your money on visas and things that can have an effect on your pocket and of course have a knock-on effect on your well-being as well. You know it just means you can't afford to kind of take care of yourself like you would and that could affect your confidence and eventually your mental health. (Tunde, Nigerian male)

In a touching account, Chifundo spoke about how she compared her life to that of her friends, and her account highlighted the challenge of maintaining a social life while navigating these stressors. Her experience shed light on the dilemmas faced when financial constraints compel migrants to choose between engaging in social events and fulfilling visa obligations. The need to allocate resources to visa fees instead of enjoying leisure activities and quality time with friends emphasised the emotional strain that results from such choices:

In some way, it worries me why can't I be like my friends. For example, you're working the same job, but your friends can afford some things which you can't afford because your money has to go for example to paying your visas. It affects you; it's depressing because you feel that you don't have the same quality of life as your friends. Things

which people can afford, you can't afford because of your living conditions. You live a constant life of uncertainty. (Chifundo, Malawian female)

In a powerful statement, Darweshi cited the lack of understanding from people in the new environment as contributing to the stress and felt he had no choice but to bottle things up. This relates to the concepts of adjustment and acculturation discussed earlier in the chapter, where he talks about the experience of othering when trying to open up about his difficulties. He then mentions that some people who cannot manage the stress end up in the hospital or are even more confused, which gives a glimpse into some of the fears that some African migrants have when it comes to dealing with mental health issues. The fear of being hospitalised or receiving a diagnosis will be covered in depth in the next section.

Even when I chose to share something with somebody you find these white people are talking about this stuff (gossiping). They talk in a way that is very demeaning you know, not believing you. You know you have to choose your fights, so you say what is important here is to keep going, to survive, it's not a sensible thing to do but you bottle things up. Remaining silent is even more deadly you know, and there are very few individuals who have enough shock absorbers to hoard things and to go through life. You know the majority end up in hospital or even more confused. (Darweshi, Tanzanian male)

Based on this evidence, I argue that to understand help-seeking behaviours, it is essential to situate African migrant experiences, perceptions, attitudes and beliefs surrounding mental health in the broader social, economic, political and cultural systems individuals live in. Regardless of their migratory experiences, participants still held their cultural belief systems and norms developed before migration, as presented in this section. Stigmatising labels were highly associated with how mental health was perceived and ultimately informed coping mechanisms. This finding is consistent with previous research where mental illness was equated with 'madness' and was used to refer to people roaming the streets displaying signs of severe mental illness (Salifu Yendork et al., 2016, Quinn and Knifton, 2014). In line with the findings of this research, Mantovani et al. (2017) reports that cultural perceptions compounded stigma was the main barrier to help-seeking. As discussed by some participants, since their migration, their perception of mental health had changed; through continued efforts to challenge these misconceptions, help-seeking behaviours can be improved.

6.2.4 Experiences with ill mental health

While discussing their perceptions of the causes of mental illness, participants shared their experiences with mental health. All participants detailed their personal experiences with self-diagnosed and medically diagnosed mental health issues and about experiences with friends, family or community members who experienced mental health issues. Many participants expressed that they did not know much about mental health until they were faced with problems themselves. Almost every participant had witnessed someone go through difficulties with their mental health or issues experienced themselves. Most participants said that made them pay attention to mental health as something to take care of because up until that point, they did not consider 'everyday stressors' as a concern and as a risk to developing mental health issues. These first-hand observations contributed to an increased awareness of the prevalence and impact of mental health challenges within their social circles. This was linked to their perception of mental health issues being labelled as 'madness', as covered in section 5.3.2. This meant that anything that did not resemble what they thought was 'madness' did not qualify to be labelled as mental health.

Adanna's account reflects other accounts by participants where they felt that stress was a normal part of life, without the awareness that when prolonged and unaddressed, daily stress could lead to more harmful mental distress. The initial tendency to attribute stress solely to external factors, like the pressures of parenting and work, is a typical response. Many participants, like Adanna, downplayed their feelings as a natural consequence of life's demands. This reflects the broader societal inclination to trivialise or overlook mental health concerns, especially when they don't fit the stereotypical image of "madness:

> *If you said I had mental health issues before, I would say no this is just stress from my kids and work. But now I know that this can be a mental health issue if I don't look after myself. Since then, I have been making sure I check in with someone to let them know how I feel.* (Adanna, Nigerian female, FG 2)

Fathima and Chifundo recall friends who were struggling to cope with post-migratory stressors, which led to a deterioration of their mental health. The lack of a safe space to discuss these issues, compounded by the stigma of admitting you are struggling, maybe the reason these individuals reached a point where their mental health deteriorated:

I have this Nigerian friend that was going through a tough time, and we were supporting him but at some point he went and he spoke to the university health and well-being team. They referred him to the hospital and then he got diagnosed and was on medication for a while. (Fathima, Cameroonian female)

A friend of mine reached the point where he had to be admitted in hospital because he had been experiencing hallucinations. I don't know whether it stemmed from people saying things (racist) to him in the past, but it could also be because of the attitude of people towards him. (Chifundo, Malawian female)

The above statements from participants show that help-seeking behaviours occur in contexts that are conducive for participants. Most participants preferred to speak to friends and family or preferred to remain anonymous when seeking support for their mental health. Though most participants did not mention the word *stigma*, their emphasis on a safe space was indicative that they held some level of stigma when thinking about mental health, and this will be explored further in section 6.3.

The impact of COVID-19 on participants' mental health

This study was carried out during the COVID-19 pandemic, and participants discussed the impact COVID-19 had on their mental health. At the time of data collection, most participants were at home and had little contact with others. The onset of COVID-19 has been found to have a massive impact on ethnic minority groups in other studies, as reviewed in detail in Chapter 2. This is mainly due to the severe financial uncertainty, increased loneliness due to isolation and increased health-related fears about post-pandemic life (Saltzman et al., 2021, Hoq and Reliford, 2023, Bambra et al., 2021). Compounded by the disparities in morbidity and mortality due to COVID-related illnesses (Chowkwanyun and Reed Jr, 2020, Hooper et al., 2020), African migrants were among the groups who were at a higher risk of being affected during this time. When asked if they had any difficulties, participants' accounts were congruent to the literature, with most participants stating that their mental health deteriorated during this time.

In Chapter Five, I discussed participants' difficulties with isolation and building communities as migrants (see section 6.3.4). This discussion provides a crucial context for understanding participants' post-migratory experiences, particularly during the pandemic. Isolation is a common challenge many migrants face as they navigate new environments, cultures and social

dynamics. Building a sense of community and support networks is vital for individuals to feel a sense of belonging and connectedness. However, this process can be impacted by various obstacles, and the COVID-19 pandemic intensified these challenges:

> *I mean the word isolation has been synonymous with the pandemic. To counter that word would be, you know, family support or something. For me that's what I had because, apart from that I was it was really sad, it was you know was absolutely difficult.* (Tunde, Nigerian male)

> *I came here, you know, it was not even up to see four or five months the coronavirus started. Then we were isolated from school, and you couldn't make friends. You're meant to sit back home and study. That isolation created more problems mentally.* (Nasha, Nigerian male)

Participants who already had diagnosed mental health issues were severely affected. Similarly, literature has found that the existing disparities in mental illness prevalence in marginalised groups were exacerbated during this time (Hansel et al., 2020, Gibson et al., 2021, Rose et al., 2020, Rahman et al., 2021). Individuals who were already dealing with diagnosed mental health issues faced a heightened level of vulnerability during the pandemic. The disruptions to daily routines, social interactions, access to support services and the uncertainty of the situation collectively contributed to exacerbating their mental health challenges. These individuals were dealing with the compounding effects of pre-existing conditions and the novel stressors posed by the pandemic.

Abidemi, who had been diagnosed with a certain condition years before the pandemic, found himself struggling to cope after years of successful management of his health with the help of his medication:

> *I think the pandemic contributed to my decline because like we used to go to places with my partner and my family, we walk here and there and having to go through lock down with no social life, apart from going to pick my children up from school. There was some kind of stress and there was nothing to counter it. It had an impact on me I think it might have contributed to my mental breakdown.* (Abidemi, Ghanaian man)

Coping mechanisms such as physical exercise and socialising were limited, making it hard for participants to cope. The uncertainty of the pandemic also placed additional anxiety on Zuri (Kenyan female), who had been recommended holistic practices such as yoga, meditation and

acupuncture in conjunction with her medication. She says the online classes were not the same as the in-person classes and she slowly stopped joining these:

> *There's a lot of other things that I was recommended to do so, I joined yoga and meditation. Instead of prescribing too much medication, the doctor gives you a social prescription on things like acupuncture and other holistic methods. So I was doing all that and then lockdown came. Although some people say we continue doing it on zoom and but it kind of fades away and everyone stops.*

One participant who lived alone also opened up about struggling with alcohol and sleep during this time:

> *Those days I was struggling to get myself off the bed, and at that time I had always had a bottle of alcohol and beverage. I also tried to take some medicine to make me sleep because you can't sleep, it was really terrible. Especially for my mental health, and any sort of cough any sort of illness would make me scared that it was COVID.* (Segun, Nigerian male)

Two participants spoke about struggling with parenting duties and how that had an impact on mental health:

> *Remember when we went on lockdown? Look at what happened, a lot of the women were going crazy. You have three, four children in the house. You were stuck in the house going nowhere. Look at what mothers were going through and the way they suffered at that point.* (Olufemi, Nigerian female, FG 2)

> *I don't ever want to go through that again, it was so difficult trying to home-school the kids and also keep them entertained while trying to stay stable yourself.* (Ekoche, Nigerian female)

Grief was also mentioned by several participants, like Zandi (South African female), who could not attend a funeral for a loved one because of the lockdown restrictions. This was compounded by the winter months when there was less sunlight; her mental health declined during this time:

> *I think probably there are two things that come to mind, the first one is losing a family member in South Africa and not being able to go [to the funeral], because of all the restrictions in place. When you decide to live abroad, that is always the reality and the possibility, but I think not being able to leave is what made it hard. The other issue is*

after Christmas when we went into that really long, hard lockdown for three months, coupled with the fact that it was winter and just seemingly dark all the time. I stumbled mentally; I was not okay.

Adedayo (Nigerian male) stated that during this time, there was increased attention to mental health because it affected a lot of people:

I think it has been a really major eye opener for people, especially in terms of mental health because of the talks about mental health and it became more mainstream, there's been more efforts to look after the mental health of people.

The COVID-19 pandemic was a critical aspect to be discussed with participants as ethnic minority groups were found to be disproportionately affected during this time. By including the personal narratives and experiences during the lockdown, I highlighted the lived realities of the participants. Their stories humanise the broader topics of isolation and mental health and provide relatable examples to connect. By examining the multiple intersections of vulnerability to mental illness and how participants approach their mental health, the complex interplay between individual experiences, cultural beliefs, societal norms, and external stressors is shown. I needed to discuss these experiences as they offer a glimpse into their decision-making and help-seeking behaviours during times of distress. Leading on to some of the factors influencing their decision-making, I build on to the earlier topics in the chapter that show the multiple intersections of vulnerability to mental illness and how it is approached.

6.3 Factors influencing help-seeking behaviours

Help-seeking behaviours in African migrant populations are rooted in the communities' perceptions, attitudes and beliefs on what mental health is and how it should be managed. The context in which these behaviours exist is important in how we understand some of the barriers that impact help-seeking. In this section, I present themes relating to help-seeking behaviours as told by the participants of this study. Building on to section 6.2, this chapter explores participants' experiences with mental health and how they choose to deal with them, mental health awareness, conducive contexts for help-seeking, religion, stigma and experiences with healthcare influence help-seeking. Participants' accounts are drawn from individual interviews and focus group discussions. Some participants had experiences engaging with mental health services in Scotland and narrated their experiences. For participants who had not sought support for mental health, they gave their views on how they would seek help should they need

to. There were also some participants who discussed their experiences with friends that had dealt with mental health issues and how they managed them. Throughout this section, I highlight the recurring theme of stigma and the importance of a safe space to discuss mental health, as expressed by the participants. I relate each theme and subtheme to a broader political and social context where applicable and argue that help-seeking is not only influenced by behaviour.

6.3.1 Awareness of mental health services

Lack of awareness of services is a frequently cited factor that impacts help-seeking behaviours amongst African migrants. One of the reasons behind the lack of awareness is that newly arrived migrants do not have all the information on health services upon arrival. This was compounded for the participants in this study by the pandemic. They may not be fully aware of how the health system works, their rights and whether or not services are free (Moroz et al., 2020). Despite the availability of services and interventions, Black migrants are still low-ranking in the number of people utilising mental health services in Scotland (Adzajlic, 2022). Similar to the literature, participants in this study had some knowledge of services offered to support them if they needed it but still held some misconceptions and differing perceptions of services. Most participants agreed that they, too, did not have a lot of knowledge on services when they first arrived in the UK.

Newly arrived Mohammed stated that he was not sure whether or not his GP could offer mental health support. He said this had not been the case in his home country, and he was not sure if he had direct access to a therapist or any form of counselling services:

> *Even if I do want to seek support, I don't know where to go, I mean I'm sure that the GPs are not going to provide that kind of support.* (Mohammed, Eritrean male)

A report produced by the Glasgow City Health and Social Care Partnership carried out research with BAME communities and found that there was still a lack of awareness of healthcare services amongst newly arrived migrants (Adzajlic, 2022). Similarly, some participants who had not newly arrived felt that there was a need for education aimed at newly arrived migrants on the healthcare services available to them upon arrival:

> *I have been here for a while but when I arrived, I did not know how the healthcare works, I had to figure it out and it is different from back home*. (Kelechi, Nigerian male)

One of the things that seems to be a problem for an African person is that even when we come from our country into this country, we don't have any system that prepares us on what to expect, how to expect it and what to do in the case of a problem (mental health related) we encounter. We don't have that background information. (Darweshi, Tanzanian male)

Things work different here and if you came here alone who will tell you how to get help. By the time you are looking for help it's too late and you are too ashamed. Also, life is just so busy sometimes you don't get a chance to ask these things. (Ibrahim, Ghanaian man, FG 2)

Two participants felt that mental health had been receiving more attention in recent times and that before, it was not as widely discussed:

There's been a lot of discussions [about mental health] and a lot of prominence in recent years, people take it more seriously. So now I look after my physical health, making sure I eat right and exercise. I try to watch out for my mental health. (Segun, Nigerian male)

A lot of people speak about mental health now, this wasn't always the case. (Tunde, Nigerian male)

Some participants were involved in migrant-led community-based organisations that provide African migrants with the resources they need to understand their mental health and the triggers that could lead to a decline. Zuri (Kenyan female) mentioned mental health awareness meetings organised in her community and expressed how things were positively changing and that more support was available for Black people in her community:

I joined this group we had some discussions; some people came to talk about mental health, it's all Black people and it's run by a friend of mine, she has a restaurant in town and she's from Kenya.

In focus group discussion 2, Enita (Nigerian female) also spoke about an organisation that she was involved with that assisted with various issues faced by migrants in Glasgow:

That takes me to the project that we are running, a homelessness intervention hub which gets people before they present as homeless. So for us, we look for those markers of homelessness, like overcrowding, living in accommodations that are not well ventilated

or poverty struggling with living expenses, paying debts and all that. Those are the triggers.

Scotland has numerous initiatives aimed at improving mental health awareness, reducing stigma and providing support services for minority groups. Initiatives such as Mental health charity Mind, Saheliya's Champions for Wellbeing and Active Life Club provide various ways tailored for minority groups to receive support on their mental health (Adzajlic, 2022). The majority of the participants in this study were not newly migrated and had lived in Scotland for at least a year (see section 4.5.1 on length of stay of participants). However, although most participants knew about services available to them, very few stated that they would speak to their GP or nurse in instances where they felt they needed mental health support. Literature shows a preference for informal support systems such as reliance on self, family and friends in African migrant communities. This may also indicate dissatisfaction with the appropriateness and suitability of services available (Bansal et al., 2014, Barnett et al., 2019). This will be covered further in this chapter.

There was an indication that some participants had knowledge and use of community-led mental health initiatives, and focus groups allowed them to share such resources. This is reflected in literature where community-led initiatives are well-positioned to understand the needs and priorities within their context (Larrieta et al., 2022, Ermansons et al., 2023, Campbell and Burgess, 2012). This was also evident with one participant referring to the various avenues of help that assist African communities with homelessness, overcrowding and poverty, which are known risk factors of mental health decline in migrant populations. Though community-led initiatives are more suitable in migrant communities, they face significant challenges with support due to a lack of funding and resources and difficulties engaging with stakeholders (Larrieta et al., 2022, Khieng and Dahles, 2015). This makes it difficult for community-led initiatives to continue providing support, which reinforces the disparities in mental health engagement.

6.3.2 Conducive contexts for help-seeking

The above section indicates that awareness of services was not the main barrier to help-seeking for most participants in this study, as the majority of them stated they had some knowledge of services. Literature cites awareness as being an integral part of improving help-seeking behaviours (Broglia et al., 2021, McCann et al., 2016), although participants in this study indicated that having some knowledge on the services available does not always translate to

the engagement with the services. When participants spoke about their decision-making when considering seeking support for their mental health, most said that statutory services would not be their first point of contact, although they knew that it was an option. This is reflected in data collected by the NHS digital that found that people who were Black, Asian, non-white or of mixed or other ethnicity are less likely to seek treatment for common mental health disorders than those in the white British group (McManus et al., 2016). When speaking about help-seeking, there was a theme throughout the data about the need to have a safe space to discuss mental health issues. Participants felt that confidentiality was a huge deciding factor when speaking about their problems. This suggests that participants felt the stigma attached to being open about their problems and mental health issues, and that determined the likelihood of help-seeking. This stigma may be related to some perceptions, attitudes and beliefs that were covered in section 5.4 that made mental health hard to openly discuss with others.

6.3.2.1 The importance of a safe space

The concept of a safe space held great significance in the context of mental health help-seeking. Although some participants did not use the words 'safe space', the sentiment alluded to conducive environments where they could speak about mental health without judgement. In this section, I refer to a safe space as an environment where individuals feel accepted, respected, and supported to express their thoughts, emotions, and struggles without fear of judgment or stigma. When it comes to mental health, a safe space is pivotal for several reasons, such as allowing open expression, reducing stigma, validation, empowerment, belonging and confidentiality. In various contexts, safe spaces can take different forms: support groups, online forums, therapy sessions, cultural community centres, or even speaking to trusted friends and family.

