Barriers to Mental Health Service Access and Utilisation: A Case of Black sub-Saharan Africans in the West Midlands of England, UK.

LAST MAFUBA

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Dedicated to all individuals of Black heritage around the world who are discriminated against, because of the colour of their skin. Power to you!

Acknowledgements

I would like to express my gratitude to the brave men and women who trusted me with their stories, and to members of the Inini peer support group whose tenacity and fortitude motivated me to conduct and complete this work.

I am also grateful to my late parents for their strong belief in the value of education and for instilling in me the understanding that education is power. I feel a deep sadness that they are not here to witness this milestone. Their example in leading and supporting communities that organise and heal themselves was instrumental in my establishment of the Inini peer support group. To my children, Patience Tafadzwa Pazvakavambwa and John Chikondi Mpaso, my grandchildren, Malachi Tatendataona Pazvakavambwa and Alaia Aria Pazvakavambwa, thank you for your patience and understanding while I focused on my studies; to the rest of my family and friends, thank you for always showing pride in my work. Your unwavering support and belief in me have been a constant source of motivation, pushing me to work harder and strive for excellence. Moses Muchaziwepi Mwanjirah, thank you for clapping the loudest.

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Abstract

Mental health problems have been identified as the leading cause of disease burden worldwide. In high-income countries, they are more common among global majority populations and in the UK, individuals of Black heritage are over-represented in their experiences as well as not accessing mental health services. Sub-Saharan Africans are the worst affected. This study aimed to understand the factors that influenced their decisions to seek help for poor mental health. The qualitative study was guided by The Silences Framework (TSF) and Critical Race Theory (CRT). It drew upon the Interpretative Phenomenological Analysis (IPA) methodology to engage with the lived experiences of 21 Black sub-Saharan African individuals, n=13 males and n=8 females, aged 23 – 60 years old, from diverse backgrounds. Semi-structured interviews were used to collect data and transcribe verbatim. IPA was used to analyse and interpret the data collated. In addition, CRT was employed to critically analyse the findings, examining how race and racism influenced their decisions to seek help for poor mental health. The findings revealed a complex landscape of barriers deeply rooted in historical, cultural, social, economic, and political contexts. Two significant superordinate themes: Struggle and Oppression and Medical Colonialism were revealed. Struggle and Oppression outlined the experiences of participants while navigating their social terrain and highlighted how these negatively influenced their decisions to seek help for poor mental health. Medical Colonialism outlined the experiences of participants while navigating mental health services. The application of CRT to the findings highlighted systemic biases rooted in historical legacies of colonialism and Eurocentrism which are perpetuated through policies and legal frameworks. This is the first time TSF and CRT were combined to investigate barriers to accessing mental health services among Black sub-Saharan Africans in the UK. In conclusion, the study showed that systemic racism ingrained in policies and legal frameworks, as well as dominant cultural narratives shaped by racial hierarchies, negatively influenced their decisions to seek help for poor mental health, calling for the inclusion of their voices in the development of mental health services.

Table of Contents

ACKNOWLEDGEMENTS **3**

ABSTRACT **4**

LIST OF TABLES AND FIGURES **8**

GLOSSARY OF TERMS **9**

CHAPTER 1 – INTRODUCTION **10**

1.1 Introduction 10
1.2 Definition of terms 11
1.2.1 Mental Health Problems and Mental Ill Health 11
1.2.2 Mental Health Services 13
1.2.3 Sub-Saharan Africa 14
1.2.4 Black sub-Saharan African 15
1.2.5 Global Majority Communities/Populations 15
1.2.6 Race 15
1.2.7 Racism 16
1.2.8 White Supremacy 16
1.2.9 Power 17
1.2.10 Colonialism 18
1.2.11 Medical Colonialism 19
1.3 Study Background 19
1.4 Researcher’s Position and Interest 36
1.5 Research Significance and Research Question 38
1.6 Theoretical Framework 39
1.6.1 The ‘Screaming Silences’ Concept 41
1.6.2 The Silences Framework 42
1.6.3 The Critical Race Theory 44
1.7 Structure of Thesis 47
1.8 Conclusion 48

CHAPTER 2: LITERATURE REVIEW **50**

2.1 Introduction 50
2.2 Search Strategy 51
2.3 Historical Relationship between England and sub-Saharan Africa – An Overview 51
2.4 The Social Environment Resided by Black sub-Saharan African Communities in England – An Overview 65
2.5 The Mental Health System in England – An Overview 75
2.6 Barriers to Access and Utilisation of Mental Health Services 78
2.8 Identifying a Research Gap 90

CHAPTER 3 - METHODOLOGY **92**

3.1 Introduction 92
3.2 Study Aim and Objectives 93
3.3 Ontological and Epistemological Position 94
3.4 Research Design 94
3.5 Insider/Outsider Perspective 97
3.6 Methodological Perspective 101
3.6.1 Inclusion/Exclusion Criteria 101
3.6.2 Sample 103
3.6.3 Pilot Study 103
3.6.4 Data Collection Instruments - Semi-Structured Interview Question Guide 104
3.6.5 Data Collection 105
3.6.6 Data Analysis 106
3.6.7 Ethical Considerations 108
3.6.8 Participant Well-being 109
3.6.9 Researcher’s Wellbeing 110
3.7 Conclusion 110

CHAPTER 4: FINDINGS 112

4.1 INTRODUCTION 112
4.2 SUPERORDINATE THEME 1 – STRUGGLE AND OPPRESSION 113
  4.2.1 Regularising Immigration Status 113
  4.2.2 Fear of Deportation 119
  4.2.3 Dealing with Unwelcoming Host Communities 121
  4.2.4 Experiences of Racial Discrimination 124
  4.2.5 Loss of Social and Cultural Identity 132
  4.2.6 Social Exclusion and Isolation 134
  4.2.7 Decreased Mental Health Awareness 139
  4.2.8 Lack of Familial and Community Support 143
  4.2.9 Mental Health Stigma 148
  4.2.10 Conclusion 152
4.3 SUPERORDINATE THEME 2: MEDICAL COLONIALISM 153
  4.3.1 Not Being Believed by Mental Health Practitioners 153
  4.3.2 Long Waiting Times 157
  4.3.3 Inadequate Assessment Tools 159
  4.3.4 Drug Treatment 165
  4.3.5 Talking Therapies 170
  4.3.6 Lack of Empathy and Human Touch 174
  4.3.7 Lack of Cultural Competence 177
  4.3.8 Conclusion 183

CHAPTER 5: DISCUSSION 186

5.1 INTRODUCTION 186
5.2 INITIAL RESEARCH AIM AND QUESTIONS 188
5.3 BLACK SUB-SAHARAN AFRICAN COMMUNITIES' LIVED EXPERIENCES OF THE SOCIAL ENVIRONMENT IN ENGLAND APPLIED TO THE CRITICAL RACE THEORY – (CRITIQUING SILENCES HEARD) 188
  5.3.1 Institutional Power and Racialised Structures 189
  5.3.2 Racialised Narratives and Representation 191
  5.3.3 Resistance and Agency (Reshaping Power Dynamics) 194
  5.3.4 Intersectionality and Compounded Inequalities 197
  5.3.5 Conclusion 198
5.4 IMPLICATIONS OF THE RESEARCH FINDINGS ON MENTAL HEALTH SERVICE DELIVERY 199
5.5 RECOMMENDATIONS 200
  5.5.1 Service Users and their Communities 200
  5.5.2 Social Services and Community Support Networks 201
  5.5.3 Mental Health Practitioners 202
  5.5.4 Policymakers 203
  5.5.5 Corporate Leaders 206
  5.5.6 Education and Training Institutions 206
  5.5.7 Legal and Immigration Services 207
  5.5.8 Law Enforcement and Criminal Justice System 208
  5.5.9 Healthcare Regulatory Bodies and Professional Associations 208
5.6 LIMITATIONS OF THE STUDY 208
  5.6.1 Participants Known to the Researcher 209
  5.6.2 Homogenising Black sub-Saharan Africans 209
  5.6.3 Using Participants on Different Immigration Statuses 210
  5.6.5 Theoretical Framework Used 211
  5.6.6 Sample Size too Small for National Policy and Practice Recommendations 212
5.7 OPPORTUNITIES FOR FUTURE RESEARCH 213
5.8 CONTRIBUTION TO THE BODY OF KNOWLEDGE 214
5.9 THEORETICAL CONTRIBUTION OF THE STUDY – (THE SILENCES FRAMEWORK AND THE CRITICAL RACE THEORY) 215
5.10 RESEARCHER BENEFITS IN CARRYING OUT THE STUDY 218

CHAPTER 6: CONCLUSION 220

6.1 INTRODUCTION 220
6.2 A SUMMARY OF THE THESIS 220

6.3 A REFLECTION ON RESEARCHING BLACK SUB-SAHARAN AFRICAN COMMUNITIES AND THEIR UPTAKE OF MENTAL HEALTH SERVICES 230
6.4 CONCLUSION 234

REFERENCES 235

APPENDICES 278

APPENDIX I: ETHICS APPROVAL FORM 278
APPENDIX II: PARTICIPANT INFORMATION SHEET 294
APPENDIX III: INFORMED CONSENT FORM 298
APPENDIX IV: DATA COLLECTION QUESTIONNAIRE 300
APPENDIX V: MENTAL HEALTH SUPPORT SERVICES INFORMATION 302
APPENDIX VI: RISK ASSESSMENT QUESTIONNAIRE 305
APPENDIX VII: CONSTRUCTING EXPERIENTIAL STATEMENTS SAMPLE 306
APPENDIX VIII: PARTICIPANTS' DATA CLUSTERS 307

List of Tables and Figures

Tables

Table 1: Governance Policy on Mental Health Inequalities Reduction 26

Figures

Figure 1: Map of Sub-Saharan Africa 14
Figure 2: The Study's Theoretical Frameworks 40
Figure 3: The Silences Framework 42
Figure 4: The Critical Race Theory 46
Figure 5: Superordinate 1 – Struggle and Oppression 186
Figure 6: Superordinate 2 – Medical Colonialism 187
Figure 7: The Inini Fan 205

Glossary of Terms

AESOP10	- Aetiology and Ethnicity in Schizophrenia and Other Psychoses
AIDS	- Acquired Immuno-Deficiency Syndrome
APA	- American Psychiatric Association
AU	- Africa Union
BAME	- Black Asian and Minority Ethnics
BACP	- British Association for Counselling and Psychotherapy
CQC	- Care Quality Commission
CRT	- Critical Race Theory
HIQIP	- Health Inequalities Improvement Plan
HIV	- Human Immunodeficiency Virus
IPA	- Interpretative Phenomenological Analysis
MAFE	- Migration between Africa and Europe
MEPS	- Medical Expenditure Panel Survey
NHS	- National Health Services
PCREF	- Patient and Carer Race Equality Framework
SDG	- Sustainable Development Goals
TSF	- The Silences Framework
UK	- United Kingdom
UNDP	- United Nations Development Programme
US	- United States
WHO	- World Health Organisation

Chapter 1 – Introduction

"Of all the forms of inequality, injustice in health is the most shocking and inhumane" - Martin Luther King Jr., Minister and leader of the American Civil Rights Movement.

1.1 Introduction

This thesis offers a qualitative analysis of the low uptake of mental health services among Black sub-Saharan African communities, basing on empirical research conducted in the west midlands of England, United Kingdom (UK). Within this broad focus, particular attention is given to how their socio-cultural, economic, and political environment influences their decisions to seek help for poor mental health. In this sense, it fulfils Laura Serrant-Green (2011)'s suggestions, which recommend that when conducting health research in marginalised groups, the social and personal contexts in which decisions are made must be considered so that the 'silences' that influence their experiences and social environment can be understood. In recent years, there has been a marked tendency to use survey and administration data when researching the access and utilisation of mental health services among marginalised and under-served groups. This thesis shows how mental health services can be radically transformed when lived experiences are brought into the conversations.