One key aspect of a safe space mentioned numerous times is the assurance of confidentiality. When individuals trust that their conversations remain private, they are more likely to share personal struggles without fear of unintended consequences. The assurance of confidentiality allows a safe space with a sense of security and liberation. It empowers individuals to reclaim control over their mental health narratives, seek the support they need, and engage in candid conversations that foster emotional well-being. In a focus group discussion, when asked to speak about their preferred source of support, Neema mentioned that she would rather seek help online because that way, she could remain anonymous. She also felt that by remaining

anonymous, she knew that no one could link the information back to her in the future, which relates to the perceived stigma of ill mental health:

> *I think the first option for me would be online support because of anonymity, that's quite important for me. Sometimes things that we go through you realize that talking to someone who doesn't know you, who can't see you and doesn't have any background that gives you more peace.* (Neema, Nigerian female)

Similarly, in the focus groups Onyi and Fathima touched on issues of confidentiality in African communities and how that makes it hard to speak to people about personal problems. Their insights shed light on the intricate interplay between cultural norms, privacy concerns, and the challenges of seeking support for mental health issues:

> *First of all, people are scared of the gossip. You might speak to this person and before you know it all the community people you know, get to know about your confidential issues.* (Onyi, Nigerian female, FG 1)

> *People are so scared of people taking their names to the community, but not everybody will do that. You sharing your problem with them places a level of responsibility to at least protect whatever you have shared. Confidentiality is very important, and it breaks my heart to be honest, to hear that people are struggling this much and are afraid of being exposed.* (Fathima, Cameroonian female, FG 2)

This discussion in focus group 2 sparked a debate where one participant felt that there is a misconception on the lack of confidentiality in African communities in Glasgow, which means people reaching out are further isolating themselves during a time of need. This exchange made me observe the unique context of African communities, where the value placed on maintaining family and community cohesion often intersects with the desire for personal privacy. Within these communities, personal matters are frequently viewed as interconnected, with the collective well-being of the family and community at large. This outlook can, at times, result in a lack of distinction between individual and communal matters, making it challenging for individuals to share personal struggles without the fear of information being disseminated more widely than intended. This discussion showed the intricate balancing act that individuals from African communities often face when navigating issues of confidentiality. While there is an understandable need to protect one's personal matters from becoming public knowledge, this very concern can hinder the willingness to reach out for support, particularly in the realm of

mental health. The fear of breaching confidentiality, unintentionally or otherwise, can lead to isolation and silence, perpetuating the stigma surrounding mental health struggles.

Anticipated stigma and stigmatising labels associated with dealing with mental illness became a powerful tool that impacted help-seeking for these participants. Numerous studies align with these findings and show that underlying discourses create a context where mental health conversations are feared (Shannon et al., 2015, Misra et al., 2021, Memon et al., 2016, Nielsen et al., 2021). In these small communities, confidentiality may be breached, and someone's mental health or personal issues might be a source of gossip or rumour in the community, which in turn may lead to the individual being ostracised and mocked (Berwald et al., 2016, Arrey et al., 2015).

Despite most participants having experienced issues with their mental health or having seen someone who was struggling, most participants stated that statutory services were the last option when seeking help, which speaks to the lack of a perceived safe space for participants. This suggested that participants did not consider statutory services as necessarily a safe space to discuss mental health-related issues. Participants like Chifundo who worked in the mental health field stated that they had full knowledge of how the system worked, but still would not access statutory services if they needed some mental health support. Drawing from participants' perceptions of the support/services offered, there is a level of mistrust in services, combined with the perception that symptoms of mental illness did not require medical support.

Similarly, Mansa said she knew about mental health services because she had seen some adverts in public places encouraging people to seek help.

> *Yes, I know where to find mental health help, but I don't think I would go there, instead I would contact my family and friends first.* (Chifundo, Malawian female)

> *You know, I've seen some signs with information on a number to call if I have mental health problems, but I have never used them. I would talk to my family and friends first because they understand me, not a stranger.* (Mansa, Ghanaian female)

The sentiment expressed by many participants about the simple need for someone to talk to resonates with the therapeutic power of open conversation. Their shared desire for an empathetic ear and a non-judgmental space reflects the fundamental human need for connection and validation in emotional distress. The next quotes from participants shed light

on the profound impact that genuine conversations can have on individuals' mental well-being, particularly within the context of societal pressures and gender roles.

For Darweshi, Segun and Kelechi, their gender roles made it hard to find a safe environment to have conversations relating to their mental health. As covered in section 6.2.2, the intersecting social identities make it hard to open up about any difficulties they were facing:

> *You know sometimes the solution is just a simple matter of sitting down to talk to discuss with somebody, to empty the basket to feel relief.* (Darweshi, Tanzanian male)

> *You're not really allowed to display emotions, because if you do you'd be seen as weak.*

> *Oh, I'm not man enough, and the last thing you want to feel like is not man enough and not fitting the expectations of people. You get told that men don't cry so you keep it to yourself* . (Segun, Nigerian male)

> *You put a facade on the outside and you would hear stories of young Niger men going through a really tough time and end up committing suicide, because people are really tired of their lives. People getting to that point where they just suffer emotional burnout and they can't do much for themselves, so they just wait for the day where everything just falls apart.* (Kelechi, Nigerian male)

Debare spoke about allowing himself to be vulnerable enough to speak to his family members about how he was feeling. This contradicts the idea that as an African man he was required to be strong and not show any weakness, but because he felt that he was in a safe space with one of his family members, he was able to open up:

> *Then it got to a point where I was speaking with my uncle's wife and I was in tears. She was encouraging me and said I should not keep the pain in and that I should let it out. So, I let myself feel vulnerable and that helped me recover.* (Debare, Nigerian male)

One participant spoke about the privilege of having a safe space where she could discuss her feelings. She stated that when struggling with some things, she would speak to her family and acknowledged that not everyone had a safe space to be supported during tough times.

> *So I have had issues and places where I was just like okay, this is weighing me down and then I was having some extreme thoughts. I spoke to my parents it was very conversational and I pulled through. But I know that is a privilege and not everyone*

has a safe space to talk about mental health when overwhelmed. (Tola, Nigerian female, FG 1)

Two participants also mentioned introducing induction programs for newly arrived African migrants, which would help them manage expectations and give them the tools they need to cope. This was also brought up by Adedayo who felt that community groups could be used to teach newly arrived migrants about the mental health challenges they might face and how they can overcome them.

So maybe an induction program to inform people about all this (mental health). A community here we can go when we face issues of mental health. (Adedayo, Nigerian male)

Speaking about mental health for participants was not as easy task when not in a safe space. There was also a comparison on how, unlike physical health, mental health was not as easy to describe without the fear of looking weak. This is a commonly cited reason for stigma in mental health (McCann et al., 2018) and was a commonly cited statement in this study. This is closely linked to the concept of resilience, discussed earlier in the chapter. The lack of a safe space to discuss mental health issues in African families and communities not only exacerbates stigma but also makes people develop coping strategies that do not include discussing issues. For some people, like some of my participants, these coping strategies work for them and they build a level of resilience to deal with post migratory issues. For some people coping mechanisms do not work, which can lead to alcoholism or a gradual deterioration of mental health (Durrant and Thakker, 2003, Horyniak et al., 2016). Two participants opened up about their struggles with their mental health and how they did not have a safe space to speak about their issues.

6.3.2.2 Dealing with mental health without support

Dealing with mental health issues without support was a significant concern raised by several participants in the study. For some individuals, the experience of navigating mental health challenges without adequate support systems was described as overwhelming and isolating. Abidemi shared his experience when his mental health deteriorated, and like many other participants, he stated that his life had not been easy and he was struggling with some stressors that may have led to the deterioration. In his reflection on the past, he stated that sometimes all he needed was someone to talk to and felt that could have helped get support for his mental

health earlier. He said that he was unaware that he was not okay until his flatmates contacted mental health services to get him some help.

> *Well, my mental health deteriorated suddenly. I was living in a flat with other flatmates and one day I received a visit from the ambulance crew. They said I was not well and were there to see me. Once I got to the hospital and saw a doctor, they put me on medication and I have been on it ever since.* (Abidemi, Ghanaian male)

Literature shows that Black and minority ethnic groups are more likely to have compulsory admission to hospitals for their mental health (Freitas et al., 2023). There are a number of reasons why minority groups get admitted involuntarily, such as racism in healthcare and police. In Abidemi's case, he stated that he did not believe in mental health issues until the day he was taken in for a consultation. Although he was not detained, he was involuntarily taken in for that consultation which led to a diagnosis and treatment for a mental health condition. He states that prior to that day, he would have never engaged with services for his mental health because he believed he was perfectly fine. As an African man, he also believed that even though he was struggling with post-migratory stressors due to unemployment and isolation, he did not have anyone to speak to and thought he had to be resilient and deal with it.

Similarly, Debare spoke about using alcohol as a way to escape the unemployment stress that he was facing. He says that the breaking point came when he had isolated himself from friends and family until one day, he got the courage to speak to a family member and received some help:

> *I got to the point where I had to start drinking alcohol, I'm not an alcoholic, but it made me so sleepy and made me forget what I was going through. It was really terrible.* (Debare, Nigerian male)

Alcohol misuse in migrant populations is an issue that is a double-edged sword (Horyniak et al., 2016). People can use alcohol as a coping mechanism, but it also makes their situation much harder to come out of. In Debare's case, he was struggling with unemployment and used alcohol to forget about his issues. In that state, Debare was unable to continue looking for employment, which would have made his situation worse. It also isolated him from support structures, which made it hard for loved ones to recognise his issue. Similarly, Horyniak et al. (2016) found that migrants and refugees who struggled with post-migratory stressors used

alcohol to ease the stress but unknowingly placed themselves in higher risk for alcohol-related conditions and the deterioration of their mental health.

6.3.3 The role of religion and faith-based communities in help-seeking

There were some contradicting opinions on whether or not religion or faith-based communities were a preferred source of support for mental health issues for the participants in this study. There is a large body of literature that shows the role of faith-based leaders when dealing with mental health in African communities (Hays and Aranda, 2016, Heward-Mills et al., 2018, Tomalin et al., 2019). The literature often refers to faith-based leaders as being a source of empowerment and security for people in their communities who need support. Their relatability and open-door policies can make them a place of refuge for people to receive support for their issues (Heward-Mills et al., 2018, Galek et al., 2015). Religion in general is also viewed as a source of strength in communities with activities such as prayer and worship providing a place of refuge and strength during difficult times. The communal nature of religious activities can foster social connections and a support network, which can be vital for individuals dealing with various challenges.

For some participants, they felt that their faith provided them with a framework to navigate challenges, maintain a positive outlook, and find meaning in their struggles. Religion can also provide a narrative that frames life's challenges within a larger context. This can help individuals find meaning in their suffering and view their experiences as part of a larger purpose or divine plan. Religion was mentioned as a source of strength in adversaries for Ekoche and Nasha who owed their resilience through tough times, to their religion.

> *Where we come from, we are built to be dogged and resilient, just looking at the positive side of things and pushing through. I think also my faith, my Christian beliefs, principles and conventions also plays a major role in my journey in Scotland.* (Ekoche, Nigerian female)

> *When I go to church services like a sermon or prayer and motivation, it reminds me that God is on my side, why are you worrying? Just do your best and He will handle it.* (Nasha, Nigerian male)

Fola (Nigerian female, FG 2) also highlighted the dangers of relying on religion as the only source of support for mental health issues. She said: "*Sometimes you keep praying for so long. You know you're being strong and then one day you just explode, and it can be very disastrous".*

While faith-based communities can offer invaluable support, there are also limitations to consider. Some argue that relying solely on religious practices might neglect the importance of evidence-based interventions in certain cases. This is consistent with literature that encourages collaboration between psychological or psychiatric practices and religious practices. This collaboration is suggested to address help-seeking behaviours that stem from perceptions that mental illness is caused by spiritual struggles (Exline et al., 2021) which is common in African communities.

Church is also where participants said they make friends and strengthen their social ties in the community. Faith-based communities can help migrants who relocate without family, it provides a way for people to meet like-minded individuals who might have the same interests which is important for adjustment. Migrants and newcomers may share the experience of adapting to a new culture and environment. This shared experience can create a bond and understanding among faith-based community members, making it easier for individuals to relate to one another. Ijeoma said that she found comfort in the friends she has made in church and felt they were there for her when she needed them:

> *Most of the friends I have here are from church, and I think they would support me if I needed the support. We meet often and talk about the Word of God and encourage each other to stay strong. Especially during the lockdown, online church helped a lot.* (Ijeoma, Nigerian female)

For some participants, the benefits of faith-based communities extended beyond spirituality. These communities provide a holistic environment where individuals find not only religious encouragement but also companionship, a sense of belonging, and practical assistance as they navigate life. Similarly Strang and Quinn (2021) found that refugee participants built some friendships with Scottish church members who became a part of their support networks. Unified by shared beliefs, these connections became pillars of support, mirroring the experiences recounted by some participants in this study.

Contradicting experiences were raised by some participants like Chukwu (Nigerian male, FG 1) ,who stated that he would not confide in the leader in his church because he did not have a close connection with them. This has also been reported in literature where religion is used as a tool to discriminate again minority groups such as LGBTQIA+ communities (Hollier et al., 2022) and in people living with HIV/AIDS. This makes faith-based leaders an unlikely source of support for some people:

> *I don't know how my pastor would help me, but maybe if I have a real connection with a church leader, I could go speak to them if I needed to*. (Chukwu, Nigerian male, FG 1)

Two participants spoke about incidents where they opened up about issues they were dealing with and felt that they were met with some judgment rather than support. Tola discussed an incident where she was being threatened by someone on social media and felt the best way to handle the situation was to deactivate her account. After realising that this would affect her role in her church community, she opened up about her situation. Instead of a supportive response, she states that she was given an ultimatum:

> *I told them I had to leave Facebook, because of my mental health and that I feel anxious when I go there and I don't feel safe anymore. They said if I feel like what I'm doing (leaving Facebook) is more important than the person I'm serving (God) then I should do it. To be honest I felt very vulnerable, why would you not prioritise my mental health. I don't feel they are the best people to go to.* (Tola, Nigerian female, FG 1)

Akin also shares a similar story about when he discussed what he was struggling with to a leader in his church but instead of getting help he was ostracised and judged.

> *It takes a lot of courage, when you have to speak to someone you have to speak to people who already accept you, not those who will bring some kind of judgement. You need to speak to someone who will not put their personal views above your issues. Because there's a certain level of vulnerability you have when you open up.* (Akin, Nigerian male, FG 1)

Overall, the literature and the findings of this study suggests that faith-based leaders and communities play a significant role in providing mental health support, particularly in African communities. Their unique blend of cultural understanding, relatability, and spiritual guidance can positively affect individuals' mental well-being. However, it is crucial to acknowledge that this was not consistent for everyone, where some participants expressed the stigma that can often be perpetuated by these communities. These diverse experiences highlight that while these communities can serve as vital sources of strength and comfort, there is a simultaneous need for awareness of potential shortcomings, particularly in relation to perpetuating stigma. Furthermore, research highlights the delays in help-seeking that can be due to the reliance on faith health issues (Hays and Aranda, 2016, Heward-Mills et al., 2018). These findings

emphasise the importance of fostering an open dialogue between mental health professionals, faith-based leaders, and the communities they serve, aiming to create an environment that maximises the benefits of faith-based support.

6.3.4 Social networks

The importance of social networks was discussed continuously by participants in this study. Participants acknowledged the role of social capital not only in their post-migratory adjustments but also discussed its importance when dealing with help-seeking for mental health issues. These networks hold profound significance in various aspects of migrants' lives, providing both practical and emotional support throughout their journey and settlement in a new country. Social networks are able to provide cultural familiarity, information and resources, emotional support, social cohesion, professional networking, advocacy and transnational support. Lower social cohesion has also been associated with poorer mental health outcomes, while higher social connectedness has been found to improve mental health and acculturation for migrant groups (explored in depth in section 2.7) (Mulvaney-Day et al., 2007, Alegría et al., 2017).

Many participants cited isolation and loneliness as being one of the main obstacles post-migration. There was also a consensus that building a community was important, especially for those without family in the country. Most participants said they preferred to speak to friends or family when going through stressful periods in their lives.

> *Family or friends would be my first option. My partner is the person closest to me so it makes senses I would speak to her first.* (Obi, Nigerian male, FG 2)

On the other hand, Olufemi spoke about the difficulties of remaining in contact with family and friends back home. She stated that because of competing demands in her life, she did not have as much time to answer calls from home, which weakened her social networks from home.

> *For me, it's the other way around, where I run away from talking to people from Nigeria, because we are all hustling here. Time is money everywhere in the world, but here, if you don't keep to time, you don't get things done. And then people in Nigeria just think they can just call you anytime and talk. So for me, my own struggle is keeping those connections going.* (Olufemi, Nigerian female, FG 2)

One participant identified the importance of social networks in relation to suicide ideation. Akin's account resonates with an established understanding in mental health research that social

connections and a reliable support system are vital in preventing and addressing suicide ideation. The presence of a support network can serve as a safety net, offering regular check-ins, emotional support, and a sense of belonging that acts as a counterweight to feelings of isolation and despair (Xiao and Lindsey, 2022, Stahlman et al., 2016). Akin spoke about the importance of having a support network to check on you and spoke about someone who had taken their life who had no connections to their community:

> *While I was in university someone committed suicide. Something I cannot just understand why, like what could be so hard you know. I then realised that this person had no support network to check if he was okay.* (Akin, Nigerian male, FG 1)

Debare spoke about how his struggle with mental health has become the motivation for him to be available for others to speak to him. He acknowledges the role his friends and family played in ensuring that he was okay.