The research programme, conducted between 2020 and 2024, draws on the Interpretative Phenomenological Analysis (IPA) methodology to describe and interpret Black sub-Saharan African communities' lived experiences relating to the uptake of mental health services. This cohort became more visible in England in the lead up to the new millennium, increasing in population from 0.4% in 1991 (Rees and Butt 2001) to 0.8% in 2001 (Scottish Government 2004). The 2021 census recorded their population at 2.5% of the total population (ONS 2022). IPA was chosen because it combines hermeneutics, the theory of interpretation, and phenomenology, the study of the structures of human consciousness and experience (Smith and Larkin 2022). Hence, it views human beings as 'experiential experts' who, through language and cognition, can describe or make sense of their lived experiences (Eatough and Smith 2017), thereby providing answers to the 'what', 'how', and 'why' of a phenomenon

(Green and Thorogood 2018). As such, researchers using this design aim to explore and interpret the lived experiences of the participants (Alase 2017). In this case, the phenomenon of interest is the experiential factors that influence Black sub-Saharan African communities' decisions to seek help for poor mental health. The programme included reviewing the literature and gathering and analysing data on the lived experiences of 21 Black sub-Saharan African participants, 13 males and eight females aged 23 – 60 years. This chapter sets out the background of the study, its significance, research questions, and frameworks guiding it. It will conclude by providing an outline of each chapter. However, before doing this, the chapter will define the terms used in the thesis, followed by the researcher's position and interest.

1.2 Definition of terms

1.2.1 Mental Health Problems and Mental Ill Health

The concepts of mental health and mental ill-health (also referred to as mental health problems in this thesis) are frequently discussed throughout this work. These concepts are shaped by various factors, including physiological, cultural, political, economic, sociological, and environmental influences (Hercelinskyj 2020; World Health Organisation 2018). The terminology also differs across languages with some cultures placing more negative connotations than others (Hercelinskyj 2020). This is made worse by the fact that there is no universally accepted definition (ibid). Different organisations and scholars use different terms to define mental health. Some definitions emphasise positive psychological well-being, others view mental health as the absence of mental illness (MHFA England 2016), and sub-Saharan African cultures believe it is something shaped and sustained through relationships and collective action (Kwamwangamalu 1999). The World Health Organisation defines it 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 is able to make a contribution to her or his community"* – (WHO 2014).

While Galderisi et al. (2016), a group of scholars, proposes a definition that integrates individual capabilities and social functioning, highlighting the importance of personal and societal factors. Their definition is given below:

> *"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" – (*Galderisi et al. 2016 pp. 231).

The definition strongly parallels the belief held by many sub-Saharan African cultures, which view individual well-being as deeply connected to community, relationships, and mutual support. However, while the two recognise that mental health is not just a personal experience but something shaped and sustained through relationships and collective action, Galderisi et al. (2016) focus more on internal equilibrium, while sub-Saharan African cultures place a greater emphasis on external social bonds as the foundation of mental wellbeing. This is rooted in the concept of Ubuntu, which emphasises the "I am because we are" philosophy: a philosophy that emphasises the interconnectedness of individuals with their communities (Kwamwangamalu 1999). The belief suggests that the mental health of one person impacts the mental health of the broader group, and thus, communal healing practices must be prioritised alongside individual treatment. This could mean recognising the importance of community-centred practices, such as family support, rituals and collective healing in mental health care.

Furthermore, the emphasis on collective identity and social responsibility in sub-Saharan African cultures encourages a view of mental health as something nurtured not just within the individual but also through social solidarity and the active involvement of the larger community. These systems provide the emotional, financial, and social resources necessary to navigate personal challenges (Kamwangamalu 1999). In this context, the cultural and spiritual dimensions of mental health extend beyond psychological symptoms to include spiritual well-being. Community rituals, cultural practices, and spiritual healing are essential in emotional recovery (Wahl 1997). The collective health of a community can be seen as critical to the individual's well-being.

By integrating the sub-Saharan African perspective into the literature on mental health, this thesis extends the traditional understanding of mental health as outlined by sources like the World Health Organization (WHO 2014), which primarily defines mental health at the individual level, emphasising the absence of disease, emotional stability, and psychological well-being. However, this view might fall short in contexts where community, culture, and relational dynamics shape people's understanding of mental health. As such, this thesis views mental health as something that cannot be understood in isolation from the social fabric and the communal context in which individuals live. This means that for sub-Saharan African communities, healing and mental health go hand-in-hand with a commitment to collective responsibility, and social unity is essential to overcoming distress and mental health challenges. Therefore, integrating the sub-Saharan African view into mental health definitions highlights the significance of social structures and community-centred healing in improving mental health care, particularly for racialised minorities in England who may face substantial barriers to conventional mental health services.

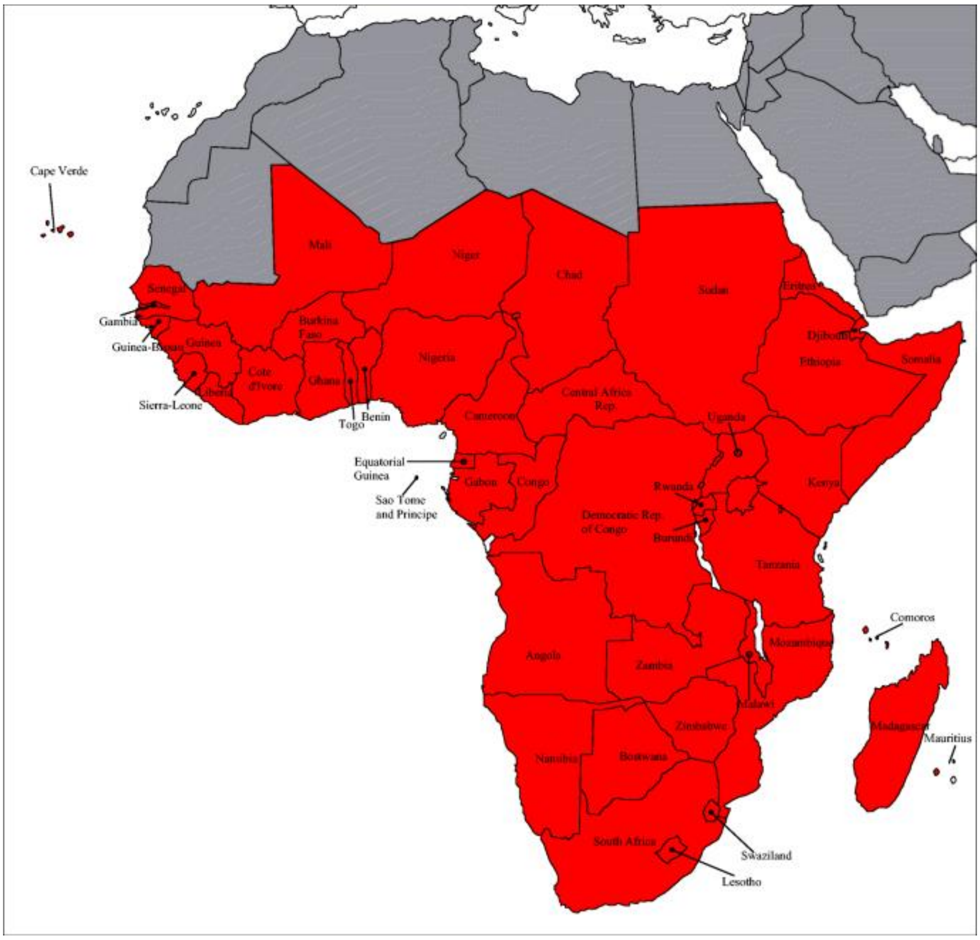
1.2.2 Mental Health Services

The term mental health services is also used widely in this thesis to refer to various interventions, programmes and resources designed to promote, maintain, and improve individuals’ psychological well-being and address various mental health concerns or conditions. These include assessments, diagnosis, treatment, therapy, education, and prevention. They can be delivered in multiple settings, such as clinics, hospitals, private practices, schools, workplaces, community settings, and online platforms.

1.2.3 Sub-Saharan Africa

Sub-Saharan Africa describes the region that lies geographically south of the Sahara (Odimegwu and Adewoyin 2022). It is a remarkably diverse continent comprising 1.2 billion people and has the world's youngest and fastest-growing population owing to the decline in infant mortality (IMF 2016). The region doubled its population between 1990 and 2013 (ibid). The number of countries in sub-Saharan Africa is confusing, ranging from 46 to 55 depending on the organisation listing them, such as the Africa Union, United Nations or World Bank. This study will use the African Union list.

Figure 1. Map of sub-Saharan Africa (Source: Google maps, 2023)



The red colour marks the area referred to as sub-Saharan Africa.

1.2.4 Black sub-Saharan African

In this thesis, the term ‘Black sub-Saharan Africa’ is used to refer to individuals whose ancestry is rooted in Africa south of the Sahara Desert. This designation is commonly employed in historical contexts within the region and is broadly accepted by its inhabitants. It serves to distinguish them from white Africans residing in the southern part of the continent, as well as North Africans of Arab descent. It also gives Black sub-Saharan African communities a specific identity within the broader Black communities that may also include African Caribbean who also originated from the sub-Saharan African region and moved to the Caribbean through slavery. (Figure 2 above shows the map of sub-Saharan Africa).

1.2.5 Global Majority Communities/Populations

This thesis uses the term global majority communities/populations to refer to groups of people from non-white backgrounds in England and worldwide. This is a new term that is being used to replace the controversial Black, Asian, and Minority Ethnic (BAME) term that has been used previously, including in the literature, to describe this cohort. This was seen as disempowering individuals from non-white backgrounds and centring whiteness as the norm, leading to the development of one-size-fits-all policies (Runnymede Trust 2020). The new term, global majority, acknowledges that non-white individuals collectively form most of the global population and challenges this Eurocentric perspective. Some view this as a way forward to decolonising language and acknowledging the demographic realities of the world (ibid). The belief is also that this helps empower marginalised groups by reframing their identity in a way that recognises their collective numerical and cultural significance on a global scale (ibid; Kapoor 2018). A point this thesis agrees with.

1.2.6 Race

Race is a social construct categorising people into distinct groups based on various physical characteristics such as skin colour, facial features, and hair texture (Smedley and Smedley 2012). These categories often reflect historical, cultural, and societal perceptions rather than biological differences (ibid). For example, during the colonial era, the concept of race was used to classify and group people into broad categories with Europeans perceiving themselves as superior thereby using the concept of race as a justification to subjugate non-European individuals (Templeton 2013). Unfortunately, Eurocentric ideologies continue to shape power dynamics, social hierarchies, and individual experiences today (Graham 2011).

1.2.7 Racism

Racism is deeply rooted in historical contexts and refers to the belief or ideology which places superiority in one racial group over others (Smedley and Smedley 2012). Hooks (1992) argues that racism is not just about individual bigotry but a system of domination that anyone, regardless of race, can participate in or resist. Racism is imbedded in social structures, policies, and institutions, often operating independently of individual intent (Bonilla-Silva 1997). As such, it shapes power dynamics, social hierarchies and individual experiences as this belief/ideology is used to prejudice, discriminate, and mistreat others based on their race (Smedley and Smedley 2012). Racism often manifests through attitude, behaviour, and institutional practices that perpetuate inequalities through policies and legislation to the disadvantage of marginalised groups (Graham 2011). Furthermore, it can occur unconsciously in individuals who hold automatic assumptions, attitudes, or stereotypes about different racial or ethnic groups (DiAngelo 2018). This is known as unconscious racial bias and can perpetuate inequalities even among those who do not consider themselves racist (ibid). Exposure to both direct and systemic racism has been found to contribute to increased rates of anxiety, depression, and PTSD among racialised global majority communities (Williams and Mohammed 2009).

1.2.8 White Supremacy

White supremacy is a pervasive ideology with deep historical roots and significant contemporary implications. It holds that white individuals are superior to those from other racial backgrounds, giving them entitlement to dominate over them and to justify systemic inequalities and discriminatory practices across various institutions and aspects of life (Fredrickson 1981). An example of white supremacy is how white Europeans used the ideology to justify and imperialise sub-Saharan Africa, where they viewed its inhabitants as needing civilisation from them as they perceived themselves as superior (Binagwaho, Ngarambe and Mathews 2022). However, it is important to note that there is a difference between individuals who identify as white and white supremacy. Not everyone who is white support the white supremacy ideology. These are beliefs held by white individuals who believe in the concept of white dominance and subjugation of other races (Delgado and Stenfancic 2017). In this thesis, white supremacy refers to the prevailing economic and cultural system in which white individuals overwhelmingly control power, conscious and unconscious ideas of white superiority and entitlement, and not the self-conscious racist white supremacist hate groups.

1.2.9 Power

Power is complex, multidimensional, and contested with different scholars offering various conceptualisations. Max Weber (1946) defines power as the ability of an individual or group to impose their will against resistance. Similarly, Karl Max (1848) supports the dominance perspective by defining power as being tied to class and economic structures, where the ruling class controls material resources and ideology. In this instance, power is not only enforced by force but also by cultural hegemony, where dominant ideologies are internalised (Fanon 1961; Gramsci 1971). The same belief is held by intersectional feminist ideologists, who believe that power operates through systems of domination for example, racism and patriarchy, but individuals can also resist and challenge these structures (Hooks 1984). However, Michel Foucault (1977) shifts the focus from power as just domination, but something embedded in knowledge, discourse, and institutions. The scholar believes that power is not just held by individuals but exercised through systems of control such as, prisons, hospitals and schools (ibid). In his publication, ‘Medical Gaze’, he describes how medicine reduces patients to clinical objects, stripping them of autonomy (Foucault 1973). Global majority, women, and LGBTQ+ populations often experience discriminatory diagnostic practices, coercive treatments, and exclusion from adequate care due to systemic power imbalances (Crenshaw 1991; Metzl 2010). Mental health laws, such as the UK Mental Health Act 1987, grant some mental health practitioners such as psychiatrists and Approved Mental

Health Professionals legal power to detain individuals involuntarily, disproportionately affecting Black and ethnic minority populations (Pilgrim 2017).

Furthermore, mental health services are said to be increasingly shaped by market forces, pharmaceutical industries, and profit motives shifting power away from patients and communities (Ross 1999). Critical psychiatry and decolonial approaches argue that Western mental health models dominate and invalidate non-Western healing traditions (Fernando 2017). In this thesis, power can be seen in how individuals of Black heritage are overrepresented in experiencing mental health problems, being detained under the Mental Health Act 1987, and experiencing poor outcomes from mental health services (Mantovani, Pizzolati and Edge 2016; Ayinde and Gillum 2014; Lubien et al. 2016). Throughout the thesis, I highlight how power affects the lived experiences of Black sub-Saharan African communities.

1.2.10 Colonialism

Colonialism is the act of political and economic domination by one territory over another, often involving the local population's subjugation and exploitation for the colonising power's benefit (Loomba 2015). Unlike the broader concept of imperialism, which refers to extending influence over other regions, colonialism is characterised by direct control and governance by the colonising territory (Young 2001). It is essential to define colonialism as an act of a territory rather than that of a nation-state or social grouping because it involves the exercise of sovereign authority over another land, backed by legal and institutional structures that enforce control (Bhabha 1994). Nation-states and social groups may participate in colonial enterprises, but colonialism, by definition, is an organised territorial endeavour that extends governance over a foreign region.

A key distinction exists between colonialism and colonisation. Colonisation typically refers to the large-scale settlement of new populations in a foreign territory, often accompanied by displacement or eradication of indigenous populations (Wolfe 2006). This colonisation was prevalent in North America and Australia, where settler populations became dominant. However, much of sub-Saharan Africa experienced colonialism without extensive settler colonisation (Mamdani 1996). Instead of mass settlement, European colonial powers imposed political, economic, and legal structures that facilitated resource extraction, labour exploitation, and indirect rule over local populations (Rodney 1972). This form of colonialism, often called ‘exploitation colonialism’, involved the control of land and resources rather than the relocation of large settler populations (Abernethy 2000). The legacy of this type of colonialism in sub-Saharan Africa persists in contemporary structural inequalities, including disparities in access to mental health services, systemic racism, and the marginalisation of Black sub-Saharan African communities (Mbembe 2001). By acknowledging the specific historical processes at play, a more precise understanding emerges of how colonial legacies continue to shape social and institutional barriers today, including access to and utilisation of mental health services.

1.2.11 Medical Colonialism

Medical colonialism refers to the imposition of Western medical practices, beliefs, and structures on non-Western populations, often disregarding indigenous knowledge systems and cultural practices. This term encompasses the historical and ongoing impacts of racism and Eurocentrism in global health care, including the marginalisation of non-Western medical practices and the systemic biases that affect the quality of care provided to racially marginalised groups (Bastos 2007; Lowes and Montero 2021).

1.3 Study Background

Mental health disorders continue to be a leading cause of disability worldwide. In 2019, the Global Burden of Disease Study reported that mental disorders accounted for a significant portion of the global disease burden (GDP 2019 Mental Disorders Collaborators 2022). The World Health Organisation (WHO) estimates that in 2019, one in eight people in the world were living with a mental disorder (Global Health Data Exchange 2022). However, the number is said to have increased significantly in 2020 due to the COVID-19 pandemic, especially for anxiety and major depressive disorders, which were initially estimated to be around 26% and 28%, respectively (WHO 2022). Unfortunately, most of the individuals experiencing mental health problems will not receive treatment, and the percentage is higher in developing compared to developed countries (ibid). Various factors are blamed for this issue, including the shortage of mental health workers, lack of research capacity, stigmatisation of mental illness, and the separation of mental health services from physical health services (Wainberg et al. 2017). In 2013, the 66th World Health Assembly adopted the WHO Mental Health Action Plan 2013 – 2020 to provide a comprehensive framework to address these issues (Singh 2021). The plan, later extended to 2030 by the 74th World Health Assembly, had its objectives modified to align with those of the 2030 Sustainable Development Agenda also due in 2030. The objectives included having countries develop or update their policies/plans for mental health to be in line with international and regional human rights instruments and increasing service coverage for severe mental disorders (Davison 2019).

In the UK, mental health problems are more common among global majority populations (Bhui et al. 2003; Singh et al. 2013; Audini et al. 2002). The most affected are individuals of Black heritage, with Black sub-Saharan Africans being at the forefront (Mantovani, Pizzolati and Edge 2016). Individuals of Black heritage are also said to have the lowest treatment rate at 6.2% against 13.3% in the white British group (Lubian et al. 2016) and accessing mental health services through the criminal justice system (Kane 2014; Bignall et al. 2019). Evidence suggests they are almost five times more likely than their white counterparts to be detained under the Mental Health Act 1983 (UK Government 2023). This legislation is used to give urgent treatment to individuals experiencing mental disorders without their consent: the reason is to protect them from harming themselves and others, and it covers their assessments, treatments and rights (NHS Digital 2022). However, a recent study on the disparities in the use of this legislation among global majority populations found no explanation for the variation in the risk of detention (Barnett et al. 2019).

In addition, individuals of Black heritage are also said to be almost ten times more likely to be released on a Community Treatment Order (NHS Digital 2021; Department of Health and Social Care 2022). This legislation allows clinicians to continue supervising the treatment of discharged patients in the community and to recall them back to the hospital if need be (The Parliamentary Office of Science and Technology 2022). NHS data released in 2020/2021 shows the rates for mental health detentions measured per 100,000 people were high in this cohort at 309.4, followed by Asian communities at 96.2, with the least being those from white populations who stood at 76.2 (NHS Digital 2021). Previously, in 2015/16, Black individuals accounted for approximately 9% of the population detained under the Mental Health Act 1983 (Barnett et al. 2019). This was three times the percentage of Black people in the general population at the time (ibid).

Once detained, individuals of Black heritage are faced with ethnically based prejudice and discrimination by health professionals (Adams et al. 2014), thereby having poorer experiences of and outcomes from mental health services (Ayinde and Gillum 2014). Because of this, they are said to have a mistrust of services which negatively influences their mental health help-seeking behaviour (Morgan et al. 2004). This cohort is also said to stay in detention longer than other ethnicities and to experience repeated admission (Care Quality Commission 2022; NHS Digital 2021; Mohan 2006; Priebe 2009). One of the reasons for this may be due to lack of eligibility for the independent mental health advocacy service. This is a service where patients detained under the Mental Health Act 1983 are supported by a qualified advocate to express their views and wishes, and to help them understand, and stand up for their rights. However, this service does not extend to those who are detained under section 4, section 5 holding powers, section 135 and section 136 of the Mental Health Act 1983 (Mind 2017) which unfortunately, is mostly used to detain individuals of Black heritage. Furthermore, there is evidence to suggest that they experience variation and inequality during assessments and are likely to be offered drug treatments over psychological therapies and experience higher levels of restraint compared to other populations (Bignall et al. 2019; Payne-Gill et al. 2021; NHS Digital 2021) and are targeted for solitary confinement (Rugkasa and Canvin 2011).

A systematic review and meta-analysis of UK and international data conducted to investigate ethnic variations in compulsory detentions confirmed higher proportions of Black populations in compulsory psychiatric detentions (Barnett et al. 2019). Of the 71 articles in the review, UK-based studies reported a significantly higher rate of mandatory admission than in other countries (ibid). This confirms a higher than global average rate of psychiatric compulsory detentions for Black populations in the UK, suggesting a reluctance by this group to access mental health services until their mental health has deteriorated. This makes the issue a complex conundrum as mental health care is free in the UK at the point of entry (UK

Government 2022). Nonetheless, some experts contest these statistics, citing the lack of detailed data. NHS data on ethnicity, which is used to formulate these statistics, is self-reported from a broad range, and sometimes patients choose to leave this area blank, thereby distorting the figures (The Parliamentary Office of Science and Technology 2022).

However, disparities in mental health care for the majority of the global population have been reported worldwide (Halvosrund 2019; Zubrick et al. 2004; Lee-Tauler 2018; Henry et al. 2020; Gajwani 2016). Higher rates of psychoses diagnosis, particularly schizophrenia have been recorded for migrants and global majority communities across four different continents over many decades (Halvosrund 2019). In Australia, the burden of mental illness is three times higher in Aborigines than it is for the mainstream population (Hinton et al. 2015). They are also said to be over-represented in not taking up mental health treatment (Zubrick et al. 2004). Interestingly, in the US, while the rate of experiencing mental illness is said to be the same for both mainstream and global majority populations (Lee-Tauler 2018), the literature reveals a lower uptake of mental health services among the latter (Henry et al. 2020). Similarly, as can be seen in the previous paragraphs, the UK maintains the global trend with high rates of mental health problems and a low uptake of mental health services for global majority communities compared to the general population (Fernando 2005).

Explanations for this are varied, including social and economic environments (Bhui et al. 2018; Coid et al. 2019; Gupta et al. 2021) and historical contexts of colonial pasts and participation in the trans-Atlantic slave trade (Lankelly Chase Foundation 2013; European Policy Dialogue Forum 2021). For example, in Australia, evidence points to their history of colonialism as one of the drivers maintaining disparities in mental health service use (Smith and Brown 2013). The literature suggests that this has had a profound intergenerational impact on the Aborigines' social and emotional well-being and has led to ongoing social, political, and economic marginalisation (ibid). Nonetheless, in the UK, explanations for this are contested. On one hand, some researchers blame the social and economic environment experienced by the global majority of communities (Jones and Patel 2021) who are said to occupy all positions of disadvantage; they are twice as poor as their white counterparts (Racial Disparity Audit 2017), experience high rates of unemployment, live in poorer housing and have lower levels of academic achievements (John Rowntree Foundation 2017).