> *I think, right now I have a different outlook to it, because I feel like if I didn't have people around me I was that close to it, I was that close to saying let me just end it, you know so I have a different outlook to mental health, now and I'm willing and available to support people around me, and you know talk about it.* (Debare, Nigerian male)

Kelechi spoke about the importance of having a social network to help you adjust to your new life. He says that this support helps alleviate post-migratory stressors. This is covered in detail in section 5.1.2, which covered participants' post-migratory experiences of African migrants and their quality of life. This is also reflected in literature, where social networks were found to be a protective factor for migrant workers. These networks not only provided emotional support but also informational support (Hasan et al., 2021), as also highlighted by Kelechi:

> *Sometimes, you don't know where to get employment or how to do certain things in this country. Trying to do it by yourself is hard, but if you have a community that can help you, it goes a long way.* (Kelechi, Nigerian man)

Social networks can consist of groups outside of the individual's ethnicity, which was to the case for one participant who spoke about the lack of community amongst people from her home country and said she found that Scottish people gave her support:

> *I didn't get much help from my Nigerian community. I got help from the Scottish community and when I say help, I mean real help, like people helped me settle in. When I came here, I was at that stage of you know, when you were going through certain*

things and you just want to disappear. You don't want anybody to notice that you're even alive. You just want an excuse to just disappear. (Monifa, Nigerian female, FG 2)

Monifa's statement reflects Putnam's (2000) concept of bridging social capital, which refers to connections between individuals from different social, cultural, or economic backgrounds. Her interactions with individuals from different social and cultural backgrounds allow the potential for building bridges of understanding and empathy. These bridges served as channels for support during times when she felt her community could not provide support.

Social networks significantly impact how African migrants approach mental health help-seeking. These networks, comprising of friends, family, fellow migrants, and members of the host society, shape individuals' perceptions of mental health, their willingness to seek help, and the resources they tap into. By providing information, reducing stigma, offering emotional support, and facilitating access to appropriate services, these networks empower migrants to prioritise their mental well-being and seek professional assistance when needed. Understanding the dynamics of social networks is crucial for mental health professionals and policymakers aiming to provide effective support to African migrants.

6.3.5 Stigma as a barrier to help-seeking

A recurring theme throughout the interviews, when speaking about mental health, was stigma. Though most participants did not use the term, there were words related to stigma that were used to describe poor mental health. As covered in section 5.3.2, common stigmatising labels associated with ill mental health were 'madness' and 'weakness'. Participants noted the shame of struggling with mental health issue, which can be found at three interacting and reinforcing levels: social, self and structural (Link and Phelan, 2001, Sheehan et al., 2017). Their beliefs and perceptions of what defined the word 'mental health' resulted in different ways in which they thought it should be treated. One common thread was that, unlike physical health issues, mental illness was an individual thing that affected the person and should be handled in private. This was congruent to Goffman's (1963) articulation of stigma, which defines the discrimination as something that occurs due to an individual label of undesirability. In many African cultures, the concept of individualism is not common, because in their essence African communities believe in a collective way of life (Berghs, 2017). This applies to all aspects of life, including health and illness. However, in this study there has been an ongoing sentiment that mental illness is something that occurs to an individual and should be dealt as such. This does not fit the beliefs of African communities, and mental health stigma seems to supersede

the collective ideology. As a result, the belief that one should manage mental health issues alone served as a barrier to help-seeking

6.3.5.1 Mental health as a private matter

The African ideology on health often reflects a holistic and communal approach, where well-being encompasses physical, mental, and spiritual dimensions. This perspective emphasises the interconnectedness of these aspects, and communities play a significant role in supporting individuals' health. However, when combined with the perception that mental health struggles should be kept private, this can create a complex dynamic that affects discussions about mental well-being (Sambala et al., 2020, Nkhata, 2010). One participant picked up on this and mentioned the term '*Ubuntu*' and how there was a contradiction when it came to how people with mental health issues are treated in African communities. '*Ubuntu*' is a term used in Nguni tribes in Southern Africa, which is loosely translated to mean 'humanity". This term encourages a spirit of compassion, giving and receiving human care and support, and it also refers to the interconnectedness in times of illness (Edwards et al., 2004, Berghs, 2017).

Zandi discussed how, ironically, when it comes to mental health, this term was often forgotten. Instead of rallying together and supporting someone who is struggling with their mental health, there was some rejection and dissociation instead. She stated that it might be because mental health was such an individual and internal thing that the collective nature of African communities somehow doesn't apply:

> *African culture says ubuntu is a collective ideology. So it's a 'I am who I am because you are'. We thrive together and I'm looking out for you. With something like mental health, it is such an inherent and individual thing that somehow we don't practice Ubuntu when it comes to that.* (Zandi, South African female)

Zandi's statement points to the power of stigma attached to mental health in African communities. It also reinforces that some physical illness often has less stigma (Mannarini and Rossi, 2019) and is dealt with in a compassionate manner, whereas mental illness is seen as a pervasive issue that does not fit in to the collectiveness (Ngomane, 2019). This aligns with initiatives that call for an integration of ubuntu principles when dealing with mental health in social work practice to reduce stigma in African communities (Ngomane, 2019, Chigangaidze, 2021). The solitude when experiencing mental health issues is reflected in the many accounts where participants emphasised the need for confidentiality when dealing with mental health

because it was attached to a feeling of shame. Participants indirectly acknowledged this shame when discussing their decision-making when seeking help. The fear of being recognised or attached to mental health issues was the main reason Tola chose not to access statutory services:

> *I'm not saying it's a shame to have mental health issues, but for me, it just makes me feel safe if no one knows, and in the future, you can't link me to that.* (Tola, Nigerian female, FG 1)

Chukwu felt that his identity as an African man could not be associated to 'weakness' attributed to admitting that you are struggling emotionally. He said that he would rather deal with it internally to avoid bringing shame to himself. Both of these accounts show the avoidance of the label associated with mental health, which is a hallmark of stigma (Sheehan et al., 2017).

> *As a man I cannot show a sign of weakness, so I rather not tell anyone instead of bringing shame to myself.* (Chukwu, Nigerian male, FG 1)

There was a convergence in the stigma that came with the labelling of mental health in African communities and the stigma that came from individuals in the form of self-stigma. Tinashe once again reinforced the idea that dealing with mental health issues was an individual path. She also expressed the fear that her experience would be minimised by her not having her life in order:

> *There is a part that you're not wanting to be to be perceived as, excuse my French not having your s*** together or just crumbling or complaining or the idea that we all suffer why is your thing noteworthy. People are generally nice, but there's always the suspicion on what are they really thinking like am I being a burden.* (Tinashe, Zimbabwean female)

Navigating the complex intersection of the African ideology on health, the value of communal support and the prevailing perception of handling mental health struggles privately presents a multifaceted challenge. This interplay reflects the delicate balance between cultural traditions, individual needs, and the evolving understanding of mental well-being.

6.3.5.2 Stigma in healthcare

Stigma was not only present in the cultural context when it came to help-seeking, stigma was also reported in healthcare for some participants. Mental health stigma within healthcare settings is a significant challenge that can hinder individuals from seeking and receiving

appropriate mental health care. It has been well established that the healthcare system can be one of the key environments where people can experience discrimination (Ungar et al., 2016). This can lead to increased self-stigma, inadequate access to care and greater avoidance of healthcare facilities in general, which can exacerbate underlying conditions (Knaak et al., 2017, Livingston, 2020). Other stigmatising behaviours can include diagnostic overshadowing, marginalisation, and less timely/inadequate treatment for mental health concerns (Ungar et al., 2016). This is especially harmful in minority groups in the UK, such as African migrants, who experience intersecting points of discrimination in their lives.

In addition to self-stigma, one participant who had experience being treated for mental health issues spoke about some of the difficulties faced while navigating healthcare. He stated that once he started taking medication, he felt that he was stigmatised and treated as someone whose decision-making had been impaired. He said he had hardly any control over his medication doses, although he had been feeling fine for some time:

> *I am able to make sense of things, I was trying to negotiate how much medication I am receiving or if I can stay without medication a little bit longer because I show no symptoms. They (healthcare professionals) say my decision-making is impaired just because I don't want to be on my medication.* (Abidemi, Ghanaian male)

Abidemi also shared how he had accepted his situation and decided to remove the negative labelling from his condition. He says by sharing and education his friends and family, he was able to challenge/counteract the power of stigma in his life.

> *Sometimes I meet people and they are unwilling to talk about my mental health, but I bring it up and by talking about it I feel free, the person feels free because I'm talking about it myself. But if I'm shielded then the person will feel more uncomfortable to talk about it and then this stigma keeps going. I know that I can think and make better decisions than someone who might not have mental health issues, so I don't see the need to stigmatise myself.* (Abidemi, Ghanaian male)

The layers of stigma had different outcomes for participants in this study. Some felt that it made them feel ashamed to seek help, and in Abidemi's case, although he felt powerless in decision-making about his condition, he was still able to overcome stigma by speaking about his condition. Stigma cannot be discussed without understanding its power in a broader context. Parker and Aggleton (2003) argue that stigma is used by individuals, communities and the state

to produce and reproduce social inequalities. When taking into consideration the broader social and political context that African migrants exist in, mental health stigma becomes an additional layer in these intersecting disadvantages. As a group that is historically found to be less likely to engage in services but at more risk of adverse mental health, stigma becomes a breeding ground for these disadvantages to thrive.

6.3.6 Experiences with the UK healthcare system and their influence on help-seeking

The discussion on stigma throughout this study has demonstrated that the origin of shame comes from various aspects of the participants' lives that range from an individual level to a structural level. Closely linked to stigma, participants' prior experiences with the healthcare system had influence on their likelihood to seek help. Participants had mixed experiences with the healthcare system in Scotland when engaging for other issues aside from mental health. Some participants had positive experiences, which serve as enablers to help-seeking in the future. Other participants had negative experiences, which potentially had an impact on their likelihood to use services in the future. Some stated that their negative experience resulted in a mistrust in services and decided to deal with issues in their way.

6.3.6.1 Positive experiences in healthcare as enabler for help-seeking

The positive experiences that some participants had with healthcare services in Scotland played a crucial role in shaping their willingness to engage in these services. These positive encounters can be seen as pivotal moments that counteract stigma, build trust, and foster a sense of empowerment. Such experiences not only reflect the potential for effective mental health care delivery but also highlight the impact of healthcare professionals' attitudes and approach. Two participants who sought mental health support had a positive experience and felt that their health had improved after seeing their GP. They spoke not only about medications received, but Zuri mentioned some holistic methods suggested to deal with her anxiety:

> *I went to the GP and I thought, maybe I would just, I will just mention my anxiety, so I was then put on some medication. The doctor also recommended I do things like yoga, massage and acupuncture. So yeah, I do that now and I found all of this very good, it helps a lot.* (Zuri, Kenyan female)

Zuri speaks about visiting her GP for another condition and deciding to mention her struggle with anxiety. Her positive experience made her feel that she had control over her anxiety and gave her the tools to deal with it holistically.

Onyi highlighted the importance of connecting with her counsellor. She discussed that she had issues in the past with healthcare providers who did not make an effort to connect with her but made her feel like they were just doing their job and not going beyond that. However, she stated that when she did meet a counsellor who was able to connect with her, she appreciated that she went beyond her role to ensure that she was okay. She felt that this 'pulled' her out of her suicidal thoughts:

> *If you're able to make the connection, you can pull someone out. You know there was a time I was thinking about suicide, nobody knew. But because I was paired with someone (counsellor) who was able to reach me I felt what she was doing wasn't just a job, she really cared about me.* (Onyi, Nigerian female, FG 1)

6.3.6.2 Racism in healthcare

Racism within the healthcare system is a critical issue that has garnered increasing attention in recent years. This is documented by many studies showing differential and unequal delivery, access, and healthcare across different conditions. Some aspects of healthcare, such as diabetes care, mental health, maternal health, pain management and end-of-life care, have been found to have increased prevalence for minority groups (Hamed et al., 2022, Morel, 2019). The presence of racism within healthcare settings can have profound consequences for both patients and healthcare providers. One reported issue was perceived racism when dealing with GP registration. One participant stated that when she and her family tried registering with a new GP, they were met with numerous questions and asked to produce identification and proof of address. One of the hallmarks of the hostile immigration laws implemented in the past was the use of patient information to locate individuals who may be undocumented or have overstayed their visas (discussed in detail in section 2.5). Some GPs still ask for documentation prior to registration, although these laws have been changed (Ciftci and Blane, 2022, Clarke, 2016). This was identified as a barrier to help-seeking, as the participant felt alienated when she was asked for various paperwork.

> *They wanted, like bills for proof of address, which when you go to register, they're not supposed to ask for that, but there were all those issues wanting IDs and all that. But in the first instance they shouldn't have asked for whatever they were asking for, because it's not the same for people who are not migrants. When they go to register, they just take them just like that. But because you're in migrant, they ask you all these questions.* (Chifundo, Malawian female)

Mansa had a similar experience when she had newly arrived and was trying to register with her local GP:

> *She asked me if I was an asylum seeker in front of the people in the room. Initially, I did not understand why she would ask that, but after that she said I need to bring proof of address. I told her I had just arrived and did not have any bills, she then said to bring something even if it was from a package delivered to my house. I found that strange.* (Mansa, Ghanaian female)

Darweshi shared his experience with prejudicial treatment from a doctor, while looking for support with the stress levels he was experiencing. He stated that the GP asked if he had checked his HIV/AIDS status when he went to consult for neck pain and headaches:

> *I had constant pain and headaches, so I decided to go to see the GP. What a shock when I got there, I will never forget. I explained that I'm studying and working so I have so much stress. The GP then asked me when I last checked my HIV and AIDS. His perception was that African people all have HIV. I remember remaining quiet, because you don't want to say anything offensive but deep down, I was angry.* (Darweshi, Tanzanian male)

Darweshi's experience had been reported amongst Black people in various countries where GPs and nurses use skin colour as a proxy for HIV/AIDS risk. Henrickson and Fisher (2016) found that this further perpetuates stigma and increases the mistrust in services, which impacts help-seeking behaviours. This can also be considered as a racial micro-aggression because it is motivated by the perception that Black people have a higher prevalence of HIV/AIDS. Racism in healthcare is a well-documented barrier to help-seeking in minority groups. Black people have been historically alienated and treated with a lack of empathy due to misconceptions such as high pain tolerance (Hamed et al., 2022, Sim et al., 2021, Ben et al., 2017). Similarly, in this study, participants who experienced racism in healthcare expressed their dissatisfaction and unlikelihood of seeking further help in statutory services.

6.3.6.3 Inaccessibility of direct mental health services

Inaccessibility of direct mental health services such as counselling was mentioned as a reason that would make participants less likely to engage with statutory services for mental health issues. Some participants found the route of accessing mental health tedious because they had to go through their GP first. Zandi made comparisons to the healthcare services in her home

country, which allowed her to see a counsellor directly without a referral from a GP first. She said that having to talk to so many healthcare professionals made it a long process before she could get the help she needed.

> *In as much as I adore the NHS, there is still a roundabout way of accessing help. Having experienced it from the physical side where you needed help for something specific the route is generally you have to go to GP first and then maybe you get referred. Whereas back home, using private health insurance, it (referral) will be more immediate.* (Zandi, South African female)

Similarly, Kelechi expressed the same issue and said that once he realised he had to speak to his GP first, he did not go ahead with seeking help:

> *Actually, someone has suggested to go see a psychotherapist, so I said you know that's good, so I went, but what I was told you oh, you need to consult a GP first because the GP is the starting point.* (Kelechi, Nigerian male)

Requiring individuals to navigate through several steps before accessing mental health support can make the process seem complex and burdensome. This complexity might discourage individuals from seeking help, especially if they are already struggling with their mental health. Going through multiple healthcare professionals, such as GPs, for referrals can result in delays in receiving timely mental health care. This delay is especially problematic considering the urgency of addressing mental health concerns. The requirement to engage with multiple healthcare professionals before accessing specialised mental health services can inadvertently amplify the stigma associated with seeking help. Individuals might feel that their mental health concerns are being treated differently than physical health concerns. Moreover, in the case of African migrants, navigating the healthcare system, understanding referral processes, and interacting with multiple professionals might be daunting for individuals.

6.3.6.4 Experiences with medicalising mental health issues in healthcare

One of the most mentioned concerns was the prescription of drugs to individuals who sought mental health support. Many participants had a fear of being put on medication that they could not discontinue or would become addicted to. This stance evidenced the mistrust of services and the perceived medicalisation of mental issues in healthcare. It also demonstrated how mental illness is dealt with in marginalised communities, where instead of addressing the determinants of mental health, efforts are placed into developing treatments (Shim and

Compton, 2018). Participants' fear of medical treatments also reflects the negative perceptions on mental health treatments that have been historically used a form of power in African populations (Fernando, 2017a). Mistrust may also stem from personal experiences or through socialisation with others who had the experience. For most participants, this further perpetuated the association of 'madness' when discussing mental health because most felt that this was the most common way that mental illness was dealt with in statutory services.

Darweshi (Tanzanian male) spoke about a conversation he had with a friend, which influenced his opinion on whether to take anti-depressants or not:

> *You know, and I remember actually at some point at the beginning, when things were very tough, somebody prescribed antidepressants. I remember sharing it with a friend at the university and they said I must never take them. If you start taking this stuff you will continue to the end of your life, so I never took them.*

Likewise, Kalu (Nigerian male, FG 1) said: *"People say that the medication is not helpful it could also be a trap",* which shows the level of mistrust of services. There was strong fear of being placed on medication and not being able to come off at a later stage. Participants also discussed the fear of addiction and not being able to cope without the drugs in the long run, as explained by Tinashe and Nasha:

> *Taking antidepressants is not the best, because antidepressants like benzodiazepine are class A drugs, if you start taking them it will lead to low mood ,it might also lead to other health issues. Your mood becomes so low, you feel empty, you are lonely. You don't want to go back to the GP because they will continue writing prescriptions.* (Tinashe, Zimbabwean female)

> *When I lost my sister, my elder sister, that period I was really down and there was a period I couldn't do anything academically. So I discussed with my GP, they gave me options that they can put me on medication to be taken to help me get relief and continue with my studies. But I'm not a believer of medication, I just imagine if I take the medication does that mean each time I go through bad times I need medication to keep me happy. No I can't start taking medication, what if I get addicted.* (Nasha, Nigerian male)

Mohammed felt that he would rather manage stress on his own, to avoid being dependent on medication:

> *I've always felt like I have to manage my stress by myself, because I don't want to be dependent on such things (medication). I try to motivate myself and try to do things that alleviate my stress.* (Mohammed, Eritrean male)

The medicalisation of migrant mental health is something that not only exacerbates the mistrust in migrant communities but also undermines the complexity of migratory experiences that do not belong to clinical characterisations. Compton and Shim's body of work argues this point and calls for more attention on upward factors that influence social and environmental aspects. They argue that by focusing on minimising adverse circumstances from childhood to adulthood, much of the burden of mental health could be alleviated and medical treatment need reduced (Compton and Shim, 2015, Shim and Compton, 2018). This is reflected in participants' accounts who speak about needing someone to understand the issues they are facing and help them find a solution. They feel that the overprescription of medication does not solve their issues but rather makes them incapable of dealing with them effectively. Fathima (Cameroonian female) reflects on how her friend's behaviour changed after being put on medication; *"…the treatment regimen took him down even more. They made him sink into the depression further because when you speak to him, he just looked like a moron. He just couldn't coordinate himself anymore".* The perceptions and beliefs of migrants show the detachment between the organisation and the needs of the individual. Though services have made efforts to educate health professionals on cultural sensitivity, the diagnostic tools and therapies are still largely standardised and rigid (Govere and Govere, 2016, Suphanchaimat et al., 2015). Research also show that Black patients are just over 50% more likely to be prescribed injectable antipsychotic drugs than white patients (Das-Munshi et al., 2018). Aside from one participant who reported they had been referred to holistic interventions in addition to medication, the rest of the participants in this study had experiences of being given pharmacological interventions when seeking help.