On the other hand, some researchers believe that the way institutions respond to factors that act as barriers to accessing mental health services is shaped by processes related to racism (Nazroo et al. 2018). They blame the attitudes of mental health practitioners (Karlsen et al. 2005; Smith and Johnson 2017) and question the validity of Eurocentric assessment tools and treatments (Chen and Garcia 2019). They argue that these cannot be fit for purpose for diverse populations because cultural factors and ethnic differences influence the way mental illness symptoms present (Smith and Johnson 2017). There also is evidence in the literature to show that mental health practitioners respond to mental illness in line with established Western medical models (Patel and Khan 2020; Bhui and Olajinde 1999; Crawford and Lipsedge 2004). This can be problematic because different cultural contexts and traditions are said to define and experience reality in various ways, including views on mental disorders (Ogundare 2020; Okello and Musisi 2006; Smith and Johnson 2017). The Diagnostic and Statistical Manual (DSM) of Mental Disorders, published by the American Psychiatric Association (APA) (APA 2013), is the official system widely used by mental health professionals to diagnose mental illness. This can lead to misdiagnoses, wrong treatments, and interferences with recovery. Some researchers have called its use of global majority groups a 'box ticking' exercise to provide a diagnosis (Pinto, Ashworth and Rodgers 2008; Nesterko et al. 2020). This has support from migration research experts such as Watters and Ingleby 2004, who, in one of their publications, reported:

> *"The voice of the refugee is only heard within predefined and compartmentalised contexts that conform to and reinforce institutional structures within the health and social care field" – (*Watters 2001 pp. 1710).

Watters's argument is clinical providers with little understanding of pre-migratory, migratory, and post-migratory experiences cannot satisfy the needs of refugees. This is especially true if the clinician cannot communicate effectively and culturally with the patient. Reflecting on this mindset may explain why, in the UK, the majority of populations receive diagnoses at the severe end. For example, Black Caribbean populations are identified among the highest in the world to receive a schizophrenia diagnosis, something that is not replicated in 'native' populations in the Caribbeans (Pinto, Ashworth, and Rodgers 2008).

However, most of the disparities experienced by global majority populations have been consistent for over six decades and across generations (Pinsent 1963; Kiev 1965; Bagley 1971; McGovern and Cope 1987; Harisson et al. 1988; Cochrane and Bal 1989; King et al. 1994; Van Os et al. 1996; Halvorsrud et al. 2020). This has been a cause for concern for the mental health community worldwide. In England, the debate started in the early 90s, prompted by the death of a Jamaican-born, Black British man in 1991 following the administration of high doses of psychotic medication, promazine and fluphenazine (Cummins 2015). This resulted in the Special Hospitals Service Authority setting up an enquiry which produced a report, 'Report of the committee of inquiry into the death of Orville Backwood' (ibid). Surprisingly, this seemed to not have an impact on the way mental health services were delivered as two years later, two more deaths of Black Caribbean patients occurred at the same hospital, prompting another enquiry and report, 'A Review of the Deaths of two African-Caribbean Patients' (Prins 1994, Sainsbury's Centre for Mental health 2002). Both reports highlighted institutional racism towards people of Black heritage in psychiatric institutions. Sadly, three decades later, the same racialised issues were highlighted by the 'Independent Review of the Mental Health Act 1983', published in 2019, showing that the same disparities have continued unabatedly. This persistence seems to reinforce the idea that mental health services are indeed racist. An extract from Bhui and Olajinde (1999)'s publication, 'Unanswered Questions: A User's Perspective in Mental Health Service Provision', had the following to say regarding racism in mental health services:

> *"Although not so blatant, racism remains firmly embedded within psychiatry; with its firm adherence to Eurocentric norms, its invalidation of the positive ideologies about life and its problems that come from Black world views and the too frequent pathologisation of Black expression of emotion, psychiatry continues to perpetuate the myth of the superior western mind"* – (Bhui and Olajinde 1999, (n.p.).

While the extract is from a legacy publication, it still is fit for purpose today considering what previous work says about the delivery of mental health among Black communities (Graham 2011; Bignall et al. 2020; Ogundare 2020). I included the extract to highlight the length of time researchers have been discussing the same issue. This is one of the reasons this study decided to employ the Critical Race Theory to critically analyse its findings.

The main issues over the years have been that individuals of Black heritage, particularly Black Caribbeans, are often diagnosed with schizophrenia (Harrison et al. 1988; King et al. 1994; Bhugra et al. 1997; Morgan, Hutchinson, and McKenzie 2006; Pinto and Ashworth 2008). However, it is essential to note that the reason Black sub-Saharan African communities are shown as not receiving as much of this diagnosis is that there has not been much research on this cohort and mental health in the literature. Nonetheless, as mentioned earlier above, both groups are known to be over-represented in being compulsorily detained in mental hospital (Audini and Lelliott 2002; Davies et al. 1996; Bignall et al. 2020), experiencing repeated admission and are more likely than other ethnicities to be subjected to the Mental Health Act 1987 detention powers that can be used by the police (McGovern and Cope 1987; Mohan et al. 2006; Priebe et al. 2009; Care Quality Commission 2022; NHS Digital 2021). They also experience involuntary treatment where they are targeted for coercive and intrusive interventions such as electroshock treatment and medication with high doses of brain-damaging drugs (Bolton 1984; Rugkasa and Canvin 2011; Payne-Gill 2021).

Changes to confront the negative issues were initiated at national level in a government publication titled, Dialogue for Change (Mental Health Task Force 1994) and are well documented and referred to in various government policies (Department of Health 1999; Department of Health 2005; NHS 2021). However, more progress has yet to be made in access, experience, and outcomes (BRAP 2012; MHFA 2016; Kapadia et al. 2022). In the late 90s and early 2000s, various NHS Trusts instigated projects such as the Trans-Cultural Psychiatry Unit at Bradford, Maudsley Outreach Support and Treatment Team in South London, and the North Birmingham Home Treatment Service to meet the needs of the global majority populations (Fernando 2005). The projects did well but were not sustained due to a lack of resources (ibid). What has also been seen to work are projects initiated and run by the voluntary and community sector, which cater for ethnic groups or subgroups, such as The Nafsiyat, Qalb Centre in East London and The Nile Centre in the London Borough of Hackney (Fernando 2005; Rudell et al. 2008; Bignall et al. 2019; Newbigging et al. 2017). The projects use different approach models to support their service users in dealing with discrimination and racism, interact with statutory services and counteract social deprivation and exclusion (ibid). These are usually run by people from their service users' backgrounds who understand their cultures and the social challenges they face in England (White 2002; ibid). The success stories of these projects seem to support the questioning of Eurocentric assessment tools and treatments and reinforce the need to support global majority populations to overcome the social challenges they experience including, racism, discrimination, and exclusion. An overview of the social environment, that is inhabited by most global majority populations in England, and a review of the literature on the barriers to mental health access are given in Chapter 2 of this thesis.

Members of the Mental Health Alliance in England also feel the mental health disparities debate is long-standing and, in 2021, they published an open letter to the government expressing concerns about the lack of acknowledgement of racism in the consultations to reform the Mental Health Act 1983 and the White Paper (Bhui et al. 2018; Kapadia, et al. 2022; Nazroo et al. 2020; Commission of Race and Ethnic Disparities 2021; Porteous-Sebouhian 2021; Fernando 2004; Mental Health Alliance 2021). This has caused controversy in the mental health field as other researchers feel this argument is misleading and harmful because there is no evidence of discrimination and racism, and upholding such beliefs run the risk of denying people appropriate care (Singh and Burns 2006). Besides, mental health services are said to be experiencing rising demands that exceed capacity for all ethnicities. Despite increased awareness around this area, the National Health Service (NHS) budget has focused more on physical health limiting resources for mental health services (Cummins 2018). This negatively affects the progress of work in reducing stigma as mental health is viewed as less serious than physical health. Patients may feel marginalised, making them reluctant to seek help (Semrau et al. 2015).

One of the pressing issues is the long waiting times by patients to be seen by mental health professionals which can take months to get an initial assessment and even longer for follow-up reviews (Punton, Dodd and McNeill 2022). Unfortunately, this causes patients' mental health to deteriorate while waiting which can lead to them reaching crisis point. This can lead them to end up in emergency departments which are not well equipped to handle mental health crises, leading to poor patient outcomes (Clibbens 2022). Apart from putting pressure on emergency services, this also puts pressure on mental health hospitals as patients may require detentions. This may be one of the reasons bed occupancy rates for mental health services is operating above the 85% level recommended for patient safety standards (NHS

Providers 2022). Reports in this area also mention the significant shortage of qualified mental health professionals, including psychiatrists, mental health nurses, therapists, and psychologists within the NHS (Huxley et al. 2005; Long et al. 2023). As such, the huge workload on current staff leads to increased workloads and reduced quality of care for patients (ibid). The quality of care is said to vary greatly according to geographical location in most cases disadvantaging those from marginalised groups (Song et al. 2022) such as, Black sub-Saharan African communities. However, the poor integration between health services and other healthcare systems such as community support, primary care and social services is of concern as this can result in disjointed care where patients fall through the cracks and need to receive comprehensive treatment (Wakida et al. 2018).

In its 2019 Long-term Plan where it outlined its visions and priorities, the NHS acknowledged the need to change the way they worked and set out how the steps were going to take to come up with a new service model that will allow patients more options, better support, and adequately joined-up care at the right time in the optimal care setting (NHS Long-term Plan 2019). It also acknowledged the mental health needs of diverse communities and committed itself to reducing mental health inequalities, including those experienced by Black people. It emphasised the importance of culturally sensitive care, improving access for marginalised groups, and the introduction of digital healthcare launched in 2022. As such, in 2022 over 28 million people had the NHS app and over 40 million people were said to have an NHS login. In addition, most NHS trusts had electronic patient record systems in place. However, despite this technological step, health outcome disparities have persisted, and some researchers say this could have been exacerbated by the new technologies: the use of technologies result in a 'digital divide' in which populations with poorer health outcomes continue to have them despite technological improvements (Saeed and Masters 2021). While there has been a push towards digital mental health services, not all patients have access to or feel comfortable using digital platforms. This can create disparities in access to care, particularly for older adults or for those from lower socio-economic backgrounds who may lack the necessary technology or skills. Robotham et al. (2016) reported that some people still need to be included in internet-enabled technology due to a lack of resources, skills, and confidence. This is still true for most refugees and newcomers to the UK who have lost all of their worldly goods and live in abject poverty (Alencar 2020).

Alencar (2020) explained how people need mobile phones to travel to the UK but mentioned that there is a barrier to knowing how to access websites and NHS resources for some refugees. This is because the immigration system has become increasingly digitalised. The UK government relies on digital immigration systems for visa applications, border crossings, and identity verification, often requiring mobile phones for two-factor authentication and access to digital visas (Home Office 2022). Additionally, some asylum seekers are required to use mobile apps with GPS tracking and facial recognition to check in with the Home Office as part of their immigration monitoring (Fussey and Leese 2021). Beyond legal and administrative requirements, mobile phones serve as essential tools for navigation, translation, and communication, helping migrants integrate into their new environment (Gillespie, Osseiran, and Cheesman 2018).

However, despite the necessity of mobile phones for travel and settlement, refugees and newcomers may struggle to access the NHS website and navigate the NHS app. Language barriers can make it difficult to understand healthcare information since the website and app are not fully optimised for multilingual access (Reidy et al. 2025). Additionally, limited digital literacy and unfamiliarity with the UK's healthcare system can create challenges in using online services effectively. As previously mentioned, many refugees and newcomers also experience financial hardship, which may restrict their access to mobile data or high-quality devices needed to run apps smoothly. Furthermore, digital verification processes, such as NHS login requirements, may be difficult for individuals who lack stable documentation or proof of address, further complicating their ability to access healthcare services online.

The literature shows how with the support of successive governments they have been working since the early nineties to reduce mental health disparities but unfortunately, they have remained persistent (MHFA 2016). An extract from the 7th Annual Report of the Mental Health Act Commission published in 1997 regarding the care and treatment of Black and global majority patients reads:

> *"Provision for patients from minority ethnic communities often remain basic, insensitive, and piecemeal leading to patients feeling alienated and isolated. It is*

> *dispiriting that the serious issues of inappropriate care and treatment of patients from Black and minority ethnic communities, which were raised in previous Biennial Reports, continue to cause concern and to be noted in the reports of the commission visits."* (n.p.).

This message, conveyed almost 30 years ago is still as relevant today as it was back then. The table below, adopted and updated from Olajinde (1999) illustrates the government's efforts in way of policy and the attention given to the care needs of global majority populations in England with the intention of reducing mental health inequalities.

Table 1 – Government policy on mental health inequalities reduction (Olajinde 1999)

Year	**Policy**	**Contents**
1965	The Race Relations Act	This was the first significant legislation in the UK specifically focused on combating racial discrimination. Its aim was to address racial discrimination and promote equal treatment and opportunities for individuals regardless of their race or ethnic background.
1967	The Race Relations Act	This act built upon the 1965 legislation and introduced more comprehensive measures to combat racial discrimination. It extended the provisions of previous act, making it illegal to discriminate in employment, housing, and public services based on race, colour, nationality, or ethnic origin.
1976	The Race Relations Act (Amendment)	Its purpose was to strengthen and expand existing legislation related to racial discrimination and promoting equal treatment for individuals regardless of their race, colour, nationality, or ethnic origin.
1983	The Mental Health Act 1983	This is the primary legislation that governs the treatment and care of individuals with mental health disorders.
1992	The Patient's Charter	It was introduced as part of an initiative to improve the quality and responsiveness of healthcare delivery. Its aim was to outline the rights and expectations of patients when accessing healthcare services within the NHS.

1993	Mental Health and Britain's Black Communities Report	This was undertaken to understand why there was an over-representation in Black individuals experiencing mental illness and findings showed areas where they were not happy with the available service including misdiagnoses and over-diagnoses, lack of cultural competence and detentions under the Mental Health Act 1983.
1993	The Orville Blackwood Inquiry, also known as, "The Big Black and Dangerous Inquiry"	Set up by the Special Hospitals Service Authority to investigate the death of Orville Blackwood at Broadmoor. Its findings highlighted how Black men were viewed as dangerous, the excessive use of restraint and medication on this cohort, as well as institutional racism and lack of cultural competence.
1994	Mental Health Task Force (London project and regional race programmes)	This was implemented to address critical inequalities and barriers that Black and other global majority communities were facing in accessing and receiving appropriate mental health care.
1994	Black Mental Health: A dialogue for Change	This promoted a new approach to integrating practices between the voluntary and statutory sectors, recognizing the voluntary sector as essential in supporting the management of mental health issues among Black and ethnic minority service users.
1994	NHS Executive Letter (EL94)77 on collating ethnic group data	Placed a requirement on all service providers to collect data on the ethnic origins of service users so as to evaluate which groups were accessing specific services and determine if their needs were being appropriately addressed.
1994	Ethnic Health Set Up	The setup of healthcare initiatives or systems that were specifically tailored to meet the needs of individuals from diverse ethnic backgrounds or minority populations. These setups acknowledged the importance of cultural sensitivity, inclusivity, and understanding in healthcare delivery.
1994	The Richie Report - The Report of the inquiry into the care and treatment of Christopher Clunis (1994)	The report highlighted several deficiencies in the mental health system and made recommendations for improvements. Its findings and recommendations influenced subsequent reforms aimed at improving the quality of mental health care and ensuring the safety of both patients and the wider community.
1995	Learning the lessons (Zito Trust Report)	It reviewed all homicide inquiries involving mentally ill perpetrators with the aim of identifying common lessons. The review also highlighted the impact of race and ethnicity on mentally ill

		individuals and examined the shortcomings of services provided to minority ethnic groups.
1995	Mental Health Towards A Better Understanding Booklet (Health of the nation public information booklet for minority ethnic groups and their carers)	It was designed to address the mental health needs of global majority communities and to improve understanding and service provision in this area. Its contents focused on mental health issues, review of the existing research and reports and their recommendations on the issues, the impact of race and ethnicity on diagnosis and treatment, the shortfalls of mental health services delivering and gave their recommendations.
1998	The Human Rights Act	This piece of legislation was implemented to incorporate the rights and freedoms set out in the European Convention on Human Rights (ECHR) into UK law and serves to protect and promote the human rights for all individuals within the jurisdiction of the UK.
1998	A First-Class Service	This was a strategic framework aimed at improving the quality of mental health services. Its purpose was to address various issues within mental health care and to ensure that services provided were of the highest standard. Its key objectives were to hold regular reviews and develop service standards, increase funding and investment in mental health services to support the implementation of best practice, training development and user involvement, and initiate to involve service users and their families in the design, delivery, and evaluation of mental health services.
1999	The MacPherson Report (Following the murder of Black teenager Stephen Lawrence and the failure of the criminal justice system to bring his murderers to justice)	It was prompted by concerns around the handling of the circumstances surrounding the racially motivated murder of Stephen Lawrence by the police. Its findings highlighted institutional racism and showed how racism could be embedded in the practices and culture of institutions including the NHS and other public bodies.
1999	The National Service Framework for Mental Health (Department of Health)	This was a landmark policy aimed at transforming mental health services. Its purpose was to create a standardized, comprehensive, and equitable system for mental health care delivery. It laid the foundation for service improvements, focusing on early intervention, personalized care, and better access to services while addressing the specific needs of vulnerable and global majority populations.

2000	The Race Relations (Amendment) Act 2000 and the EC Article 13 Race Directive	Its role was to strengthen the existing, Race Relations Act 1976 following the findings of the MacPherson Report 1999. It addressed its shortcomings and extended anti-discrimination laws to public authorities making them legally obliged to not discriminate on the grounds of race when carrying out functions.
2000	The NHS Plan	This was a ten-year plan implemented by the UK government to modernise and improve the NHS addressing such issues like underfunding, long waiting times, and inequalities in healthcare provision.
2002	Race for Health Programme	The programme was introduced to tackle the disparities in health outcomes experienced by ethnic minority communities as they were found to have worse outcomes and poorer access to services compared to the general population.
2003	Inside Outside Census	This was implemented as part of the Delivering Race Equality strategy aimed at examining the representation of global majority staff within the NHS workforce and to identify the extent of racial disparities in both employment and service delivery within mental health care. Its findings revealed underrepresentation of global majority populations staff in senior and managerial roles within the NHS. It also highlighted workforce discrimination and the lack of career progression opportunities among this cohort.
2004	Delivering Race Equality	This was implemented to address the disproportionate and unequal treatment of individuals from global majority populations in mental health services, especially in secure psychiatric settings, and their often-negative experiences in the system. The policy focused on building inclusive services with staff trained to understand the needs of patients from global majority populations by working closely with these communities to develop mental health services that are trusted, accessible, and reflective of their cultural values and beliefs.
2005	Delivering Race Equality: An Action Plan for Reform Inside and Outside Services	This was a comprehensive reform strategy aimed at addressing the racial disparities identified by reports like the Inside Outside Census. It set out a series of reforms to improve racial equality within mental health services both inside (service structures, workforce practices) and outside (community relationships and engagement).

2007	Mental Health Act Review	This was initiated to assess and update the Mental Health Act 1983, focusing on ensuring that it was fit for purpose in a modern healthcare system and addressing criticisms of how the Act impacted certain groups, particularly the persistent and increase in detentions of Black groups under the Act and patients being released on Community Treatment Orders.
2007/2008	The Human Rights in Healthcare Frameworks	These are interconnected systems that aim to ensure the protection and promotion of individuals' rights to health and well-being. These frameworks recognise the fundamental rights and dignity of every person and provide guidelines for healthcare policies, practices, and decision-making.
2010	The Equalities Act	Allows collection of data and publication on ethnicity to monitor disparities closely.
2011	Equality and Diversity System (EDS)	This is a structured approach adopted by organisations to promote and ensure fairness, inclusion, and equal opportunities for all individuals. Its aim is to eliminate discrimination, address inequalities, and create an environment that values and respects diversity in all its forms.
2013	Equality and Diversity System 2 (EDS2)	It provided a comprehensive framework for NHS organisations to promote equality and diversity and to address disparities in healthcare access and outcomes.
2014	Workforce Race Equality Standard (WRES) 2014	This is a framework that was introduced to address race inequality within the healthcare workforce. It is designed to promote diversity, equality, and inclusivity in the NHS workforce.
2016	Five Year Forward Plan for Mental Health	It was designed to outline a comprehensive plan for improving mental health services across the country over a five-year period highlighted the importance of addressing mental health inequalities and improving care for marginalised communities.
2017	The Independent Inquiry into the Death of David Bennett	This inquiry examined the circumstances surrounding the death of David Bennett, a young Black man who had experienced mental health problems. The report highlighted systemic failures and racial disparities within mental health services and made recommendations for improving care.
2018	Modernising the Mental Health Act Report	The review aimed at addressing criticisms and concerns about the Mental Health Act 1983, particularly its use and impact on different groups of people. The report sought to ensure that the

		legislation was fit for purpose and aligned with contemporary standards of mental health care and human rights.
2018	The Race Equality Framework (REF) for Mental Health and Wellbeing	This framework was developed to provide guidance to local organisations on how to address racial inequalities in mental health care. It focuses on improving access, experience, and outcomes for people from global majority populations.
2019	The NHS Long-term Plan	This plan outlines the vision and priorities for the NHS. It acknowledges the mental health needs of diverse communities and commits to reducing mental health inequalities, including those experienced by Black people. The plan emphasises the importance of culturally sensitive care and improving access for marginalised groups.
2020	Independent Review of the Mental Health Act 1983	The review was conducted to assess the Mental Health Act 1983 and propose necessary reforms to ensure it met contemporary standards of mental health care and human rights. It aimed to address longstanding concerns about the Act's application, particularly in relation to coercion, patient rights, and disparities in mental health services.
2021	Reforming the Mental Health Act - White Paper	This outlined the proposed reforms to the Mental Health Act 1983 based on the findings and recommendations of the Independent Review of the Mental Health Act 1983. Its aim was to set out a clear strategy for modernising the Act to improve mental health care and address various issues identified during the review.
2021	The NHS Health and Race Observatory	It was established to address and tackle racial health inequalities within the NHS and broader healthcare system. Its primary purpose was to improve the understanding of how race and ethnicity impact health outcomes and to drive meaningful change in how services are delivered to address these disparities
2023	Patient and Carer Race Equality Framework (PCREF)	This is an anti-racism approach coproduced on the back of recommendations from the Independent Review of the Mental Health Act. Its aim is to ensure that services are equitable, inclusive, and responsive to the needs of all patients and carers, regardless of their racial or ethnic background.

The table shows a long awareness of mental health inequalities. Unfortunately, this has not significantly improved access, experience, and outcomes (Kapadia et al. 2022). Some scholars argue the reason they have failed is because they have not been appropriately funded and had limited action time (Postnote 2007), while others insist there is little evidence to show they were adopted and implemented widely (Moffat et al. 2009; Sass, Moffat and McKenzie 2009). However, in 2023, NHS England launched its first-ever anti-racist framework, the Patient and Carer Race Equality Framework (PCREF), one of the recommendations put forward by the Independent Review of the Mental Health Act 1983, to support NHS mental health trusts and mental health service providers to become anti-racist organisations (NHS Digital 2023). Their expectation is to achieve this by co-producing and implementing concrete actions to reduce racial inequalities within services (NHS Digital 2023). Nevertheless, further attention is required to gain a more comprehensive understanding of the overall mental health status of Black sub-Saharan African communities in England. Their perspectives and experiences with mental health care offer valuable insights that should be integrated into the existing healthcare system. This supports the European Policy Dialogue Forum (2021), which called for the engagement of migrants and refugees in public-making processes, in order to reflect real situations and needs, thereby increasing their effectiveness. This also shows how timely this study which relies on lived experience is. Understanding the social factors that influence decisions to seek help for poor mental health among Black sub-Saharan African communities will give an insight into what their mental health needs are and what is lacking in the current mental health service provision. Not only will this save the government money and other resources, but it may also save the lives of Black people and communities at large.

Nonetheless, while there has been a reasonably long history of Black sub-Saharan African communities settling in England and them becoming one of the fastest-growing ethnic groups in the UK in recent years, the research interest and policy focus on this group does not reflect their long-standing presence. A review of the current literature shows that only a handful of studies have been conducted, with very few using lived experience to address the factors influencing their decisions to seek help for poor mental health (Daley 1998; Ochieng 2013; Nyashanu et al. 2024). The limited research on this topic among these communities and the lack of awareness by mental health professionals of the mental health needs of these groups are the two primary concerns for this study.