The mistrust of services and medication has a wider political root cause. As covered in Chapter 2, the history of mental health and how African migrants have been treated historically makes it hard for these groups to trust that services have their best interests at heart. CRT provides an appropriate analysis on the historical mistreatment of African people when it comes to mental health. Throughout the years, the history of mental health treatment for African people in Western societies is marked by a legacy of discrimination, exploitation, and unequal access to appropriate care. Throughout various historical periods, African individuals have faced

systemic racism, cultural misunderstandings, and stigmatisation within mental health systems. During the colonial era, African individuals were often subjected to racist and dehumanising practices. Western colonisers frequently depicted African cultures and traditions as inferior, leading to the mistreatment and disregard of mental health needs within African communities. Racist ideologies influenced mental health practices (Fernando, 2010, Whitley, 2015). Eugenics movements promoted the belief that certain racial and ethnic groups were genetically inferior, contributing to harmful stereotypes and discriminatory practices within mental health care (Fernando, 2010, Bhugra and Bhui, 2018). This speaks to the permanence of racism in Western societies that is engrained in institutions which are evident to this day. This is seen in the overrepresentation of Black African and Caribbean people in mental health institutions and related detentions, which has been discussed for decades, but is yet to be adequately addressed.

6.4 A way forward for mental health support for African communities in Scotland

As discussed earlier in this chapter, the majority of the participants felt that they would not immediately/readily seek help for their mental health from statutory services. Participants were also asked to discuss the ways they felt that mental health support in their communities could be made suitable for African migrants. They were given the opportunity to talk about the changes they would like to see, and there were numerous suggestions centred around collaborating community-led initiatives with statutory services, increasing the visibility of diverse professionals in predominantly Black communities, including international students as part of the migrant community interventions, and increasing opportunities for support during mental health difficulties.

The participants' suggestions regarding mental health support indicate a strong inclination toward community-centred initiatives. These suggestions highlight a collective desire for solutions that are attuned to their cultural backgrounds, personal contexts, and the nuances of their challenge. Tunde underscored that it would not be sufficient to just set up committees in Scotland, but for there to be an actual impact on the mental health needs of African communities:

> *It's one thing to set up the committee, it's another thing to actually get it working. To have a diverse and inclusive committee and not just ticking a box but make sure it is impactful.* (Tunde, Nigerian male)

Ijeoma mentioned the need for increased visibility of diverse leaders and health professionals in predominantly Black communities, which indicates the importance of representation. Having mental health practitioners who share their cultural background can foster trust and promote a sense of cultural competence.

> *It would be good to see more Black people in positions of power. For them to lead with initiatives to improve the lives of African people. For example, I have not seen a Black GP ever since I got here. I would feel more comfortable speaking to a person that looks like me.* (Ijeoma, Nigerian female)

Segun and Debare spoke about the lack of support for international students and suggested that tailored interventions to meet the specific needs of international students that reflect their unique challenges. The discussion about the lack of support for international students brings to light a critical and often overlooked aspect of mental health within migrant communities. These challenges can encompass various dimensions, including feelings of isolation, financial stressors, and uncertainties related to transitioning from student life to professional life. These factors can significantly impact mental health and well-being, necessitating support structures that are sensitive to their unique circumstances. Debare specifically suggested support and guidance for international students who would like to transition from student life to work/employment:

> *We need more support directed at people who have come and left everything back where they came from and have come to this country to study to become a better version of themselves. This is in terms of trying to break down that barrier and offer some positive experiences to international students.* (Segun, Nigerian male)

> *Reduce all the strict guidance what job you can do, where you can work and how much you can get paid. And stop making it harder for employers to want to employ these people after their studies. There are a lot of considerations going through your mind when you're studying, you're thinking about finishing your master's and now you have to worry about securing a job, which is hard.* (Debare, Nigerian male)

Two participants also discussed the need for various educational opportunities to provide support and guidance to African migrants especially those who have newly arrived:

> *We create committees and bring people who have the same background. Then, we bring in programs that educate people about the migrant realities and help you solve them.*

And for those who are informed they can use those committees to create awareness, then people can share. (Nasha, Nigerian male)

There are no systems for newly arrived migrants especially those who come to study or work. They rely on the university or workplace but there needs to be a broader induction for them to know where to go and how to use the system. (Darweshi, Tanzanian male)

According to participants in this study, the way forward for African migrants' mental health in Scotland involves a comprehensive and multi-faceted approach that addresses systemic inequalities, promotes cultural sensitivity, and empowers individuals to seek and receive appropriate support. Moreover, there is a strong need to interrogate the deep-rooted impact of systemic racism and address the structural inequalities that perpetuate disparities. To interrogate these structures, there needs to a critical analysis of policies that perpetuate disparities. There is also a need to continue and increase the cultural training and cultural competence in the institutions that African migrants engage in. The testimonies of Segun and Debare emphasise a significant gap in mental health and wellbeing support for international students, an often underrepresented group in both research and policy discourse. Their reflections reveal how the challenges of migration, academic pressure, cultural adaptation, and the precarious transition from student to professional life converge to create a uniquely stressful experience. Feelings of isolation, uncertainty around employment, and the absence of culturally sensitive support systems exacerbate these pressures, leaving many international students without the tools or guidance necessary for a healthy and successful integration into UK society.

Institutions, particularly those within the mental health and education sectors, must move beyond colour-blind frameworks that overlook the profound impact of intersecting vulnerabilities such as race, gender, sexuality, and social class. Far from being neutral, such approaches not only neglect the specific needs of marginalised communities but actively reinforce systemic inequities by failing to acknowledge the structural and cultural barriers they face, barriers that are especially pronounced for African migrants and other racialised groups.

6.5 Conclusion

This chapter has provided an in-depth examination of the perceptions, attitudes, and beliefs about mental health among African migrants, emphasising the significant influence of pre-

migratory cultures. The findings illustrate the perceptions, beliefs and attitudes that participants have on mental health, which bring forward sources of stigma leading to barriers to help-seeking. By illuminating these pre-migratory cultural influences, the chapter sets the stage for comprehending the unique challenges and viewpoints that African migrants encounter regarding mental health.

I argue that in this study, mental health awareness and knowledge of services did not necessarily lead to engagement because of the intersecting layers of participants' relationship with statutory services. This finding, in conjunction with the continued theme of stigma, points towards a need to further rethink the implications of culturally sensitive mental health approaches. As highlighted by Shim and Compton (2018), there is a strong need to interrogate the upwards factors in which mental health disparities thrive. Stigma emerged as a central theme, revealing its powerful role in impeding open discussions about mental health and creating substantial barriers to seeking help. The chapter delves into the various forms of stigma, highlighting the contradictions it presents to African communities' collective way of life. Additionally, the intersection of racism and stigma is explored, providing a nuanced understanding of the compounded challenges faced by African migrants.

Through the participants' stories, valuable insights have been gained into the factors contributing to mental health challenges and the impact of post-migratory experiences on psychological well-being. The chapter also addressed participants' interactions with healthcare services, discussing the implications these experiences have on their future help-seeking behaviours. The concluding section presents suggestions from the participants on improving mental health within their communities. Notably, with the majority expressing reluctance to use statutory mental health services, the chapter concluded with alternative solutions that participants believe would enhance mental health outcomes for African migrants.

Throughout this chapter, I have reflected on concepts from Critical Race Theory and its possible contribution to interrogating structural inequalities. This theory provides an opportunity for collaboration to decolonise the way in which mental health is dealt with in African communities. With these findings, I suggest that an in-depth look into African migrants' intersectional positions in society is necessary to improve help-seeking in Scotland.

Chapter 7

Discussion and concluding remarks

7.1 Overview

This concluding chapter summarises the key findings, discusses the original contribution to knowledge made by this research, and proposes recommendations for future research and practice in addressing barriers to help-seeking mental health support among African migrant communities. This chapter also shows how a critical analysis of the intersecting contexts helps with the understanding of help-seeking for African migrants in Scotland. I begin this chapter by outlining my original contribution to knowledge concerning the three research questions that have driven my research. A discussion of my theoretical approach in my thesis follows this. In this section, I reflect on the value of Critical Race Theory (CRT) in analysing the post-migratory conditions that impact African migrants' mental health and help-seeking behaviours. Lastly, I reflect on the research process and key findings, outlining the current study's limitations and possible implications for future research, policy and practice.

7.2 Original contribution to knowledge

This section outlines my original contribution to knowledge concerning the three research questions my study has addressed. The first section outlines how my research contributes to the limited understanding of African migrants' perceptions and experiences of mental health and healthcare in Scotland. The second section discusses the factors that influence help-seeking for mental health, as identified by the participants in this study. The third section outlines how migration affects individuals' mental health experiences and help-seeking. This section discusses how my approach to understanding pre and post-migratory experiences using Critical Race Theory contributes new knowledge in relation to what influences African migrants' mental health and help-seeking behaviours.

Research question 1: What are African migrants' perceptions and experiences of mental health and healthcare in Scotland?

My findings in answering this first question bridge the gap in existing literature on African migrants' perceptions and experiences of mental health and healthcare in Scotland. Existing studies have focussed on asylum seekers and refugees (Quinn, 2014, Zimmerman et al., 2009,

Isaacs et al., 2022) or broadly on the experiences of ethnic minority groups (Jabeen and Snowden, 2022, Simpson and Gray, 2021, Kapilashrami and Marsden, 2018). However, these have not distinguished African nationalities. While this literature is essential and helpful in helping us understand the different perceptions and experiences that asylum seekers and refugees may have, settled African migrants are not included in these findings. Therefore, this question was posed to understand how mental health was perceived and described by African migrants living in Scotland. With this question, I also intended to uncover African migrants' experiences of mental health and the mental health of other African migrants they knew. I hoped to explore the perceptions and experiences of individuals and anticipate the influence of societal and cultural factors on their perceptions and experiences of mental health in these accounts. Taking on a social constructivist paradigm, this question allowed for the exploration of multiple influences in how participants perceived and experienced their mental health before and after migration, also in the context of a global pandemic. Overall, my data indicates that pre-migration perceptions, attitudes and beliefs of mental health were mainly maintained after migration, while new views and beliefs were also developed (see section 6.2). This aligns with previous research findings in the UK and other European contexts (Hickson et al., 2017, Satinsky et al., 2019, Ward et al., 2019) , which show that although a majority of participants acknowledged the harmful stigmatising labels that come with their cultural and pre-migration perceptions of mental health, some health behaviours were still influenced by these perceptions.

The findings indicate that the concept of 'mental health' was challenging for participants to define, and many reported that it was neither a concept they had considered nor a phrase they had used prior to migration. The data also revealed that participants perceived that the personal issues they faced were not connected to their mental health. Participants commonly viewed low mood and stress as normal life experiences that could be mitigated by addressing their underlying causes. These causes included post-migratory factors such as visa-related stresses, education, employment, racism, isolation, and overall adjustment to their new environment. Although participants did not associate these with their mental health challenges, this finding could suggest that the mainstream definition and approach to mental health may not align with African migrants' perceptions. As discussed in Chapter 6, Section 6.2.1, participants conceptualised mental health in diverse ways, attributing it to biological, genetic, spiritual, religious, or substance abuse factors. The understanding of mental health has an influence on

how it is treated and how people seek for help. This finding is consistent with studies that critique mainstream psychology's one-size-fits-all approach and advocate for a more holistic perspective on mental health to accommodate diverse backgrounds (Swartz, 1996, Morgan et al., 2017b, Arafat, 2016). These studies assert that mental health cannot be understood by conventional terms, which may suggest the reason that mental health services do not seem appropriate in ethnic minority groups. Participants also noted that the intangible nature of mental health, in contrast to physical conditions like cancer, made it more challenging to identify and treat successfully. While this observation has been noted in other studies on the difficulties in conceptualising mental health (Dare et al., 2023), it underlines the need for mental health promotion efforts to be tailored to better resonate with African communities. Additionally, understanding the disempowerment experienced by African migrants due to visa-related challenges, unemployment, and discrimination, it becomes evident that their stressors should be viewed not only as mental health issues, but as intersections of post-migratory difficulties. The delays in seeking help may be a result of the incongruence between Western and African perceptions of mental health, and this is further explored in the following section.

The data collected also underscored the intersectionality of factors influencing participants' social identities, significantly impacting their perceptions and experiences of mental health post-migration. Gender norms and the associated stigma related to mental health emerged as a recurrent theme, with male participants reporting more difficulty discussing their mental health compared to female participants. This finding is consistent with other studies (Ezeugwu and Ojedokun, 2020, Olawo, 2019) that highlight the problems with expressing mental health struggles in men, as also discussed in Section 6.2.2. Male participants openly discussed the societal expectations and norms that deter them from addressing their mental health concerns. These social pressures often result in the suppression of emotions and reluctance to seek help or the adoption of harmful coping mechanisms, thereby perpetuating the stigma surrounding mental health within male African migrant communities. The insights from this research emphasise the heightened risk faced by male African migrants in terms of how they perceive and experience good mental health. This risk is intricately tied to the gendered expectations placed upon them, which can serve as barriers to seeking and receiving the necessary support.

Female participants did not cite gender norms as a direct barrier to discussing mental health issues however they emphasised that their responsibilities as mothers or wives often took precedence over their mental well-being. This finding reveals the subtle yet profound impact

of gendered expectations on women's mental health in African migrant communities. These findings were similar to Bletscher and Spiers (2023) that highlighted the gendered impacts of migration on women. They also discuss the experiences of loneliness and isolation that women face post migration all the while having to continue their household responsibilities. These findings suggest that women may neglect their own mental health needs, focusing instead on the well-being of their families. This self-sacrificial behaviour is deeply ingrained in many cultures including African cultures. It can lead to significant mental health challenges, as women are less likely to seek help or allocate time for self-care (Giscombe et al., 2020). This often means that women are responsible for managing household responsibilities, often in a new and challenging environment, which can exacerbate feelings of isolation, anxiety, and depression (Said et al., 2021).

Studies (Stypińska and Gordo, 2018, Sedacca, 2024, CEDAW, 2014) also show that migrant women experience more gender discrimination as they navigate employment, which means that they are often in lower professional ranks and lower-wage jobs. This may be a source of intersecting social identities such as socioeconomic status, age, gender and class, which place them at a vulnerability to stress, depression and anxiety. My findings provide knowledge of gender norms in African migrant communities that extend to their post-migratory context. These norms play a crucial role in decision-making on discussing mental health and help-seeking behaviours. Therefore, understanding and addressing these gendered expectations is essential for developing mental health interventions that are responsive to the specific gendered needs of African migrants, ensuring that cultural norms are understood and addressed appropriately.

These findings shed light on the imperative of recognising the intersectionality of social identities, such as class, socioeconomic status, migration status and gender, when addressing mental health disparities within African migrant communities. Intersecting social identities are crucial in shaping mental health outcomes. For instance, the compounded effects of socioeconomic status and migration status can exacerbate the challenges faced by African migrants. Research has shown that Black people are disproportionately represented in lower socioeconomic backgrounds and may experience more significant financial stress and increased exposure to precarious living conditions, all of which can negatively impact mental health (Thomas, 2016, Castañeda et al., 2015, Chang, 2019). Further complicating these challenges are the financial pressures associated with visa costs and remittance obligations.

Most participants in this study expressed that they had to pay substantial costs related to visa renewals, which often place an additional financial burden on already tight household budgets. Moreover, many migrants feel the moral and cultural responsibility to send remittances to support family members back in Africa. According to a report by (IOM, 2023) one in nine people rely on remittances sent by migrant workers and the number of people sending remittances has decreased in recent years. This could be due to the rise in the cost of living and the impact of COVID-19. This dual responsibility, managing their own financial survival in a foreign country while providing for families back home, creates a heightened sense of financial stress and insecurity (Lindley et al., 2023).

The perceived causes of mental health issues, as highlighted by the study, significantly influenced attitudes and behaviours regarding responses to mental ill health and the pursuit of help. These perceptions were deeply entrenched in cultural, spiritual, and religious beliefs, with additional mentions of genetic and biological factors. Cultural and spiritual beliefs hold significant influence within African migrant communities, shaping the way individuals perceive and respond to mental health challenges (Akyeampong et al., 2015, Dare et al., 2023). This study's findings highlight the pervasive impact of these beliefs, which encompass a wide array of explanatory models. It is well-documented that African migrants often rely on cultural, spiritual, and religious frameworks to interpret and manage mental health distress (Dare et al., 2023). Nevertheless, while these approaches are valuable, they may not be entirely sufficient and can sometimes hinder the effective resolution of complex mental health disparities within African communities.

Multicultural approaches alone may not suffice in addressing mental health disparities, emphasising the necessity for a multifaceted strategy that combines culturally sensitive interventions with evidence-based practices. Mental health disparities within African migrant communities may require tailored interventions that effectively bridge cultural beliefs with contemporary mental health care strategies. These interventions should aim to integrate cultural and spiritual frameworks into mental health promotion and treatment while simultaneously addressing systemic barriers and promoting destigmatisation. Previous research has highlighted some of these gaps in Scotland (Quinn, 2014, Isaacs et al., 2022, Knifton et al., 2010) however, this study's participants highlighted a need to continue this work. Overall, the findings of this study highlight the need for a contextualised understanding of the intersecting

social identities that influence how African migrants in Scotland perceive and experience mental health.

Research question 2: What are the factors that influence help-seeking for mental health amongst African migrants in Scotland?

This question was posed to understand what factors would provide a conducive environment for help-seeking and which would serve as barriers to help-seeking. The findings demonstrated the multifaceted nature of factors influencing help-seeking behaviour across individual, interpersonal, and structural dimensions. A prominent theme was the pervasive impact of multilevel stigma, identified as a significant deterrent to seeking support. This aligns with existing research highlighting stigma as a formidable obstacle in discussions about mental health (Clement et al., 2015, Quinn and Knifton, 2014, Eren and Çavuşoğlu, 2021, Soghoyan and Gasparyan, 2017). Closely linked is the lack of a safe space to discuss issues of mental health, which participants mentioned as a barrier to help-seeking. Examining help-seeking behaviours within African migrant communities revealed a complex interplay of influences shaping individuals' decisions and actions regarding mental health support. These influences encompass cultural norms, social expectations, personal beliefs, and institutional frameworks.

Stigma, particularly within the context of mental health, emerged as a prevalent and deeply entrenched barrier to help-seeking amongst participants. This multilevel stigma encompasses societal stigma, which perpetuates stereotypes and misconceptions about mental health, as well as self-stigma, where individuals internalise negative beliefs and judgments about themselves. Self-stigma is also heavily influenced by various social identities held by individuals (gender identities covered in the previous section). These social identities are bound by cultural beliefs and attitudes that perceive mental health problems as a source of shame or weakness. The perception that seeking help for mental health challenges may be seen as a personal failure or a sign of weakness can contribute to the reluctance to engage in conversations about mental health and seek appropriate support, which has been found in other studies, such as Mantovani et al. (2017) who looked at African faith communities in the UK. Additionally, structural stigma within healthcare systems and institutions can further compound the challenges faced by African migrants seeking mental health support. This is consistent with existing theories on stigma (Goffman, 1963, Link and Phelan, 2006).

Self-stigma

The concept of self-stigma was discussed by multiple participants in this study, and although they did not mention the word explicitly, their accounts of how they felt about mental health indicated some self-stigma. Participants associated feelings of shame and weakness when thinking about seeking help, and some felt that their identity as an African person did not afford them the right to have any mental health issues. These findings were consistent with the literature that highlighted the interplay of cultural context and public attitudes that reproduced high levels of self-stigma and fear of the consequence of disclosure (Mantovani et al., 2017, Bansal et al., 2022, Codjoe et al., 2021).

In African communities, there is often a convergence of external stigma related to societal perceptions of mental health and internalised self-stigma. The labelling of mental health issues can carry significant stigma within these communities, potentially leading individuals to perceive their condition through a lens of shame or fear of judgment (Mantovani et al., 2017). Participants' accounts show this dynamic. The accounts of participants made me notice a stark contrast that when discussing mental health, it was an individualised experience for participants. As I discussed in Section 6.3.5.1, the individualisation of mental health issues is a paradox in how African culture views life and health in general (Berghs, 2017). As a result, participants discussed the internal turmoil they would have when faced with mental distress. By emphasising that dealing with mental health concerns is an individual journey, they reflect a common sentiment that individuals may feel isolated or responsible for managing their mental health alone. This can stem from fears that admitting to mental health struggles could lead to their experiences being minimised or judged, particularly if they perceive their life circumstances as not being in perfect order. This self-stigma can be a significant barrier to seeking help or discussing mental health openly. It reinforces the importance of addressing not only external societal attitudes towards mental health, but also empowering individuals within these communities to overcome internalised stigma and seek support without fear of judgment or diminishment of their experiences.

Participants' feelings of isolation in dealing with their mental health issues also mirror the broader experiences of migrants navigating an unfamiliar environment. Drawn from the findings, I argue that this places them in the centre of intersecting vulnerabilities, such as stigma, cultural dislocation, language barriers, and economic and limited social support networks. These factors can exacerbate the sense of self-stigma and hinder effective help-

seeking behaviours. These insights show the necessity of developing a more nuanced understanding of stigma in African migrant communities. This is an understanding that highlights the importance of healthy community ties reducing individualism when it comes to mental health discourse.

Cultural stigma

Stigmatising labelling of mental health issues emerged as a key theme in participants' discussions. When participants reflected on the language used to describe mental health in African communities, both pre and post-migration, it showed the widespread cultural stigma surrounding these issues. Despite acknowledging the derogatory and stigmatising nature of these labels, participants conveyed that such sentiments persisted in conversations about mental health. This stigma is not merely linguistic, but is deeply ingrained in cultural perceptions and attitudes toward mental health. These findings were similar to studies that discussed the difficulties in discussing mental health in African communities. These studies highlight the cultural and religious misconceptions that attribute mental illness to spiritual manifestations, which reinforces the stigma (Codjoe et al., 2021, Shannon et al., 2015, Berwald et al., 2016). The association of mental health issues exclusively with extreme and untreated cases further entrenches negative stereotypes and deters individuals from seeking help for more common or early-stage mental health concerns. This dichotomy highlights a significant barrier to effective mental health discourse and support within African migrant communities, necessitating culturally sensitive interventions to reshape perceptions and promote a more comprehensive understanding of mental health.

Stigma can then be understood to impact help-seeking through its oppression on the individuals' various social identities, which leaves no safe space to discuss mental health issues. By applying an intersectionality lens, the findings of this study highlighted that individuals with multiple marginalised identities can experience cumulative disadvantages. In this case, an African migrant might face stigma related to both their migrant status, their racial or ethnic background and their social class position. These intersecting stigmas can compound the challenges they face in seeking help for mental health issues. This draws on the fact that these intersecting stigmas leave no safe space for individuals to discuss their difficulties. Mental health services and awareness campaigns often do not consider the intersectionality of individuals' identities, leading to a lack of tailored support and a failure to address the complex ways in which stigma operates. Applying CRT and intersectionality to understand these social

identities can be a useful tool in mental health services and awareness campaigns. By doing this, policies and services may have a nuanced understanding of the source of issues faced by individuals and provide multistakeholder support and advice to address these. Neglecting these intersections can lead to policies and funding decisions that may fail to address the nuanced needs of marginalised communities, perpetuating health disparities and inequities.

Structural stigma

Concerns about the medicalisation of mental health issues were another common theme amongst the participants (see section 6.3.6.4). This not only fosters mistrust of services within these minoritised communities but also oversimplifies the complex experiences associated with migration, which cannot always be neatly categorised into clinical characterisations. This aligns with the accounts of participants in this study, who expressed a strong desire for health practitioners' understanding of their mental health challenges and practical solutions rather than the over-prescription of medications. They emphasised that medication alone often failed to address the root causes of their mental health challenges and, in some cases, could even exacerbate their conditions. The perceptions and beliefs of migrants highlighted a disconnect between the mental health services offered and their individual needs. By moving beyond a purely medical lens and addressing the social determinants of mental health, including migration as a social determinant, healthcare providers can better support the mental well-being of migrants and ensure that treatment approaches are more aligned with their complex realities.

Participants' perceptions and experiences significantly contributed to the understanding of structural stigma in mental health care. One participant, drawing on their interactions within the healthcare system, discussed the perpetuation of stigma by healthcare providers while navigating health services. This participant highlighted how healthcare providers often inadvertently reinforce stigma through their attitudes and behaviours, exacerbating the challenges faced by African migrants. This was mentioned by other participants as a barrier to future help-seeking for other conditions. While issues related to the lack of autonomy and decision-making are not exclusive to African migrants, it is crucial to recognise that these issues add a layer of vulnerability for this population. African migrants frequently experience a sense of disempowerment due to various factors associated with migration, including financial instability, visa uncertainties, and discrimination. This disempowerment is further compounded by the lack of autonomy in healthcare decisions, which can significantly affect their sense of control over their health and well-being. The inability to actively participate in

decision-making processes within the healthcare system can lead to feelings of powerlessness and mistrust towards healthcare providers. This lack of agency is particularly detrimental, as it not only affects the immediate health outcomes, but also discourages African migrants from seeking help in the future, thereby perpetuating a cycle of poor mental health and inadequate care.

The culmination of all the factors discussed by participants highlights their emphasis on a lack of a safe space to discuss mental health. This lack of safe spaces is evident across multiple levels within their communities and institutional settings. The lack of safe spaces is thus a multifaceted issue that requires comprehensive solutions. Culturally sensitive mental health services, co-production of services, community-based support networks, and institutional reforms are essential to create environments where African migrants feel safe to discuss and address their mental health concerns. By fostering inclusive and supportive spaces at both community and institutional levels, it is possible to break down the barriers to mental health care and support the well-being of African migrants.

Research question 3: How does migration play a role in mental health behaviours and experiences?

Migration has been considered a social determinant of health in many contexts (Castañeda et al., 2015, Paremoer et al., 2021, Hynie, 2018). To my knowledge, this is the first study that looks at the role of migration on Africans' mental health behaviours and attitudes in Scotland through a Critical Race Theory lens. After migration, participants' experiences of racism not only had an impact on their mental health, but also on their confidence in discussing mental health with medical professionals. Though this approach is unique to my study, it is congruent with research exploring the legacy of colonial methods in dealing with Black people and mental health in minority groups (Wood and Patel, 2017, Cullen et al., 2020, Stoll et al., 2022). This is a legacy that has left a level of hostility when dealing with mental health in Black people, which is evident in the disparities facing Black Caribbean and Black African groups in mental health institutions in the UK (Halvorsrud et al., 2018).

Authors of critical race theory (West, 1995, Delgado and Stefancic, 2017, Warmington, 2020) emphasise the importance of the historical context and recognise that racism has deep roots in society and functions at multiple levels, from structural to everyday experiences. By considering the historical experiences of racialised communities, including systemic oppression, discrimination, and trauma, CRT helps us understand how these factors can impact

mental health outcomes. This is particularly salient in psychology, psychotherapy and psychiatry, which, as Fernando (2010) states, have the potential to discriminate systemically and are rooted in institutional racism in the past and present. The mental illness labels, diagnoses and treatments have resulted in minority groups being over-represented in mental institutions, which, unless understood through the CRT lens, cannot be fully understood (Roy et al., 2017). Thus, through the findings of this study, I argue that after migration, African migrants' health decisions become a source of vulnerability and uncertainty. Moreover adjustment into their new environment can be a source of mental health vulnerability due to issues faced post migration.

Findings in this study show that adjustment post-migration becomes an obscure target because racism operating at multiple levels reminds individuals from migrant backgrounds of their marginal position in society. Racism was experienced by participants on an individual and structural level, which contradicted their expectations of safety from the insecurities they had experienced in their countries of origin. The incongruence between expectations and reality reinforces their feeling of not belonging or not being allowed to belong, which has a profound impact on mental health. Several authors highlight the positive association between the feeling of belonging in the host country and positive mental health outcomes (Straiton et al., 2019, Brance et al., 2024, Lincoln et al., 2021). Participants in this study were acutely aware of the disparities in their living conditions and opportunities compared to their white counterparts. These observations highlight the critical importance of considering contextual factors such as racism and discrimination when analysing help-seeking behaviours in minority groups. This emphasis aligns with other studies that explore the impact of race-related stressors on mental health and help-seeking behaviours. Recognising and addressing these contextual factors is essential for developing effective mental health interventions and support systems that are responsive to the unique challenges faced by African migrants and other minority groups (Williams, 2018, Wallace et al., 2016, Nazroo et al., 2020) .

Recognising and addressing racism and discrimination in the participants' context is particularly important in the current political climate that promotes anti-migrant sentiments and policies. Although my participants were all living in Scotland at the time of the study, it is important to consider the political climate of the UK as this has a direct impact on their well-being (see section 2.4 for a detailed discussion on immigration policies in the UK). The constant changes in immigration rules are a constant form of Othering which can exacerbate

mental health and well-being. The recent political climate in the UK during the Conservative-led government which ended in July 2024, was characterised by stringent immigration policies and heightened anti-migrant rhetoric, which has profound social and psychological impacts on migrants. Though the Labour party rule may bring changes to immigration, this is yet to be seen. The perpetuation of xenophobic and racist sentiments through political discourse and media representation exacerbates feelings of inferiority among migrants, contributing to chronic stress and anxiety. Understanding these dynamics through the lens of CRT highlights the critical need to address the systemic nature of discrimination and its multifaceted impacts on migrant communities.

Critical Race Theory theorises that advancements in rights for marginalized groups, such as migrants, often occur when they align with the interests of the dominant majority. In the UK context, the Brexit referendum in 2016 marked a significant turning point by ending the free movement of most EU nationals, thereby reshaping the immigration landscape. Following Brexit, the Conservative UK government in power until July 2024 implemented new immigration rules that imposed more stringent criteria for EU nationals seeking to work or study in the UK. However, concurrently, there was an increase in arrivals of non-EU nationals, particularly skilled workers and health and social care professionals, who were still allowed under less restrictive rules designed to address labour shortages (Portes and Springford, 2023). This phenomenon demonstrates interest convergence as the policy changes initially served the economic interests of the UK by ensuring essential workers could still enter the country, albeit from different global regions. Nevertheless, this apparent alignment of interests shifted again in 2023 when the Home Office introduced further changes to curb the increase of migrants. These revisions were aimed at tightening immigration rules once more, reflecting a pivot away from accommodating even essential workers under more lenient terms (see section 2.4 for detailed discussion).

From a CRT perspective, this fluctuation in immigration policy highlights how migrants' rights are contingent upon broader socio-political interests and economic considerations, often at the expense of ethnic minority migrants who may face disproportionate barriers to entry and integration. This cycle of policy changes not only shows the precarious nature of migrant livelihoods but also highlights their vulnerability within an unequal system. Ethnic minority migrants, who often face intersecting forms of discrimination based on race, ethnicity, and nationality, bear the brunt of these fluctuations in policy, while experiencing overt and covert

racism in their daily lives which places them at a vulnerability of mental health issues. This continuous exposure to racism not only undermines their sense of belonging, but also perpetuates a cycle of marginalization and psychological distress among ethnic minority migrants in the UK.

Throughout the interviews and focus groups, participants discussed the notion of strength and perseverance through their post-migratory obstacles. Although all participants did not use the word resilience, many referred to the concept in other words. *Resilience* was used as a positive attribute; however, it also became clear in these findings that it can be a tool of oppression for individuals struggling post-migration (see section 5.2.3). The term resilience is also commonly used when referring to migrants in literature (Ciaramella et al., 2021) which, I argue, can be problematic. The concept of resilience may inadvertently place the onus of adaptation solely on the migrants themselves, overshadowing the structural and systemic barriers contributing to their challenges. This framing can obscure the responsibility of host societies to address these barriers and create supportive environments conducive to the well-being of migrants. Resilience also implies an inherent ability to withstand and recover from hardships, which can lead to a narrative that glorifies endurance over advocacy for systemic change. When resilience is advocated, there is a risk of minimizing or ignoring the significant impact of racism, discrimination, and other structural inequalities that migrants face. These systemic issues are not mere obstacles to be individually overcome but are pervasive challenges that require comprehensive policy responses and societal shifts (Tippens, 2017, Preston et al., 2022, Ndomo and Lillie, 2023). This also reinforces the stigma discussed earlier in this chapter which perpetuates a cycle of oppression in multiple levels.

For instance, participants in this study reported experiences of racism at both individual and structural levels, which not only contradicted their expectations of safety but also reinforced their sense of marginalisation. The expectation that migrants should exhibit resilience in the face of such adversity can exacerbate feelings of isolation and undermine their mental health. This is particularly problematic when resilience is framed as an individual trait rather than a collective outcome influenced by environmental factors. The incongruence between migrants' expectations of belonging and the reality of exclusion they face stresses the importance of addressing the broader socio-political context in which they live. Moreover, the resilience narrative can lead to insufficient support from institutions that may assume migrants do not need as much assistance due to their supposed resilience. This assumption can result in

underfunded programs, inadequate mental health services, and a lack of targeted interventions aimed at addressing the unique needs of migrant populations. It can also perpetuate a cycle where migrants are expected to constantly adapt and endure without adequate support, further entrenching systemic inequalities. Therefore, it is crucial to adopt a more nuanced understanding of resilience, perhaps using the CRT lens that recognises the role of structural conditions. This involves addressing racism, improving access to culturally appropriate services and fostering inclusive communities that support the mental health and well-being of African migrants.

7.2 Methodological contribution

The research goal of exploring perceptions and experiences with mental health was central to informing my research design. My decision to conduct interviews and focus groups was influenced by the need to collect nuanced data that allowed participants to discuss their experiences in their own words. The COVID-19 pandemic moved my data collection to online however, which presented some positive outcomes that will be discussed in this next section.

Online data collection

As discussed in Chapter 4 (section 4.6), the data from my research was collected during the COVID-19 pandemic, which meant that all interviews and focus groups were conducted exclusively online due to pandemic-related restrictions to travel and social gatherings. One distinctive and original methodological contribution of this study lies in its utilisation of online recruitment and data collection platforms to explore mental health among African migrants. Although this method was not unique to this study, at the time of this study, it was not a commonly used form of data collection in mental health research with African migrants. The limitations imposed by the pandemic necessitated this approach, and it strayed from previous, more traditional qualitative research practices. The use of online platforms offers several advantages. Firstly, it facilitated a broader and more diverse participant pool beyond geographical constraints. I could contact stakeholders and potential participants from various locations. Secondly, traditional qualitative research often involves in-person interviews or focus groups, typically requiring participants to travel to a designated location. The pandemic made such travel logistically challenging and potentially risky. By conducting interviews and focus groups online, this study was able to cast a wider net for recruitment (see section 4.4) without incurring the usual travel-related expenses for both researchers and participants. This,

in turn, ensured a more diverse and representative sample, enriching the depth and breadth of the research findings.