1.4 Researcher’s Position and Interest

The starting point for this research was witnessing asylum seekers, refugees and migrants struggling to engage with mental health services when I volunteered for Coventry Refugee and Migrant Centre. I had done the same when I first arrived in England two months prior. The need for the research was later reinforced when I established a social enterprise, Inini Initiative Ltd, to support the global majority of communities in overcoming the challenges of integration. The aim was to help prevent the onset of mental illness that is usually induced by the process and offer an intervention for those already experiencing low-level psychological distress. Working at Inini, I realised that even individuals who are referred to community mental health services after detention under the Mental Health Act 1983 struggled to engage with these and other mainstream mental health services. As such, they would often relapse and get detained again, becoming what is known in the mental health industry as ‘revolving door’ patients. One of Inini Initiative’s offerings is peer support, which meets every week. An informal, safe space is provided for individuals to come and connect with others and engage in conversation on the various challenges they encounter while trying to navigate their social terrain; these include racism, discrimination, housing, immigration, mental health, and the heartache of having their children not being able to access higher education due to their immigration status. In addition, various professionals come in to deliver workshops on different topics. In this space, the research questions for this study were first generated. These concepts were further refined through discussions with my supervisory team during the first year of my PhD studies.

I situate myself as a practitioner guided by Karanga values and principles. I was born and raised in this culture in a small rural village in colonial Rhodesia (now Zimbabwe). Like many other sub-Saharan African cultures, the Karanga values and principles mirror the concept of ubuntu. As such, they emphasise the interconnectedness of the individual with their community and surroundings and the belief that an individual’s identity is closely linked to their family, clan, and community. Hence, their decisions and actions have a significant bearing on their communities. This means that their decision-making processes involve the community as a whole. Important matters are collectively discussed and decided upon, with various members' input. This reflects a consensus-building approach that values the perspectives of multiple individuals. Because of my Karanga background, one of my biggest concerns for the Inini service users and the asylum seekers, refugees, and migrants I witnessed disengaging from services when I volunteered with Coventry Refugee and Migrant Centre was the influence their social environment was having on their decisions to seek help for poor mental health.

Growing up in the village back home, I observed there were different laws for Black and white populations, and the relationship between the two groups was based on dominance and subservience: Black populations were treated as second-class citizens and had no voice whatsoever. Because of this, I developed, early on, an understanding of the power dynamics that exist among groups and the inequalities inherent in society. I also created a curiosity and eagerness to understand people and the world around me. Sadly, the findings of this study revealed the existence, although not so obvious, of similar power dynamics between Black and white populations in England today. These are facilitated through policies and legislation and Eurocentric ideologies that privilege white over Black populations. For example, dominant cultural customs are presented as universal and used to characterise those of Black populations as not qualified for admission into mainstream mental health services. Dominant cultures inform the delivery of mental health services, and poor performances by individuals of Black sub-Saharan African heritage are viewed as a failure on their part to engage with services.

Witnessing the challenges of integration faced by Black sub-Saharan Africans in my practice and listening to narratives of their lived experiences fuelled and fed my innate curiosity to understand the factors that influence their decisions to seek help for poor mental health. By embarking on this study, I aim to inform the development of adequate interventions for this cohort that can be used at Inini Initiative and contribute to the knowledge of good practice in delivering mental health services. I understood that my position and interest in the study could skew its outcome: hence, I took significant measures to ensure that reflexivity was embedded at every stage of the research process. I maintained a reflexive journal where I documented my thoughts, emotions and reflections, and addressed bias of self-reported data by asking probing questions during interviews.

1.5 Research Significance and Research Question

This research is timely and worthwhile. It supports the current world trend calling for the reduction of disparities in access and utilisation of mental health services. It complements the synergy among senior National Health Services (NHS) leaders and commissioners of mental health care in England. The senior officers responded to the Black Lives Matter protests by signing a National Statement of Intent pledging to reduce ethnic inequalities in mental health services (Synergi Collaboration Centre 2020). One of their pledges supported progressive research in this area (Synergi Collaboration Centre 2020). In addition, the National Healthcare Inequalities Improvement Programme (HiQiP), was launched in 2021 to ensure equitable access, excellent experiences, and optimal outcomes for all (NHS 2021). To do this, the programme works with other programmes and policy areas across NHS England and partners in the more comprehensive system, patients, and communities. Additionally, the study responds to Bansal et al. (2022), who call for interpretative research methods to explore the complexity of experiences among people from diverse ethnic backgrounds and gain insight into how ethnic inequalities are formed and perpetuated in mental healthcare.

The research also supports the United Nations General Assembly Agenda (Sustainable Development Goal – SDG 3), which calls for ‘Healthy lives for all’ by 2030 (WHO 2020). Their recommendations for achieving this include the development of coherent, integrated approaches, and they emphasise equity and multi-sectoral action (ibid). As such, the research holds significant implications for both academic and practical purposes. Academically, it contributes to the growing knowledge of good practice in mental health service delivery. By explicitly targeting Black sub-Saharan African communities in the English West Midlands, this study addresses a gap in the current literature. It provides insights that can inform culturally sensitive interventions and policy recommendations. From a practical standpoint, the potential findings of this study will aid mental health practitioners, policy-makers, and community leaders in tailoring mental health services that better suit the needs and preferences of not only Black sub-Saharan Africans but also other global majority communities within the larger population. Acknowledging and understanding their unique cultural contexts and perceptions leads to developing interventions that mitigate barriers. These will enhance awareness and foster an environment where seeking mental health support is acceptable and encouraged. Inini Initiative is a founding member of the Coventry and Warwickshire Cultural Inclusion Network. I am the Independent Chairperson for the Coventry and Warwickshire Mental Health Alliance with access to strategy planning meetings involving senior leadership from major organisations such as Coventry and Warwickshire NHS Partnership Trust, Rethink, Coventry and Warwickshire Mind, NHS England, NHS Confederation and West Midlands Police. I also sit on the Coventry and Warwickshire Mental Health Act Detentions, Coventry Healthwatch, and Coventry Migration steering group committees. Besides sharing the research findings with these groups, they will also be used to shape the design and delivery of mental health interventions at Inini Initiative.

My research aim was to understand why there was a low uptake of mental health services among Black sub-Saharan African communities and the central research questions were:

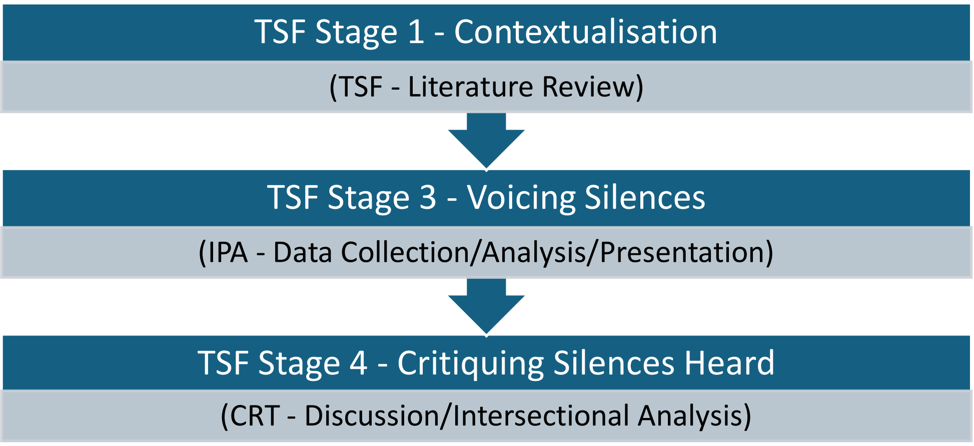
- What socio-cultural and socio-economic issues influence the uptake of mental health services among Black sub-Saharan African communities?
- What beliefs and perceptions do Black sub-Saharan African communities hold towards the uptake of mental health services?

The interview questions, analysis of interview findings, and the theoretical model's development were specifically designed to answer the research questions. I believe that this study is crucial for understanding the factors that influence the decisions to seek help for poor mental health among Black sub-Saharan African communities in the English West Midlands. The theoretical model developed from this study is both relevant and capable of guiding future action on how this population group uses mental health services more effectively. The following section gives a summary of the theoretical framework used.

1.6 Theoretical Framework

The theoretical framework for this study is anchored in ‘The Silences Framework’. Laura Serrant-Green developed this framework to investigate sexual decision-making and risk-taking among Black Caribbean men, and hence, it is suitable for researching health issues in marginalised communities (Serrant-Green 2010). The Silences Framework emerged from the concept of "screaming silences," aiming to identify areas of research and experience that are under-explored, poorly understood, and seldom discussed within the community (Serrant-Green 2004). Hence, it highlights the importance of examining what is silenced or omitted in discourse, shedding light on the power dynamics inherent in these omissions. Due to the complexities of this study, it was employed as a guiding tool to help uncover the hidden narratives and unspoken perspectives among Black sub-Saharan African communities. However, while the Silences Framework comprises five stages, four core and one optional stage designed for action planning in studies aimed at changing service delivery or community action, this study used only three stages. These will be described in Section 1.6.2. In stage three, the study adopted IPA to collect, analyse and interpret the data, while in stage four, the Critical Race Theory was adopted to examine the findings critically. This framework is grounded in exploring racial dynamics and systemic inequalities. It offers a comprehensive approach to dissecting power structures, discrimination, and the role of race in shaping societal narratives. The synthesis of The Silences Framework and the Critical Race Theory provides a robust foundation for a comprehensive examination of why there is a low uptake of mental health services among Black sub-Saharan African communities in the West Midlands of England in the UK. It provides a nuanced understanding of silenced voices, and the racial dimensions involved. Figure 3 below provides a visual representation of the theoretical framework used. Additionally, to help the reader grasp the overall theoretical framework guiding the study, the 'screaming silences' concept, The Silences Framework, and the Critical Race Theory are summarised.

Figure 2 – The Study's Theoretical Framework



1.6.1 The ‘Screaming Silences’ Concept

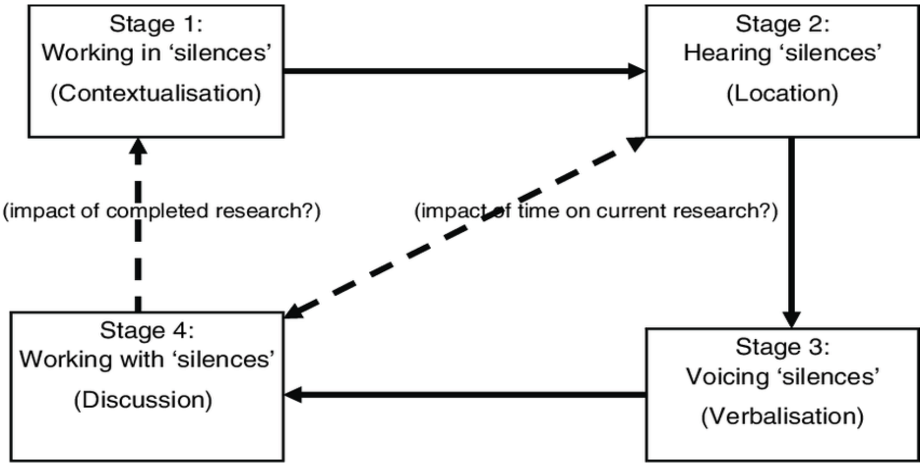
As mentioned in 1.6 above, The Silences Framework was born out of the ‘screaming silences’ concept; a concept derived out of anti-essentialist viewpoints which believe that reality is constructed in given societies based on experiences and contexts, emphasising the idea that there is no one version of reality in existence (Williams and May 1996, Serrant-Green 2011; Phoenix 2013). This theory demonstrates that the ‘screaming silences’ concept values individual and/or group interpretations of events and human experiences as a crucial component of what people perceive as ‘truth’ (Serrant-Green 2011). This aligns with my beliefs and is one of the reasons why I adopted part of The Silences Framework to guide this study. To explain the theory further, what it means is that the main thrust of the concept is that ‘screaming silences’ are situated in the subjective, and therefore, different individuals and groups experience them differently in different contexts and attach different importance to their experiences and contexts (Serrant-Green 2011). The location or broader context in which a subject matter unfolds also significantly shapes the ‘silences’ surrounding it (ibid).

For instance, the effects of power and inequality experienced by individuals and groups within a specific location and time frame influence how ‘silences’ are both created and perceived: certain locations or contexts may amplify or suppress certain narratives, thereby distorting the overall understanding of the phenomenon. In short, it can be said that the listeners (individuals and groups) experience the ‘screaming silences’ in their social and personal contexts and calculate the importance they attach to them. This study's listeners were the Black sub-Saharan African communities in the West Midlands of England, UK. By examining the intersections of their social contexts with their decisions to seek help for poor mental health, the ‘screaming silences’ inherent in their lives were revealed. Doing this is important, as their voices become weapons that can challenge the dominant narratives, thereby contributing to establishing policies and legislation that support the design and development of more inclusive mental health services. This is because when the ‘silences’ of Black sub-Saharan African communities are not heard, their needs are not considered when mental health services are designed. Unfortunately, historical and political dominance in research often allows the perspectives of dominant societies to shape the interpretation and direction of research projects. This influence can determine which studies are funded and conducted, leading to significant gaps where marginalised voices and perspectives—referred to as ‘screaming silences’—are overlooked or ignored (Millen 1997; Pilcher 2001; Serrant-Green 2011).

1.6.2 The Silences Framework

The Silences Framework consists of five stages that are essential for research studies exploring sensitive issues and marginalised perspectives (Serrant-Green 2011). However, for this research, Stage 2 was rearranged, and information regarding the research topic ‘silences’ was written under Chapter 2, while that of the researcher’s identity and research participants was written in Chapter 3 under methodology as required by IPA, which was used in Stage 3 instead of the cyclical research methodology proposed by The Silences Framework. Figure 3 below gives a visual representation of The Silences Framework and a summary of the stages.

Figure 3 –The Silences Framework (Serrant-Green 2011)



Stage 1 – Working in Silences

This is the contextualisation stage where exploration of the literature takes place. It must be situated in the research subject or object and may include exploring the proposed research's cultural, clinical, psychosocial, or moral context. Doing this makes the research project defined, proposed, and located within a certain period and in a specific society. In this study, at this stage, I sought to identify what was known about the barriers to accessing mental health services among Black sub-Saharan African and other global majority communities in

England. Few studies have been conducted on Black sub-Saharan African communities in this area. I also included studies carried out on most global populations outside England. Hence, I explored different perspectives from global majority groups inside and outside England.

Stage 2: Hearing the Silences (Location)

This stage requires the researcher to identify themselves and give reason/s for their relationship to the study and what personal or professional drivers motivated them to conduct the study. It also compels them to identify specific aspects that make the research subject sensitive and identify the 'silences' arising from those voices that have not been included. This stage was rearranged, and the researcher identified herself in this chapter and in Chapter 3, while the silences were also identified in Chapter 3 and in Chapter 4.

Stage 3: Voicing the Silences (Verbalisation)

This stage calls for the data collection and analysis of the research. Instead of the cyclical character method of collecting and analysing data proposed by The Silences Framework, which includes evidence from social networks that are not directly affected by the issue (Serrant-Green 2011), I opted for the qualitative IPA design. This was chosen because of its theoretical elements, which combine hermeneutics and phenomenology (Smith and Larkin 2022). Besides, its interpretative nature is one of the critical philosophical assumptions important in qualitative research (Smith and Larkin 2022), which is the belief that to understand human behaviour, it is important to consider the context in which it takes place, as well as the thinking processes that motivate it when conducting investigations (Parahoo 2006). Since this study was investigating lived experiences, I found it suitable. Thus, at this stage, I described the theoretical underpinnings of IPA, study aims and objectives, insider and outsider perspectives, gave details of the research design, sampling, and data collection, and explored the identified silences in context as presented by participants.

Stage 4: Working with the Silences (Recontextualisation)

This stage incorporates the discussion of the study's findings. As previously mentioned, in this study, I engaged the Critical Race Theory to examine how race and racism influence decisions to seek help for poor mental health and to provide a holistic understanding of what role ‘silences’ play in relation to race and power dynamics in deciding to seek help for poor mental health.

Stage 5: Planning for the Silences

This stage is for action planning and does not apply to all studies but those whose findings are used to change service delivery or community action (Serrant-Green 2011). However, this stage of The Silences Framework was not applied to this thesis, as the aim of the study was to explore how the findings can be implemented to design better services that meet the needs of Black sub-Saharan African communities.

The Silences Framework has been successfully tested and applied in other doctoral studies addressing sensitive issues. Nyashanu (2017) utilised it to explore beliefs and perceptions in the construction of HIV stigma and sexual help-seeking behaviours among Black sub-Saharan African communities. Similarly, Eshareturi (2016) employed the framework in his study titled ‘Mapping The Offender Health Pathway: Challenges and Opportunities for Support Through Community Nursing’. This highlights the relevance and application of The Silences Framework in shaping researchers and research studies at the doctoral level.

All in all, The Silences Framework provided a powerful lens through which I could analyse and understand the ‘silences’ inherent in Black sub-Saharan African communities, which negatively influence their decisions to seek help for poor mental health. By examining their social and economic environment, I unearthed hidden narratives that tell of how their social circumstances influence their decisions to seek help for poor mental health. Thus, applying this framework to my research study exposed the determinants that shape, influence, and inform both individual and group understandings of the uptake of mental health services behaviours.

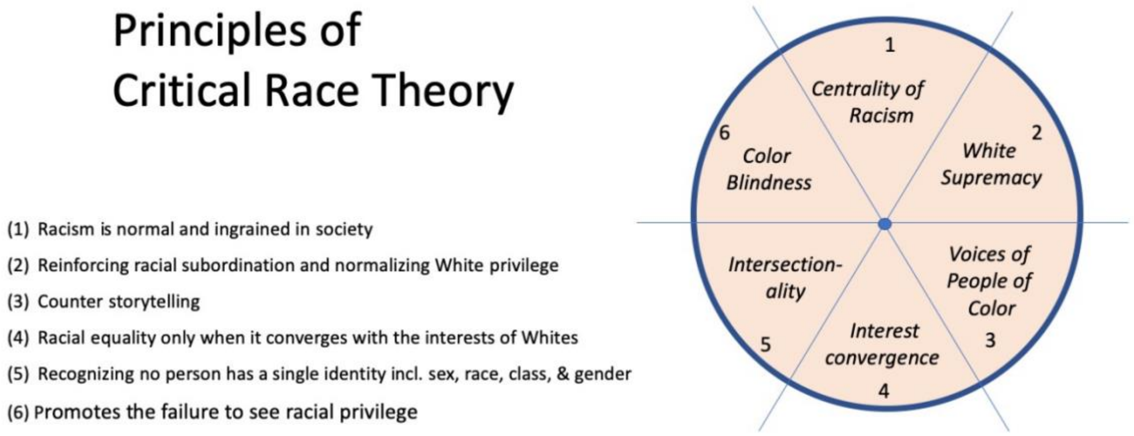
The following section will give a summary of the Critical Race Theory.

1.6.3 The Critical Race Theory

In addressing the central research questions outlined in Section 1.4, I also developed an appreciation of the Critical Race Theory, a theory established to challenge dominant systems of racial oppression and support the amplification of marginalised voices (Graham et al. 2011). The Critical Race Theory is a complex and evolving field of study that originated in legal scholarship in the United States in the 1970s and 1980s (Freeman 2011; Delgado 2008). Professor Derrick Bell, a critical legal studies scholar, is credited as its architect. However, cumulative work by different scholars, including Richard Delgado, Charles Lawrence, Mari Matsuda, Patricia Williams and Kimberlé Crenshaw, make up the Critical Race Theory known today (Khalifa, Dunbar and Douglas 2013; Hughes, Noblit and Cleveland 2013). The theory is based on 'racial realism' and explains the long-standing continuity of racial inequality better than theories grounded in assimilationist, cultural, or progress paradigms. It argues that those affected by racism do not have any illusions about its existence as purported by other theories, such as the assimilation theory, which acknowledges that racial boundaries are fluid, shifting, and blending, and it accepts the prevailing distribution of societal power as the limits of possibility (Jung 2009; Treitler 2015). In a similar vein, boundary theorists often attribute varying forms of agency to different racial groups while neglecting the influence of racial structures. This perspective tends to conceptualise the agency of racial groups as an unconstrained array of choices, overlooking the structural constraints they face (Ray 2019; Treitler 2015), and the Critical Race Theory does not support this.

The Critical Race Theory can be viewed as a movement involving scholars committed to challenging and upsetting racism and its associated social, legal, political, and educational connotations (Taylor 1998). It works to understand and challenge how racism functions in society and does this by looking into under-served communities' experiential knowledge (Delgado and Stefancic 2017) and scrutinising how race and racism, directly and indirectly, affect them (Yosso 2005; ibid). The framework begins with several basic understandings, such as, 'racism is normal and ingrained in today's society' and 'racial subordination is reinforced, and white privilege normalised' (Freeman 2011; Delgado 2009). However, scholars describe the Critical Race Theory themes as slightly different but with the same meanings. This study focused on the six tenets shown in Figure 4 on the next page.

Figure 4. Critical Race Theory



Principles of
Critical Race Theory

(1) Racism is normal and ingrained in society
(2) Reinforcing racial subordination and normalizing White privilege
(3) Counter storytelling
(4) Racial equality only when it converges with the interests of Whites
(5) Recognizing no person has a single identity incl. sex, race, class, & gender
(6) Promotes the failure to see racial privilege

(Freeman, 2011; Delgado, 2009; Montoya, Matias, Nishi, & Sarcedo, 2016; Lynn & Parker, 2006; Fernando & Rinaldi, 2017; Khan, 2016; Gander, 2006)

While it is acknowledged that racism encompasses an enormous scope, it is worth mentioning that the racism discussed in this study is the one between Black and white populations, emphasising the historical divide between sub-Saharan Africa and England as a key context for this analysis. This distinction is relevant because racial hierarchies in these regions have been historically constructed and maintained, shaping systemic inequalities. While racism operates through broader power structures, this study specifically examines how Black communities experience racism from white-dominated institutions and individuals. Although racism is not always a simple binary, the focus here remains on the structural and interpersonal racism Black populations face from white populations. While acknowledging that Black individuals may also experience discrimination from other groups, this thesis primarily explores anti-Black racism perpetuated by white communities, situating it within the historical and institutional contexts that sustain these racial divisions.

In conclusion, the Critical Race Theory seeks to understand and challenge how race and racism function. Therefore, it is committed to social justice and aims to dismantle systems of oppression and eliminate racial inequalities. This study presents narratives from Black sub-Saharan African communities' viewpoints on how cultural, social, and personal factors intersect and negatively affect their decisions to seek help. This paves the way for discussing more equitable and effective mental health services.

1.7 Structure of Thesis

The thesis is structured according to the stages of The Silences Framework, which partially guides the research study (Serrant-Green 2011). The following description outlines each chapter of the thesis. Chapter 1 sets the context by detailing the background of the study, along with the rationale and influences that motivated me to undertake this research. It also presents the theoretical framework before offering an overview of the study. While it is uncommon to discuss the theoretical framework before the methodology chapter, the structure of The Silences Framework allows for its presentation prior to Stage 1, the literature review chapter.

Chapter 2 follows Stage 3 of The Silences Framework to provide context to the study. It starts by giving an overview of the historical relationship between sub-Saharan Africa and England, followed by an overview of the positions occupied by Black sub-Saharan African communities in England today. This helps the reader understand the historical and current power dynamics between this group and the dominant white English populations and institutions. The chapter provides an overview of the English mental health system before exploring what other researchers discover in their investigations and publish about the topic. The literature review highlights racism, discrimination, and other social challenges, such as access to education, employment, and housing, acting as barriers to seeking help for poor mental health among Black sub-Saharan African communities.

Chapter 3 engages IPA in the collection and analysis of data. It starts by describing the theoretical underpinnings of the methodology and outlines the study's aims and objectives, followed by the ontological and epistemological positions, details of the research design, and the researcher's insider and outsider perspectives. The chapter also offers the methodological perspective of the study, including sampling and data collection strategies. It explores the identified silences in context as presented by participants in the research and concludes by detailing how the participants' and researcher's well-being are considered.