The online methods also allowed the participants to have a level of convenience and flexibility. They had the opportunity to engage in the study from the comfort and safety of their own homes. A suitable time and date were agreed upon to ensure participants were comfortable discussing personal experiences. This was particularly advantageous for individuals with various responsibilities, such as familial obligations or work commitments, which might have otherwise deterred their participation in a conventional, in-person research setting. For example, one participant could participate during her lunch break while working from home. It also allowed participants to be more in control of the data collection process as they were advised to exit the call at any time if they felt uncomfortable which would be easy with just a click. By removing the need for physical presence, the study effectively eliminated travel costs and other inconveniences, making it more accessible and accommodating to a broader spectrum of potential participants. Online data collection also serves as a testament to the adaptability of research methodologies in the face of unforeseen challenges, showing the capacity of innovative solutions to maintain the rigor and scope of qualitative research in ever-evolving times (Carter et al., 2021).

Researcher's positionality

My positionality as an African migrant and as a researcher meant that there was a unique way in how participants related to me. In some ways, I was an 'outsider', but in many ways, I was an 'insider', which presented different benefits and challenges (see section 4.5.2 for detailed discussion). My outsider position was based on the fact that I was a university-based researcher, which has an influence on the power dynamic during data collection and perceptions of education status and power. This dynamic could have shaped the way participants related to me, prompting a nuanced interplay between my roles as an outsider and an insider. As an outsider, I had certain attributes that set me apart from some of the participants, such as my educational background, nationality, gender and age. This "outsider" status could have made some participants wary and concerned about potential biases or a lack of genuine understanding of their lived experiences. It was crucial for me to acknowledge and address these concerns and to establish a rapport prior to data collection to build on trust and mutual respect. However, in many ways, I was an insider based on my shared identity as an African migrant, gender and age which connected me to the participants on a deeply personal level. This commonality

fostered a sense of trust and empathy, which was achieved through conversations before the interview and adopting a conversational approach during the interview. Participants often perceived me as someone who could grasp the intricacies of their experiences, whether related to migration, cultural adaptation, or the challenges they faced within Scotland. This insider perspective facilitated a level of comfort and openness during interviews, as participants felt confident that they were sharing their stories with someone who could truly relate and empathize.

Focus groups also allowed some constructive discussions on how people could receive support, and it highlighted the need for more social cohesion, especially for newly arrived migrants. This perspective created a safe space for candid discussions and allowed for the collection of rich, authentic narratives that might have been less forthcoming in the presence of an entirely external researcher. Moreover, the fact that I shared a cultural and experiential background with the participants was seen as an asset. It contributed to a deeper level of rapport and facilitated more meaningful connections, enhancing the quality of the data gathered. Many participants expressed their appreciation for the research, recognizing its value in shedding light on important issues within African communities and the opportunity to share their experiences.

This unique positionality also carried historical and socio-political significance. It contrasted the conventional research dynamic where minority groups are often studied by researchers who do not share their background or experiences especially in migration studies. For example, in cases with African migrants where the researcher's identity is of a white, middle-class individual, the historical colonial remnants and potential power imbalances may affect the rapport and comfort of the participant. My position as both a Black African migrant and a researcher disrupted this standard, enabling a more equitable and authentic exchange of perspectives. In essence, my multifaceted position deepened the research process and outcomes, showing the significance of conducting research within minority communities with researchers who share their backgrounds. This offered a more authentic and inclusive approach to understanding their experiences and addressing their unique challenges.

Moreover, conducting research from this standpoint allows for a nuanced understanding that transcends surface-level observations. By sharing a common background with the participants, I was able to navigate cultural nuances, build trust more easily, and interpret data through a lens that recognizes subtle cultural and historical contexts. This insider perspective is

invaluable in avoiding misinterpretations that often occur when cultural outsiders conduct research. Additionally, it challenges the traditional academic narratives that have historically been shaped by external viewpoints, often perpetuating stereotypes or lacking depth in understanding. By bringing my lived experience as a Black African migrant into the research process, I could offer a voice that resonates with the community, thereby promoting a sense of ownership and empowerment among participants. This not only enriched the data collected but also helped in advocating for research practices that are more inclusive and reflective of the communities being studied.

7.3 Contribution to theoretical understandings and applications of CRT in mental health research

This research has examined how engagement with mental health support is rooted in complex cultural, social and structural conditions that can either create conducive spaces or serve as barriers to African migrants' access to support. The analysis drew on the tenets of Critical Race Theory to understand the role of race in these conditions (as seen in Chapters 5 and 6). In understanding the role of race, the intersecting layers of its implications show how the journey of migration for most of the participants starts as a hope for security but opens vulnerabilities to poor mental health. In identifying this gap in the literature, my thesis contributes the knowledge that employs CRT to understand the complexities of migration, mental health and help-seeking for African migrants.

This research explains how both overt and covert forms of racism within societal institutions significantly influence mental health outcomes and behaviours among African migrants. Chapter 5 examines the various racist encounters experienced by participants, which I argue are deeply intertwined with prevailing public sentiments towards migrants in the UK. These sentiments are shaped by broader socio-political dynamics and are often exacerbated during periods of national tension or crisis. A pertinent example of this is the recent riots that erupted across England and Ireland following the tragic stabbing of three young girls in July 2024 (Gabon, 2024). Although the fieldwork for this study was completed prior to this incident, the aftermath of these riots highlights enduring issues related to race, migration, and public perception. These events are not anomalies but rather reflect a continuum of historical and contemporary right-wing ideologies that have frequently positioned migrants and Muslims as scapegoats for broader societal challenges. Such ideologies are perpetuated through certain

political narratives and segments of media coverage that employ nationalist and xenophobic rhetoric, further entrenching negative stereotypes and fostering a climate of hostility.

By applying Critical Race Theory (CRT) in this thesis, I shed light on how these racially charged experiences contribute to a ripple effect that profoundly impacts African migrants' ability to adjust and acculturate within the host society. CRT helps to unpack the ways in which racism, both explicit and implicit, creates barriers to integration, reinforcing feelings of exclusion and marginalization. These barriers not only hinder social and economic participation but also have severe repercussions for mental health, as individuals struggle with stress, anxiety, and a diminished sense of belonging. The findings of this research reveal that these experiences of racism are not merely peripheral issues but are central to understanding the mental health trajectories of ethnic minority groups. The impact of such discrimination is far-reaching, affecting help-seeking behaviours and overall psychological well-being.

This thesis also highlights the role of structural racism which has been covered in mental health research in the UK by various authors (Nazroo et al., 2020, Younis, 2021, Ghezae et al., 2022, Kalin, 2021, Qassem et al., 2015). Structural racism, as identified in this study, encompasses the policies, practices, and norms within health and social services that systematically disadvantage African migrants, restricting their access to critical economic, physical, and social resources. These forms of racism are not always overt; they are often subtle yet deeply ingrained within the structures of service provision, influencing both the manner in which support is delivered and the degree to which it is accessible. This can lead to a pervasive distrust of services among African migrants, who may perceive these services as inequitable or unwelcoming.

By employing CRT to examine structural racism, this thesis argues that understanding the ordinariness of racism—the idea that racism is a common, everyday experience for people of colour—is essential for comprehending its impact on mental health outcomes. CRT provides a valuable framework for revealing how structural racism is normalized and perpetuated within institutions, thereby influencing mental health disparities. As Nazroo et al. (2020) have highlighted, the increased risk of psychotic illness among racial and ethnic minorities is closely linked to social and economic disadvantages rooted in both structural and interpersonal racism. They advocate for a research agenda that critically examines how institutions perpetuate racial and ethnic hierarchies, thereby contributing to persistent inequalities. This thesis builds upon these arguments by reinforcing the necessity for a comprehensive research agenda that

explicitly acknowledges the role of structural racism in the mental health field. It is imperative to understand that structural racism is not an incidental factor but a fundamental determinant of health outcomes. This perspective demands a shift in research focus towards understanding the mechanisms through which structural racism operates and its tangible impacts on mental health disparities.

Furthermore, this thesis suggests that future research should prioritize longitudinal studies to explore the long-term effects of structural racism on mental health. It should also consider the intersectionality of various social identities, including race, immigration status, and socioeconomic background, to fully capture the multifaceted nature of these experiences. By doing so, mental health research can move beyond individual-level explanations and address the broader systemic factors that contribute to health inequities. Therefore, it is crucial that mental health research incorporates a nuanced analysis of racial dynamics and their implications. Ignoring these factors risks oversimplifying the complexities of migrants' experiences and undermines efforts to develop effective, culturally sensitive mental health interventions and policies.

7.4 Limitations of the study

There are several limitations that should be recognised in this research. Firstly, the qualitative data collection methods and sampling meant that the findings could not be generalised to all African migrants in Scotland. The participants' accounts and narratives reflect their unique, situated experiences and perspectives during their time in Scotland. However, it is important to acknowledge that the broader UK societal, institutional, and policy contexts significantly influence and shape the lived experiences of these migrants. Factors such as perceived public perceptions on migrants, evolving immigration policies, and shifting political discourse around migration are not confined solely to the boundaries of Scotland but are broader societal dynamics that impact migrants across the UK. Despite this, the findings from this study do reveal post-migratory experiences and challenges that are broadly like those found among African and other migrant communities in England (Mantovani et al., 2017, McCann et al., 2016, Yorke et al., 2016) and other European countries (Grupp et al., 2019).

One key limitation stemmed from the fact that the recruitment of participants for focus group discussions was facilitated through various stakeholders, who were actively engaged with African migrants (see Chapter 3). This recruitment approach was instrumental in reaching the

intended participants, particularly during a global pandemic, and fostering a sense of trust and rapport. However, it also introduced a degree of complexity when contacting participants. I relied on these stakeholders to extend invitations to potential participants and forward informed consent forms and information sheets. This method of recruitment, while practical, had implications for the consistency of communication with the focus group members outside of the stakeholders. This did not disrupt the data collection process, as the primary objective of the focus group discussions was to generate discussions and explore shared experiences and perspectives.

Although the online data collection methods were a strength of this study, there were also some limitations. One limitation pertained to the synergy and engagement of the participants in the focus group discussions. The literature highlights the potential advantages of online data collection, particularly for sensitive topics sensitive to anonymity and comfort (Wettergren et al., 2016). However, a unique challenge exists in fostering group dynamics and genuine interaction when participants are physically distanced from one another and unfamiliar with the other members. The absence of face-to-face contact and non-verbal cues can create a disconnect that may affect the quality of the discussions, as some participants chose to keep their cameras off. Additionally, online data collection introduced the possibility of disruptions during the focus group discussions. Participants might have been in environments with background noises or had other individuals present who could overhear the matters being discussed. These disruptions could potentially hinder the conversation's depth and participants' willingness to share openly. To address this, measures were taken, such as muting participants with background noise and providing gentle reminders to minimise external disturbances. Another important consideration was the need to emphasise confidentiality. Given the virtual nature of the discussions, it was imperative to remind participants of the importance of maintaining the confidentiality of the discussions. Encouraging participants to participate from a private and secure environment was crucial to ensure they felt comfortable sharing personal experiences and sensitive information.

Lastly, this study intended to also collect data from professionals involved in providing mental health support through services to offer an understanding of how perceptions of providers matched or differed to African migrants. However, this phase encountered certain recruitment obstacles influenced by the unique challenges posed by the COVID-19 pandemic. Initial attempts to contact potential participants via email resulted in some delays. This could be

attributed to various factors, including the volume of emails received during the pandemic, which may have caused some messages to go unnoticed. Additionally, mental health providers and services were grappling with increased workloads and competing responsibilities due to the demands imposed by the pandemic, making it difficult for them to commit to research participation. I compensated for this shortcoming by looking at existing provisions through policy documents, guidelines and brochures to map out the context of service provision. Despite these challenges, the recruitment process benefited greatly from the relationships established with key stakeholders within the African migrant communities. These stakeholders, such as community leaders and organisations, were vital in facilitating informal communications and connections with participants. They recognised the importance of this research within the context of African migrant communities and expressed a keen interest in its outcomes.

Looking ahead, I plan to provide a summary of findings to the community leaders and participants in the study. This feedback holds the potential to be mutually beneficial. It demonstrates appreciation for their involvement and serves as a means to share the research findings with those who contributed to its success. Furthermore, this feedback may offer valuable insights and recommendations for future research and initiatives on mental health within African migrant communities.

7.5 Recommendations

7.5.1 Recommendation 1: Make improvements to mental health support services

The findings of this research highlighted that most participants knew about support services available to them; however, they chose not to use many of these services, for various reasons. Analysing participants' narratives and suggestions, it becomes evident that there is a compelling need to enhance existing mental health support services within statutory services. These reasons could include perceived stigma, concerns about confidentiality, lack of trust in the effectiveness of the services, or a mismatch between the services provided and the participants' needs. This highlights a crucial gap between awareness and actual utilization of mental health resources, suggesting that awareness alone is not sufficient to ensure effective use.

To bridge this gap, it is essential to enhance existing mental health support services within statutory services by improving accessibility and reducing stigma for African migrants.

Scotland has national programmes such as ‘See Mee’, ‘Breathing Space’ and ‘Time to Talk’ which are aimed at providing confidential services to encourage people to discuss their mental health and reduce stigma (Scottish Government, 2017). There are also numerous programmes aimed at supporting refugees and asylum seekers with their mental health, however there is a paucity of programmes and services tailored for settled African migrants. Enhancing existing national mental health services to consider the needs of this group is not only important in preventing the deterioration of their mental health, but can also be used to address stigma rooted in cultural beliefs in African communities. This can be achieved through public awareness campaigns that normalize the use of mental health services in African communities and by ensuring services are genuinely accessible and inclusive for all. Building trust is equally important, which can be fostered by tailoring services to better meet individual needs that extend to all facets of their lives. Moreover, implementing evidence-based practices and continuously evaluating service outcomes can help build confidence in these services.

A vital aspect of this recommendation involves the active involvement of African migrants in the leadership and provision of mental health services and this can be achieved through co-production. Relationships with organisations and participants formed during the data collection phase of this study opened the door for conversations around mental health in African communities in Scotland. I argue that this thesis serves as a starting point for reimagining the delivery of mental health services for African migrants, emphasising the need for inclusive, community-driven approaches. Boyle et al. (2010) argue that the principle of co-production is rooted in a transformational approach to service delivery, recognizing that people’s needs are best met when they actively participate in shaping the services they receive. This perspective challenges traditional top-down models of care and instead promotes an inclusive framework where African migrants are not merely passive recipients of mental health support but are actively engaged in decision-making, policy formation, and service delivery. By embedding co-production within mental health services, the significance of representation and lived experiences is foregrounded. Their direct involvement ensures that services are culturally competent, accessible, and responsive to their specific needs. Moreover, co-production fosters trust and engagement within migrant communities, breaking down stigma and encouraging individuals to seek support.

Through the conversations that were sparked with participants in this research, it became evident that many participants felt disconnected from mainstream services, often citing barriers

such as cultural insensitivity, lack of representation, and distrust of institutions. These barriers not only discourage help-seeking behaviour but also contribute to a pervasive sense of invisibility and marginalisation among African communities in Scotland. Community groups, particularly those led by and for African migrants, can play a transformative role in mitigating these challenges. These organisations act as trusted spaces where dialogue about mental health can begin, often in more culturally relevant and less stigmatising ways. They serve as intermediaries between individuals and formal health systems, helping to interpret not only language but also cultural understandings of distress and wellbeing. However, their potential is frequently underutilised due to a lack of sustained institutional support, funding, and genuine partnerships with statutory services. The insights and relationships developed through this research can serve as a valuable foundation for initiating the essential conversations needed to address mental health within African migrant communities.

In conjunction to co-production, the application of a CRT framework would be significant in this context as it emphasizes the importance of representation and the centrality of race and lived experiences in understanding and addressing mental health challenges. African migrants, who may face unique stressors related to migration, racial discrimination, and cultural dislocation, are likely to benefit more from services that are not only culturally sensitive but are also co-created by individuals who share similar backgrounds. Adopting CRT to enhancing services also challenges the often Eurocentric paradigms that dominate mental health services, instead advocating for a model that is more inclusive and reflective of the diverse experiences of African migrants.

7.5.2 Recommendation 2: Incorporate Critical Race Theory to the training of mental health service providers

Enhancing mental health services and ensuring they are racially sensitive will have limited impact unless mental health professionals are adequately trained to deliver these services. The application of Critical Race Theory (CRT) to the training of service providers is essential in this regard. CRT emphasizes the importance of understanding the socio-cultural and historical contexts that shape the experiences of marginalized groups, including African migrants. By integrating CRT principles into the training programs for mental health professionals, these providers can develop a deeper awareness of the specific challenges faced by African migrants, such as systemic racism, cultural displacement, and the intersectionality of their identities. Incorporating CRT into training equips mental health professionals with the tools to recognize

and address the various forms of discrimination and bias that African migrants may encounter within the mental health system. This approach fosters a more culturally competent workforce that is better prepared to engage with and support African migrants in a meaningful and effective manner. Training programs informed by CRT would encourage professionals to critically reflect on their own practices and the broader structural inequalities that may impact their clients' mental health, leading to more responsive and equitable care.

Moreover, by embedding CRT into the professional development of mental health service providers, the training goes beyond mere awareness-raising. It empowers professionals to take actionable steps in their practice to dismantle the barriers that African migrants often face. This could involve developing culturally tailored interventions, advocating for systemic changes within their organizations, and engaging in ongoing learning about the diverse cultural backgrounds of their clients. Ultimately, this approach ensures that the enhancement of services is not just a superficial improvement but a deep, transformative change that genuinely meets the needs of African migrants in a racially sensitive and effective manner.

In their respective studies Tagorda-Kama et al. (2023) and Tsai et al. (2021), explore the practical application of Critical Race Theory (CRT) frameworks in the education of physicians and public health professionals in the United States. They highlight the significant impact that CRT-informed education can have on enhancing cultural competence and empowering healthcare professionals to actively address and challenge health inequities. They emphasize that integrating CRT into health education in the US is crucial for developing a deeper understanding of the structural and systemic factors contributing to disparities in healthcare outcomes, particularly among marginalized racial groups. To my knowledge, there are currently no training programs or educational frameworks in the UK that explicitly incorporate CRT principles. This gap is important given the vital role that CRT can play in revealing the socio-political contexts in which Black people and other racial minorities live and receive healthcare. By failing to integrate CRT into the training of healthcare professionals, the UK risks perpetuating a healthcare system that inadequately addresses the unique challenges faced by Black communities, thereby reinforcing existing health inequities.

In addition, an initiative to advance culturally competent mental health services could involve the appointment of a "Race Relations Champion" within relevant institutions that provide mental health support. This role would be crucial in ensuring that the principles outlined in racial equality guidelines are not merely aspirational but are actively implemented in day-to-

day practice. The Race Relations Champion would be responsible for overseeing that all training provided to professionals is current and aligned with best practices in cultural competence and anti-racism. This position would also entail monitoring the integration of these practices across all levels of service delivery, ensuring consistency and effectiveness.

The establishment of a Race Relations Champion within mental health services would have a profound impact on enhancing the cultural competence of service providers. By having a dedicated individual or team focused on these issues, organizations could more effectively address the systemic barriers that African migrants face in accessing equitable care. This role would not only involve the implementation of ongoing training but also the continuous evaluation and updating of these programs to reflect the evolving needs and challenges of diverse populations. Furthermore, the Race Relations Champion would serve as an advocate for Black people within the organisation, ensuring that their unique needs and perspectives are considered in the development and delivery of mental health services. The Race Relations Champion would play a key role in bridging the gap between policy and practice, ensuring that the commitment to racial equality is reflected in the tangible outcomes experienced by African migrants within the mental health system.

7.5.3 Recommendation 3: Make improvements to mental health policy

This recommendation advocates the embedding of Critical Race Theory (CRT) principles into policies to scrutinise the governance of migrants in Scotland. Central to this proposal is the acknowledgement that policies and guidelines need to go beyond surface-level awareness and actively engage with the intricate nuances of the migrant experience, especially in the context of mental health support. This, according to (Sim et al., 2021) challenges the liberal policies that reinforce colour blindness and does not highlight the difficulties faced by minority groups. By embedding CRT into policy frameworks, it becomes possible to move beyond mere acknowledgment of diversity and towards a deeper engagement with the complex realities faced by migrant communities. CRT provides a lens through which policymakers can critically examine how systemic inequities and racial dynamics shape the lived experiences of migrants. This approach challenges the often superficial understanding of diversity, pushing for policies that are not only aware of but are actively responsive to the specific needs and challenges of migrants, particularly in the realm of mental health.

Integrating CRT into policy frameworks allows for a more nuanced analysis of the intersectional factors that affect migrant communities. This includes understanding how race,

immigration status, socio-economic background, and other social determinants of health intersect to create unique barriers to accessing mental health support. For example, policies informed by CRT would critically assess how racial discrimination, cultural biases, and institutional barriers contribute to the marginalization of migrant groups within mental health services. By acknowledging and addressing these intersectional factors, policies can be developed that are more comprehensive and inclusive, ensuring that mental health support is tailored to the specific needs of migrant communities.

Ultimately, applying CRT to the governance of migrants in Scotland fosters a more equitable approach to policymaking, one that is attuned to the diverse and often underrepresented experiences of migrants. This framework can help dismantle systemic barriers that impede access to mental health services, ensuring that these services are more accessible, culturally sensitive, and effective. By recognizing and addressing the nuanced realities of migrant life, especially concerning mental health, policymakers can develop strategies that truly reflect the diverse needs of Scotland's migrant population, promoting a more inclusive and just society.

7.5.4 Recommendation 3: Develop and promote African migrant-led support for newly arrived individuals

The perspectives shared by participants in this study illuminate a widespread sentiment within the African migrant community: a perceived lack of effort in creating an inclusive and supportive environment for economic migrants and international students. Participants detailed the challenges and barriers they encountered as newly arrived individuals in a foreign country, particularly in educational or employment contexts. A recurring theme in their narratives was the difficulty of adjusting to a new society and unfamiliar healthcare systems. Despite the existence of institutional programs, such as university induction programs and support services for international students, many participants felt these initiatives fell short of addressing the complex realities they faced. The gap between the intended institutional support and its real-world application left many feeling unsupported, leading to a sense of isolation and a belief that they were navigating the transition largely on their own.

Participants expressed a desire for more tailored and comprehensive support mechanisms, particularly for newly arrived migrants. They emphasised the importance of initiatives led by African migrants themselves, which could provide practical guidance, knowledge, and tools to facilitate a smoother adjustment into their new lives, whether in the realm of education or employment. These African migrant-led initiatives would serve as a bridge between the

aspirations of these newcomers and the resources available to them. They could offer insights into the intricacies of the local culture, societal norms, and the practicalities of navigating the education or job landscape. Such initiatives have the potential to fill the existing gaps in support by providing first-hand knowledge and experiences from individuals who have undergone similar transitions. Moreover, these initiatives could foster a sense of community and belonging among newly arrived migrants. The shared understanding of the challenges and achievements of the migration journey can create a network of support, ensuring that individuals do not feel isolated or adrift during this phase of their lives.

Some participants were either current students or had arrived in the UK as students, which adds another layer to their experiences as newly arrived migrants. This student status often intersected with other challenges, such as financial precarity, housing insecurity, and the pressures of academic performance, all of which can heighten vulnerability to poor mental health. Navigating university systems, often without adequate institutional support or cultural understanding, further compounded feelings of isolation and stress. These experiences underscore the importance of universities as key sites of support and intervention, and point to the need for more tailored, accessible, and culturally sensitive services within educational institutions. Recognising the specific vulnerabilities of migrant students could inform both mental health support strategies and broader integration policies.

An example of such an initiative is the Scottish Refugee Council's Refugee Peer Education program, which focuses on educating refugees and asylum seekers on health services, health, and well-being. Evaluations of this program have shown that peer-led education can produce positive outcomes, both for the peer educators and the participants (Strang, 2015). Expanding similar peer-led initiatives to other migrant groups, could provide effective and culturally sensitive form of support. These initiatives not only offer practical advice and resources but also foster a sense of community and belonging among migrants. By connecting individuals through shared experiences, peer-led programs help to mitigate feelings of isolation which was cited as an important need by participants.

7.5.5 Recommendation 4: Implement effective measures to address the multilevel racism migrants face

The theoretical contributions made within this thesis emphasise the importance of critically examining the multifaceted layers of racism experienced by African migrants at both the individual and structural levels. This recommendation draws heavily on one of the central

tenets of Critical Race Theory (CRT), namely the critique of colour-blind policies and interventions, as elaborated in Chapter 4. This tenet highlights the need to dissect how migration and institutional policies inadvertently contribute to and perpetuate racial discrimination against Black migrants. The experiences shared by the participants serve as a touching illustration of how their post-migration distress can be predominantly attributed to the daunting challenges encountered within migration processes, as well as difficulties in securing employment and accessing services. As economic migrants and international students, they often find themselves situated in a group that has historically received less attention and consideration compared to other migrant cohorts, such as asylum seekers and refugees.

At the core of the theoretical contributions lies a critical examination of migration policies and practices. African migrants frequently grapple with systemic barriers that hinder their successful integration and participation in their host societies. These barriers encompass a wide spectrum of challenges, including visa and immigration procedures, recognition of foreign qualifications, access to suitable employment opportunities, and deskilling. This is also true in health systems where policies encourage inclusive and accessible mental health support but this is often not translated to practice for ethnic minority groups. These policies may be designed with seemingly colour-blind intentions, their lack of acknowledgment of the unique challenges faced by Black migrants is the problem. Consequently, they inadvertently perpetuate disparities and inequalities along racial lines. The experiences of the participants underline the pressing necessity for more inclusive and equitable policies that acknowledge the distinct racialised experiences and hurdles encountered by African migrants. This thesis contributes to the larger discourse by advocating for a shift in perspective, one that acknowledges the structural racism embedded in migration and health policies and institutions.

To put this recommendation into practice, the first step is to ensure that anti-racist policies are not just surface-level commitments, but are deeply embedded within the structures and practices of organisations and institutions. This requires a multifaceted approach that includes leadership accountability, workforce training, evidence-driven interventions, and sustained community engagement. A key example of this is the NHS Race & Health Observatory, launched in 2020, which aims to provide evidence-based recommendations to improve health outcomes for ethnic minority communities and reduce disparities in access to healthcare, treatment, and outcomes. It advocates for anti-racist policies within the NHS and calls for

systemic changes to address the healthcare inequalities experienced by ethnic minorities (National Health Service, 2020).

One of the first steps toward implementing anti-racist policies is to ensure that leadership within organisations and health institutions is fully committed to these changes. This requires not only declarations of support but also measurable actions to ensure progress. Leaders should be held accountable for making anti-racist policy implementation a priority. Organisations can also appoint anti-racism champions at senior levels, whose role is to oversee the implementation of these policies, monitor progress, and hold the organisation accountable for addressing racism. To ensure that anti-racist policies have real and lasting impact, organisations must engage in continuous monitoring and evaluation of their efforts. This requires transparency about goals, progress, and setbacks. Institutions should set clear, measurable targets to reduce racial inequalities and publish regular reports on their achievements or areas needing improvement.

Implementing anti-racist policies also requires a long-term commitment to systemic change, rather than one-off initiatives. This means ensuring that once anti-racist policies are implemented, they are sustained over time through policy refinement and ongoing funding. Anti-racist initiatives should be institutionalised within the organisation's core functions, ensuring they remain a priority regardless of changes in leadership or external pressures. This can be done by embedding these policies into organisational frameworks, creating dedicated teams or departments to oversee anti-racist work, and ensuring consistent budget allocations to support anti-racism programs.

7.5.6 Recommendations for future research

The findings in this thesis point to several recommendations for future research on mental health in migration contexts. This could include studies that:

- Explore healthcare providers' perspectives on the barriers and enablers of help-seeking for mental health issues for African migrants. This study explored African migrants' perspectives, while future research could seek to find similarities and differences in the perceived factors influencing help-seeking in this group. Due to time constraints, this research was unable to make such comparisons. However, this could provide a more comprehensive understanding of this topic. By comparing the findings, interventions could be better tailored to address barriers.

- Research the role of third-sector organisations in providing mental health support. This research exposed me to numerous voluntary organisations that work with African migrants in various ways. Future research could be focused on coproduction with these migrant-led organisations and groups supporting African communities in Scotland and further highlight issues that these communities face. Furthermore utilising participatory methods could provide valuable collaborative research to address well-informed issues.
- Exploring mental health support within specific African migrant groups, such as children, young people, or students, is essential for understanding their unique perceptions and experiences in the context of migration. Children and young people from African migrant backgrounds face distinct challenges related to dual cultural identities, educational pressures, and family dynamics, all of which can impact their mental health and well-being.
- African migrants' experiences with varying levels of racism underscore the critical need for further research to thoroughly understand the scale and nuances of this issue. While the findings from this study provide a valuable starting point, deeper exploration is essential to capture the diversity of experiences and develop effective solutions. Research should investigate the different forms of racism encountered, including interpersonal discrimination, institutional biases, and structural inequalities, while also examining how these intersect with other identities, such as gender, socio-economic status, and immigration status. This research should inform policy and structural changes to address systemic racism, promote equity, and foster supportive environments for African migrants.
- The methodological limitations identified in this study underscore the importance of exploring alternative research methods, such as participatory approaches, to enhance our understanding of mental health in African communities. This approach is particularly aligned with the aims of CRT, which emphasises the value of storytelling and narrative as a means of advocacy and empowerment. By incorporating participatory methods, researchers can foster a collaborative environment that respects and amplifies the voices of African migrants, ensuring their experiences are accurately represented and understood.

7.6 Concluding remarks

This thesis demonstrated that to improve mental health outcomes for African migrants, there is a need for multifaceted changes at individual, cultural and structural levels. While acknowledging the significance of cultural considerations in understanding mental health behaviours, this thesis shows that a critical approach is imperative to address the challenges faced by African migrants. The findings highlight the need for a strategy aimed at dismantling the various vulnerabilities that contribute to poor mental health outcomes among African migrants. These vulnerabilities include racism, discriminatory policies, negative public attitudes towards migration, stigma, lack of awareness about mental health, and mistrust of healthcare services. To improve mental health outcomes, there is a pressing need for structural changes that address the root causes of these vulnerabilities. This involves advocating for policies that combat racism, discrimination, and xenophobia and promoting inclusivity and diversity within societies. Although fostering inclusivity and diversity is not a novel idea in Scotland, the growing diversity should be reflected in policy and practice.

Public attitudes towards migration and mental health stigma must be actively challenged through targeted awareness campaigns. These campaigns should aim to dispel stereotypes, reduce prejudice, and foster empathy and understanding. Furthermore, healthcare services should be culturally competent, and this involves training healthcare professionals to provide culturally sensitive care and be aware of their own inherent biases. Cultural competency should go beyond being a tick-box exercise; it should use lived experiences to guide training and involve African communities in discussions surrounding what matters most to them. This would require building strong support networks within African migrant communities and designing culturally appropriate services that are co-produced with communities. These networks can serve as a source of social cohesion, solidarity, and mutual assistance for improving policy and practice.

Findings from this thesis suggest that promoting mental health awareness and education within African migrant communities is vital in reducing stigma and improving the understanding of mental health issues. Furthermore, recognising that individuals hold multiple intersecting identities, such as race, gender, and social class, is crucial for a more nuanced understanding of how these identities interact and impact mental health experiences.

In conclusion, this thesis emphasises that improving mental health outcomes for African migrants necessitates a comprehensive and multi-layered approach. It calls for a critical examination of the interconnected challenges faced by this population and advocates for systemic changes that address cultural and structural factors. By dismantling the multiple vulnerabilities that contribute to poor mental health outcomes, society can create a more inclusive and supportive environment for African migrants in their mental health journey.

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Appendices

Appendix A. Participant information sheets and consent form

Participant Information Sheet for Focus group

Name of department: School of Social Work and Social Policy
Title of the study: African migrants and mental health support in Scotland: an exploratory study

Introduction

Hello, my name is Sne Zondo and I am a student at the University of Strathclyde. I am grateful that you have expressed interest in my research project. I would like to tell you about my research before you decide whether you would like to take part or not. You are welcome to ask further information outside what is provided in this information sheet.

What is the purpose of this research?

African migrants are amongst the fastest growing minority groups in the country. They are also the least likely to voluntarily seek mental health support through statutory services. Although there have been studies on the mental health of Black and minority ethnic groups in the UK, there have been no recent research focusing exclusively on African migrants in Scotland. The aim of this study is to understand the factors affecting mental healthcare engagement amongst African migrants living in Scotland. I would like to understand African migrants' beliefs and understandings of mental health and healthcare. I would also like to understand what influences help-seeking for African migrants experiencing ill mental health. Lastly, I would like to explore possible solutions for the improvement of mental healthcare engagement.

Do you have to take part?

If you do not want to take part, you do not have to. If you decide to take part now, but change your mind later, you can stop whenever you want without any consequence to you. You are free to withdraw up to the point of data processing and become excluded from the study. Information collected will be used up till the point of your withdrawal. Your decision to take part or not in this study will not in any way affect the health-related services you receive.

What will you do in the project?

You will be asked to participate in an online focus group discussion with your peers (other

African migrants) and myself. The discussion should last roughly an hour, and video and audio will be recorded. You can opt to switch your camera off and use an agreed upon alias (fake name) if you would like to remain anonymous. I will use a guide to inform the questions that I will ask, to direct the discussion session. However, most questions I will ask will depend on what information you provide concerning mental health, support and experiences of African migrants living in Scotland.

Why have you been invited to take part?

You have been invited to take part in this study as you are identified as part of the African migrant community in the Scotland. Other people will be recruited to discuss their perception of mental health and healthcare engagement. There will be other African migrants in this project that will be interviewed individually.

What are the potential risks to you in taking part?

There are no risks to taking part in the project. If you are worried or concerned about anything at any stage, please contact me or my supervisor (see below for contact details).

What are the possible benefits/advantages?

I hope that you will find the interview interesting and will take satisfaction from helping to develop a greater understanding of African migrants' perceptions and experiences in relation to mental health in Scotland. I also hope that you will find the results interesting and helpful to provide deeper understanding for African migrants living in Scotland. The results of the study can be made available to you as a report, upon request, when the research is completed.

What information is being collected in the project?

Questions concerning mental health, healthcare and your experience as an African migrant living in Scotland will be asked. A full copy of the questions that are going to be asked in the interview will be available for you to read through at your request. Any questions you are not comfortable answering can be omitted from the interview.

Who will have access to the information?

The video and audio recording made during the online interviews will be converted into a word document and used to gain a better understanding of the African migrants' engagement with mental healthcare in Scotland. The findings will be presented in my PhD document, in conferences, seminars and academic journals for publication. All the information will be anonymised, so no one knows your name, where you live or where you access your health

services. All the information will be securely stored at my university. None of the information you tell me will be passed on to anyone else unless you tell me you or someone else are in danger. If this happens, I will need to contact the appropriate services, but I will discuss this with you first.

The University of Strathclyde is committed to comply with the principles of the European General Data Protection Regulation (GDPR) and the UK Data Protection Act (2018). All personal data will be dealt with in accordance to the data protection policy. (for further information see https://www.strath.ac.uk/whystrathclyde/universitygovernance/accesstoinformation/dataprotection/)

What happens next?

If you agree to take part, you will sign a consent form. A date and time will be arranged for the discussion. If you do not want to take part in the project, you can contact me or my supervisors and the interview will be cancelled at no consequence.

Researcher contact details:

If you have any questions or concerns during any stage of the research, please do not hesitate to contact:

Sne Zondo (Researcher)	Neil Quinn (Sne's supervisor)
School of Social Work and Social Policy	School of Social Work and Social Policy
Lord Hope Building, Level 6	Lord Hope Building, Level 6
16 Richmond Street	16 Richmond Street
Glasgow	Glasgow
G1 1XQ	G1 1XQ
Email: sinenhlanhla.zondo@strath.ac.uk	Email: neil.quinn@strath.ac.uk
	Phone number: 0141448652

This investigation was granted ethical approval by the University of Strathclyde Social Work and Social Policy ethics committee. I am a registered member of the protecting vulnerable groups (PVG) scheme.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to ask further questions or obtain further information, please contact:

Social Work & Social Policy ethics committee

hass-swsp-ethics@strath.ac.uk

School of Social Work & Social Policy

University of Strathclyde

Participant Information Sheet for inteviews

Name of department: School of Social Work and Social Policy

Title of the study: African migrants and mental health support in Scotland: an exploratory study

Introduction

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Information collected will be used up till the point of your withdrawal. Your decision to take part or not in this study will not in any way affect the health-related services you receive.

What will you do in the project?

You will be asked to participate in an online interview with me. The interview should last roughly an hour, and video and audio will be recorded. You can opt to switch your camera off if you would prefer to do so, however audio needs to be recorded for me to ensure I capture everything. I will use an interview guide to inform the questions that I will ask, to direct the discussion session. However, most questions I will ask will depend on what information you provide concerning mental health, healthcare and your experience as an African migrant living in Scotland. The interview will be arranged at a time and location suitable for you.

Why have you been invited to take part?

You have been invited to take part in this study as you are identified as part of the African migrant community in the Scotland. Other people will be recruited to discuss their perception of mental health and healthcare engagement. There will be other African migrants in this project that will be interviewed individually.

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The video and audio recording made during the interviews will be converted into a word document and used to gain a better understanding of the African migrants' engagement with mental healthcare in Scotland. The findings will be presented in my PhD document, in conferences, seminars and academic journals for publication. All the information will be anonymised, so no one knows your name, where you live or where you access your health services. All the information will be securely stored at my university. None of the information you tell me will be passed on to anyone else unless you tell me you or someone else are in danger. If this happens, I will need to contact the appropriate services, but I will discuss this with you first.

The University of Strathclyde is committed to comply with the principles of the European General Data Protection Regulation (GDPR) and the UK Data Protection Act (2018). All personal data will be dealt with in accordance to the data protection policy. (for further information see https://www.strath.ac.uk/whystrathclyde/universitygovernance/accesstoinformation/dataprotection/)

What happens next?

If you agree to take part, you will sign a consent form. A time and location will be arranged for the interview. If you do not want to take part in the project, you can contact me or my supervisors and the interview will be cancelled at no consequence.

Researcher contact details:

If you have any questions or concerns during any stage of the research, please do not hesitate to contact:

Sne Zondo (Researcher)

School of Social Work and Social Policy

Lord Hope Building, Level 6

16 Richmond Street

Glasgow

G1 1XQ

Email: sinenhlanhla.zondo@strath.ac.uk

Neil Quinn (Sne's supervisor)

School of Social Work and Social Policy

Lord Hope Building, Level 6

16 Richmond Street

Glasgow

G1 1XQ

Email: neil.quinn@strath.ac.uk

Phone number: 0141448652

This investigation was granted ethical approval by the University of Strathclyde Social Work and Social Policy ethics committee. I am a registered member of the protecting vulnerable groups (PVG) scheme.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to ask further questions or obtain further information, please contact:

Social Work & Social Policy ethics committee

hass-swsp-ethics@strath.ac.uk

School of Social Work & Social Policy

University of Strathclyde

Consent Form

Participant ID:

Name of department: School of Social Work and Social Policy
Title of the study: African migrants and mental health support in Scotland: an exploratory study

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.
- I consent to being audio recorded as part of the project
- I consent to being video-recorded (optional) **Yes/No**

Please indicate whether or not you agree to the above statements (circle as appropriate):

Yes / No

(PRINT NAME)	
Signature of Participant:	Date:

Appendix B. Demographic questionnaire

Participant name:

Participant ID:

Name of department: School of Social Work and Social Policy
Title of the study: African migrants and mental health support in Scotland: an exploratory study

How old are you?

- 18-29
- 30-39
- 40-49
- 50-59
- 60 and above

What is your gender?

- Woman
- Man
- Transgender woman
- Transgender man
- Other
- Prefer not to specify

What is your highest level of education completed?

- Primary school
- GCSEs, O-levels or equivalent
- A-Levels or equivalent
- University undergraduate programme
- University post-graduate programme
- Doctoral degree
- Other: Please specify _____

Do you practise a religion, and if so, which one?

- None (atheism)
- Christianity
- Hinduism
- Islam
- Other: Please specify _____

Which African country do you originate from?

What best describes your immigration status in the UK?

- British citizen
- Indefinite leave to remain
- Refugee
- Other visa (student, work etc)

Is Scotland the first country you've lived in since leaving your home country? If not, where else have you lived before (excluding your country of birth)?

What best describes your employment status?

- Unemployed
- Full time student, with part time employment
- Full time student, without employment
- Part time student, with employment
- Part time student, without employment
- Self-employed part-time
- Self-employed full-time
- Part-time employment within organisation/company
- Full-time employment within organisation/company
- Other: please specify_____

Which of the following best describes your living situation:

- I am a homeowner and I live in my property

- ☐ I pay rent to live in my current home

Other: Please specify_____

How many people do you live with in your household?

- ☐ _____ adults (above 18 years of age)
- ☐ _____ children

What is your household income?

- ☐ Under £5,000 a year
- ☐ £5,000 - £10,000 a year
- ☐ £10,000 - £20,000 a year
- ☐ £20,000 - £30, 000 a year
- ☐ £30,000 + a year

Appendix C. Focus group and interview guides

In-depth interview guide

1. Introduction

Hello, my name is Sne Zondo and I am a PhD student at the University of Strathclyde. Thank you once again for agreeing to participate in my research. The aim of this research is to increase our understanding of mental health support that is used by African migrants living in Scotland. Furthermore, I would like to speak to you about your experiences as an African migrant in this country which is why you are here with me today. Our interview will not run longer than an hour. As mentioned before in the consent form that you have already signed, this interview will be video and voice recorded to assist me in capturing everything. However, real names will be anonymized, and personal information will not be used. Your confidentiality will be maintained by myself unless you express that you pose a risk to yourself or someone else. In that instance, I am liable to notify someone. If you would like to stop the interview at any point in time, feel free to do so, there will be no consequences to that decision. Do you have any questions before we begin?

2. General warm up discussion

- Tell me about yourself and your experience as an African migrant living in Scotland

3. General perceptions on immigration

Theme: The role of immigration in mental health behaviours and experiences

- Tell me about your perception on the public attitudes towards African migrants in Scotland/UK?
    - Prompt for:

  Opinions on the media narratives of African migrants
  Perception and/or experience of racism and/or xenophobia
  Opinions on Brexit and/or Windrush scandal
  The impact these attitudes have on migrants' wellbeing
- What do you think about the political environment in the country towards migrants, especially Black African migrants?
- What impact do you think being a migrant has on one's wellbeing, if any?

4. General thoughts on mental health

Theme: Attitudes, knowledge, and beliefs on mental health amongst the Black African migrant communities

- Tell me a bit about what the words 'mental health' means to you?
    - Prompt for:

    Beliefs about mental health

    Perceptions about healthy or ill mental health
- Tell me about any experience or story that you know of an African migrant with ill mental health in Scotland.
- Tell me about your experience during the Covid-19 pandemic
- How has the lockdown affected you?
    - Financially
    - Relationships (probe on family, friendship and community life)
    - Physical health (underlying conditions, exposure to the virus)
    - Mental health (isolation, anxiety)

5. General thoughts on mental healthcare, support and treatment

Theme: Mental health self-management and help-seeking

- In your opinion, how do you think mental health is best managed?
    - Prompt for:

    Perceptions on prevention, intervention and help-seeking
- Have you or anyone you know received support for their mental health in Scotland?
    - If yes, please tell me more
    - If no, how would you access support, if you needed to?
        - Prompt for:

    Healthcare service use, community, family or faith-based support etc.
- How has the pandemic affected the support you use or would have used regularly?

Theme: Perceptions of health professionals' relationship with African migrants with mental ill health in Scotland

- What is your perception of services to help people with mental health problems in Scotland?
    - Prompt for:

    Past experiences with healthcare

Preferences when it comes to health-related support

Theme: Perceived challenges to accessing mental healthcare services to African migrants

- What challenges or barriers do you think African migrants have on access to mental healthcare services in Scotland?
- One of the biggest barriers to help-seeking for mental health problems is stigma. Stigmatization of mental health is when someone is negatively labelled because of their mental health problem. Which often leads to negative actions or discrimination towards them.

  What are some of the stigmatizing attitudes that you have heard about people with mental health problems?
- Thinking about your culture and how mental health was spoken about, do you see any similarities or differences with the culture in Scotland
    - Prompt for:

  Perceptions before and after migration

  Any barriers to help-seeking as a result of culture

6. Thoughts on future initiatives

Theme: Interventions and solutions to improve mental health/care for African migrants

- What suggestions would you give to overcome some of the barriers to mental health support we spoke about?
    - Prompt for:

  Health service needs

  Language/interpretation

  Social support

  Practical support

7. Debriefing

If you think of anything else you'd like to ask or say, you can contact me on the details in the information sheet. Thank you for your time.

Focus group discussion guide

1. Introduction

Hello everyone, my name is Sne Zondo and I am a PhD student at the University of Strathclyde. Thank you all once again for agreeing to participate in my research. The aims of this research are to increase our understanding of mental health support that is used by African migrants living in Scotland. Furthermore, I would like to spark conversation about the different experiences as an African migrant in this country which is why you're all here today. Our discussion will not run longer than an hour. As mentioned before in the consent form that you have already signed, this interview will be voice recorded to assist me in capturing everything. However, real names or personal information will not be used. Your confidentiality will be maintained by myself unless you express that you pose a risk to yourself or someone else. In that instance, I am liable to notify someone. Although your confidentiality will be maintained by myself and my supervisors, we cannot guarantee that other participants will always do the same. Therefore, I alert you to be mindful of the information you share and I also urge all participants to respect each other and keep the discussion confidential. If any one of you would like to stop the discussion and leave the room at any point in time, feel free to do so, there will be no consequences to that decision. Do you have any questions before we begin?

There are just a few ground rules before getting into the discussion:

- May we please ensure that we have only one speaker at a time so that everyone gets a chance to express themselves undisrupted.
- There are no right or wrong responses so may we all please respect each other's opinions.
- Lastly, as mentioned earlier, my confidentiality is guaranteed however I cannot ensure that all participants maintain their confidentiality. I would like to ask everyone in this group to maintain privacy and not discuss anything said in this group with someone else

2. General thoughts on the life of African migrants in Scotland: group activity

For this activity, the participants will be split into groups or pairs (depending on the number of participants). In the case of an online focus group, participants will be split into breakaway rooms.

Each group will be asked to discuss and write down their thoughts on the following questions:

- What is the first thing that comes to mind when you think about African migrants in Scotland?

  Prompt groups to share thoughts on the life of African migrants in Scotland and note these down.
- What are some of the challenges faced by old and new migrants in Scotland?

  Prompt group to discuss pre & post migration life (i.e. community, relationships, friendships, adjusting to new country)
- What are some of the differences to life in your home country and life in Scotland?
    - What have been some of the ways you've learned to adjust better?

After 10-15 minutes of discussion, the groups will be asked to summarise their answers and they will be recorded.

3. General perceptions on mental health

- What comes to mind when you hear the term mental health?
    - How has that changed (or not) before and after arriving in Scotland?
- Do you think Black and Minority Ethnic Groups groups are more likely to present with mental health issues more than the rest of the population in the UK?

  I will ask participants to vote in agreement or disagreement to the question. In the case of online focus group discussions, I will use the polling function for participants to select yes or no.
    - Ask participants to elaborate on their answers
- Tell me about the attitudes towards mental health in your home country/place of origin
    - Prompt for discussion on beliefs, stigma in self, community, work, family etc.
- Are the attitudes towards mental health similar or different amongst African migrants living in Scotland?
- In your opinion, how would you describe mental health amongst African migrants in Scotland?
    - Prompt for discussion on risk factors such as SDOMH (culture and societal adjustment, employment & income, living conditions, experiences with services)

4. General thoughts on mental healthcare, support and treatment

- What kind of support is available for African migrants and mental health in your community?

  Ask participants to get into groups or pairs again and give them a list of sources of support for mental health and ask them to rank them from the one they would most likely use to the least likely

  (Online groups will be put into breakaway rooms and given a padlet link to rank the types of support)

Types of support
Hospital or emergency services
Local GP or nurse
Faith-based leader (church leader)
Community/Group leader
Family
Friends
Online support

- Ask participants to discuss their decisions to rank their preferred support the way they did
  - Prompt for discussion on what influences help-seeking behaviours

5. Closing

- Are there any additional remarks that anyone might want to add?
- *Briefly outline the other on-going data collection activities (individual interviews with African migrants and mental health professionals).*

  As mentioned before, I will be conducting individual interviews with African migrants and if there are any volunteers please leave your name and preferred contact details

with me or contact me or my supervisors using the details provided on the information leaflet.

Lastly if you have any follow up questions that you would like to ask, please do not hesitate to use the contact information provided.

Thank you for your time.

Appendix D: Information leaflet and social media advert

Let's talk about mental health support

What is this leaflet for?

This leaflet gives you some information about a project that I am doing in Scotland. I would like to talk with African migrants in the country about how they access mental health support. I would also like to talk to them about their experiences as an African migrant living in Scotland. **If you are a settled African migrant living in any parts of Scotland and would like to share your opinions and experiences, I would love to talk to you.**

What is this project about?

The project is about migrants of African origin from all parts of Scotland and what they think about their experience in a different environment, their opinions on mental health and how they access mental health support in their communities. I am looking for individuals above 18 years of age, with settled migrant status, living in Scotland for any period time.

Why participate?

You might want to participate in the project because:

- It is a chance to say what you think;
- I will listen to what you have to say;
- You will help us know more about the issues African migrants face in Scotland
- You will contribute to the literature and information about African migrants in Scotland

What will I have to do?

I would like to organise a group discussion with African migrants from your organisation or community. In these groups, we will talk about African migrants' experiences in Scotland and how they access mental health support services here. **You will only have to contribute if you want to, and you can stop at any time**. Thereafter I will be looking for volunteers for individual interviews, where we will talk in depth about personal perceptions and experiences.

How can I be one of the participants?

You will need to let me know that you want to take part by contacting me on any one of the contact details below. Afterwards, you will have to complete a form called the Consent Form to confirm that you understand what the study is

about and what our interview will be used for. We will then schedule a time and date for the group discussions and individual interviews if you choose to take part. Remember this is completely voluntary, and you can withdraw at any point!

Will you record what I say?

We would like to voice record what everyone says, so we can remember everything later on. When we write down what people have said later on, we will not use real names.

Who will be told what I say?

We will write a report on the project later on, but we will not use real names of places or people. This means that no one except the researchers will know your name. No official person will be told about what you said, unless you tell us you or someone else is at risk of harm.

Can I change my mind?

Of course. You can change your mind at any time, you can leave the project or not answer any of the questions. It's entirely up to you!

I have a few questions, who can I talk to?

I would be pleased to talk to you about the project or any other questions you might have before you sign up.

Email us:
Sne Zondo Sinenhlanhla.zondo@strath.ac.uk
Neil Quinn neil.quinn@strath.ac.uk
Daniela Sime Daniela.sime@strath.ac.uk

University of Strathclyde Glasgow

Follow us:

Allaboutafricanmentalhealth

allaboutafricanmentalhealth

Let's talk about mental health support

I am conducting a research study that will look at how migrants of African origin living in Scotland access mental health support in their communities.

WHO IS ELIGIBLE?

People 18 years old and above. Individuals with settled status in the UK born in any African country. You have to be living in Scotland.

WHAT WILL I HAVE TO DO IF I AGREE?

You can choose to volunteer to participate in a group discussion, an individual interview or both. we will talk about African migrants' experiences in Scotland and how they access mental health support services. **You will only have to contribute if you want to, and you can change your mind at any time!**

INTERESTED?

Please contact Sne Zondo at Sinenhlanhla.zondo@strath.ac.uk

Or follow us on Twitter, Facebook or Instagram and send me a direct message on **AfricanmentalhealthSC**

University of Strathclyde Glasgow

Appendix E: Ethics approval

SCHOOL OF SOCIAL WORK & SOCIAL POLICY

University of Strathclyde
Humanities & Social Sciences

African migrants and mental health support in Scotland: an exploratory study

7 September 2021

To whom it may concern,

I am pleased to confirm that the research project *African migrants and mental health support in Scotland: an exploratory study*, led by Sne Zondo and Neil Quinn, has been given ethical approval by the University of Strathclyde School of Social Work and Social Policy School Ethics Committee (SWSP SEC).

Please do not hesistate to contact me if you require any further information.

With best wishes,

Dr Dan Heap
Chair, SWSP SEC

dan.heap@strath.ac.uk

Appendix F: Overview of themes and sub-themes

Global theme	Organising theme	Subtheme
Adjustments and migration experiences	Pre-migration	Financial issues Study and work opportunities
	Post-migration	Financial stability Quality of life Studies International fees Work opportunities Settling in other countries before Scotland Culture shock Language adjustment (accent) Weather Lack of guidance/induction for new arrivals Lack of diversity
	Resilience	Adjustment difficulties Attempting to blend in Isolation Being misunderstood by society Work difficulties African perspective of resilience Not being able to share experiences with family at home
Racism	Overt racism	Physical attacks Name calling Verbal attacks Scottish people friendlier than other countries
	Covert racism	Microaggressions when accessing services Racial profiling in shops GP registration difficulties Stereotypes
	The role of media and politics	Language and imagery used when talking about African migrants Right-wing political agendas on immigration Scotland more welcoming

		Media highlighting racism when famous people are involved Media exposing racism but not criticizing racist system Strict immigration laws
Attitudes and beliefs about mental health	Common issues experienced by African migrants	Anxiety for the future Depression Post migratory stress Isolation Post natal depression
	Stigmatizing language in mental health	Cultural stigma Stigma from family and friends Labelling of mental health issues with stigmatizing language Weakness/failure Madness Prolongs delays in help-seeking Pessimism in future Men cannot be vulnerable Women as caregivers
Experiences with ill mental health	Stress as a normal life event	Disregarding stress as something that impacts mental health Stress being caused by post migratory life
	Experiencing friends with mental health problems	
	Covid-19 and mental health	Isolation Mental health worsening during lockdown Online meetings with friends and family Disruption to normal life Parenting during lockdown as a single mother Dealing with loss whilst being far from home Using alcohol as a coping mechanism
Experiences with the UK healthcare system	Help-seeking behaviours	Negative past experiences with healthcare Racial microaggressions Mistrust of services

		Not enough knowledge on services Informal support (church, friends and family) Stigma Fear of outcome, medication Mental health is an individual problem
	Experiences with medicalising mental health issues in healthcare	Fear Mistrust Medication as a tool for control by government Fear of being dependent on medication Therapy not available directly
	Positive experiences	Holistic treatment for anxiety
A way forward for mental health in African communities	Diversity in people in power More support for newly arrived migrants Less harsh conditions for people looking for work opportunities	