Chapter 4 presents my interpretations of the meanings participants construct and attribute to their lived experiences. These reveal a nuanced landscape of beliefs and perceptions deeply rooted in social, cultural, and historical contexts in two superordinate themes.

Chapter 5 employs Critical Race Theory to critically analyse the findings and highlights how the functioning of institutions, which is based on the values, principles, and foundations of dominant cultures, creates barriers to seeking help for poor mental health. This sustains inequalities through subjective bias and/or the privileging of specific cultural orientations over others. The chapter provides recommendations on how the uncovered silences can be addressed, considering the findings and limitations of the study. Following this, I detail the opportunities for future research by conducting this study before highlighting its contributions to the existing body of knowledge, including theoretical contributions. The chapter concludes by outlining the researcher's benefits of carrying out the study.

Chapter 6 concludes the thesis. It summarises its contents and reflects on my research on Black sub-Saharan African communities and their uptake of mental health services.

1.8 Conclusion

In conclusion, this chapter has outlined the importance of understanding the factors affecting the decisions to seek help for poor mental health among Black sub-Saharan African communities. It started by introducing the thesis and structure of the chapter and went on to define the terms used. This was followed by the background of the study, which confirmed its significant relevance. This section summarised the mental health situation of global majority populations, highlighting the challenges they face, including cultural barriers, socioeconomic factors, and systemic obstacles such as racism that hinder their access to mental healthcare. In addition, it also highlighted how the topic has been a subject of discussion for over six decades and yet more change has yet to be realised. The following section explained the researcher's position and her interest in the study which she followed by highlighting the research significance and research questions. After this, she gave a detailed summary of the theoretical framework used, which set the foundation for the thesis. The section touched on the concept of 'screaming silence', The Silences Framework, and the Critical Race Theory, and the chapter concluded by offering a structure for the whole thesis.

The next chapter gives an overview of the historical relationship between sub-Saharan Africa and England, the environment occupied by global majority communities in England, the English mental health system, and a review of the existing literature before presenting the identified gaps in knowledge and the need for research to address the challenges.

Chapter 2: Literature Review

“Inequality is the root of social evil” — Pope Francis

2.1 Introduction

The production of this chapter is guided by Stage 1 (Working in Silences) of The Silences Framework. It aims to establish the tone for this study by contextualising the broader social, economic, and political characteristics experienced by Black sub-Saharan African communities in the West Midlands of England in the UK, while also identifying existing knowledge related to the research subject. The chapter starts by offering the search strategy used to determine the literature included in the review, followed by a description of how the themes discussed emerged. To give context to the study, the chapter first provides an overview of the long-standing relationship between sub-Saharan Africa and England, followed by an exploration of the positions occupied by global majority communities in England. Here, the debate focuses on their experiences of the socio-cultural and economic environment to provide understanding as to what factors influence their decisions to seek help for poor mental health. The sixth section of this chapter describes the English mental health system, followed by an overview of the mental health situation of the global majority communities in the United Kingdom (UK), including the perceived barriers to accessing mental health services among these groups. Here, the study broadens its focus to global majority communities because few studies have been carried out on the uptake of mental health services among Black sub-Saharan African communities in England. Also, most studies on utilising mental health services among most global communities were conducted in the United States of America. Hence, besides studies conducted on Black sub-Saharan African communities, the review will include studies on global majority groups inside and outside England. While it is acknowledged that the English health system’s operational structure is different compared to other health systems globally, this review recognises that mental health histories of global majority communities often follow similar trajectories regardless of how the mental health system is structured and which countries they are resident (Bhui et al. 2003; Galvan et al.

2017; Jankovic et al. 2020). The chapter concludes by highlighting the gap in the literature the study is looking to close.

2.2 Search Strategy

The researcher consulted the internet, libraries, and bibliographies of pertinent literature and databases such as Psych Info, Google Scholar, Medline, PubMed, as well as, mental health journals, and PhD theses to find relevant literature. A broad range of articles were published from 2004 until 2024, emphasising barriers and facilitators to access and utilisation of mental health services among Black communities and other global majority communities and the literature search continued until submission date to make sure that all relevant and current literature was included. Literature from legacy studies were included due to the paucity of studies investigating this topic area on individuals of Black heritage. Search terms for the review were themed around racism, discrimination, migration, unemployment, poverty, education, housing, crime and policing, hostile environment, fear, and policy, and their links to mental health and uptake of mental health services. The themes emerged based on the literature exploration and the researcher's discussions with service users of the Inini peer support group, whose members are predominantly of Black sub-Saharan African heritage. It is in this space, where the idea of embarking on this study first emerged. The themes were later discussed and agreed upon with her supervisory team. Please note, in searching the literature, the term 'Black and minority ethnic' (BAME) communities was used in place of global majority populations because most literature used this term instead of the more up-to-date 'global majority' term.

2.3 Historical Relationship between England and sub-Saharan Africa – An Overview

The Silences Framework guiding this research suggests the characteristics of the situation where research takes place be explored (Serrant-Green 2011). The Critical Race Theory supports this study by critically analysing its findings, which says that to allow for historically based analyses of racial ideologies and practices, besides reviewing the literature, researchers should also provide their historical contexts (Rich 1986). To give context to the study, this section will provide an overview of the historical relationship between England and sub-Saharan Africa. It outlines the features of colonialism, including medical colonialism, capitalism, globalisation, and coloniality, as well as their implications on the social, political, and economic situation of Black sub-Saharan African communities in England and the UK, setting the context for the positions they occupy in this country as discussed in section 2.4. Understanding this information may give insight into the reasons why there is a low uptake of mental health services among Black sub-Saharan African communities in the West Midlands of England, UK. This also considers Fanon's (1986) powerful account, which emphasised how the collective and personal experiences of individuals of African and African Caribbean descent are inextricably linked to histories of colonialism, racism, and social injustice: factors that all contribute to psychological harm.

Sub-Saharan Africa describes the region that lies geographically south of the Sahara. It is a remarkably diverse continent comprising 1.2 billion people and has the world's youngest and fastest-growing population owing to the decline in infant mortality (UNDP 2019). The region doubled its population between 1990 and 2013 (World Bank 2015). The total number of countries in sub-Saharan Africa is confusing. The United Nations Development Programme lists 46 of Africa's 54 countries by excluding Algeria, Djibouti, Egypt, Libya, Morocco, Somalia, Sudan, and Tunisia (United Nations 2020), while the World Bank lists 48 countries by adding Sudan and Somalia to the UNDP list (World Bank 2021). This study will use the World Bank's list.

England, on the other hand, is part of three countries (the other two being Scotland and Wales) that make Great Britain, the largest island of the British Isles situated in Western Europe. Its population is estimated at 56,550 million, and 2.5 percent of this is said to be made up of people of sub-Saharan African origin living in England (UK Government 2022).

England and sub-Saharan Africa have a relationship dating back to the 17th century when England was leading in transporting millions of enslaved Africans to British colonies (Walvin 1992). When the slave trade was finally abolished in the late 18th century, she and other European countries colonised the continent. By 1914, they had occupied almost 90% of the continent, exploiting it economically (Austin 2016). These acts are blamed by some academics for negatively affecting the region's development, reducing its prosperous empires, and stalling ground-breaking advances in architecture, mathematics, and metalwork (Bertocchi and Canova 2001). Almost five hundred years later, sub-Saharan Africa is still on its knees and the poorest region in the world (Juju et al. 2020). In 2018, 40% of the continent lived below the poverty line, accounting for two-thirds of the global impoverished population (ibid).

For this reason, sub-Saharan Africa is said to have slowed down the United Nations Development Programme's (UNDP) Sustainable Development Goal 1 (SDG-1) commitment to eradicating poverty by 2030 (Schach and Lakner 2020). Poverty has been a cause for concern for the United Nations for many decades, and at the 2015 global summit, member states adopted SDG-1, committing to eradicate extreme poverty globally by 2030 (ibid). In aiming to go further to end all forms of poverty, not only did member states pledge to not leave anyone behind but also to support those lagging far behind (ibid).

While various factors, including poor governance, corruption, and high population growth, are often identified as the drivers holding sub-Saharan Africa back, other researchers argue that it was the way colonialism manipulated its political, social, and economic contexts which is the leading cause of sub-Saharan Africa’s problems (Rodney 1972; Poesche 2019). Furthermore, colonial powers are said to have continued to manipulate them even after granting independence (Kyriakides and Virdee 2003). The countries received direct political control at independence while the power of economic and human resources remained firmly in their hands (ibid). A good example is that of France, who, six decades after granting independence to her colonies, has continued to have access to their resources and markets, and yet they are among the poorest nations in the world. This continuing legacy of colonialism may be one of the explanations why in the UK, health inequalities have continued unabatedly for so long.

Reports in the literature highlight colonialism as having been based on the white supremacy ideology (Bond and Inwood 2016). Scholars define this as an ideology rooted in the superiority of white racial identities and ideologies in support of the cultural, political, and economic domination of non-white groups (ibid). Proteges, of this ideology, believe in racial hierarchy and that white populations are superior and should have greater power, privileges, and rights over other races (Graham 2011). When Europeans, including the English, arrived in sub-

Saharan Africa, they looked down upon the indigenous people and their beliefs, thoughts, traditions, religions, and cultures, casting them as paganism to be destroyed and replaced by superior European values (Chikowero 2015). Missionaries were used as key agents, condemning practices like traditional marriage practices, initiation rites, spirituality, medical knowledge, and healing practices (ibid), and their attitudes and actions impacted on the indigenous people's consciousness and sociocultural security (Comaroff and Comaroff 2008). This destroyed their self-worth and changed their psychosocial worldview (ibid). Hence, it can be said that the relationship between England and sub-Saharan Africa changed the way sub-Saharan Africans perceived themselves and the world around them (Bakewell 2011). They may have internalised inferiority as the relationship was based on dominance and subservience engineered by the white supremacy mindset (Binagwaho, Ngarambe and Mathews 2022). The Europeans took away power from the indigenous populations and left them with limited influence and decision-making authority (Rodney 1972). This may explain the reason why there is a low uptake of mental health services among populations of Black heritage in the UK. While they may have solutions to remove the barriers stopping them from accessing and utilising mental health services, they may lack the power to implement those solutions. Also, those holding power may be looking down upon their ideas. However, the continuing legacy of colonial history was identified as one of the factors negatively influencing the uptake of mental health services among individuals of African descent in England (Lankelly Chase Foundation 2013).

Once in control, the colonial powers introduced capitalism, which brought about significant changes to the economic and social structures of the region (Rodney 1972). One of the key factors through which capitalism was introduced was exploitation through the exportation of extracted sub-Saharan Africa's natural resources, such as timber, minerals, and agricultural products, to the colonial powers' home countries for their benefit (Dauncey, Desai and Potter 2024). Similarly, traditional subsistence farming practices were transformed by introducing cash crop agriculture such as cocoa, coffee, rubber, and palm, which they exported to global markets for their benefit (Monga and Lin 2015). This type of farming required vast amounts of rich land, so colonialists implemented policies that involved appropriating rich land from indigenous communities (ibid). Because this type of farming required colossal labour, the colonial powers exploited indigenous people by imposing forced labour, indentured servitude or enforcing harsh labour conditions (Boone 1992). To justify this, they introduced legal and governance power systems such as property rights, contract law, and commercial regulations, all designed to support capitalist practices and facilitate European control and exploitation of resources (ibid). Colonialists also introduced financial institutions, such as banks and currency systems, to promote trade and extract wealth from their colonies (Idemudia and Bonkhe 2020). These institutions were mainly designed to serve European interests and were often biased against indigenous populations (Boone 1992).

To avoid a power struggle amongst themselves, the colonial powers had their representatives meet in Berlin at a conference to be later known as the Berlin Conference and drew colonial boundaries, made decisions on matters such as, trade rights and control of major rivers. The borders drawn reflected colonial conquests and disregarded the ethnic ties of the indigenous people. Hence, the colonialists defined their powers by the territories they controlled, and the borders defined the extent of that authority and made it easier for them to collect taxes, implement social policies, run military services and other social, political, and economic concerns (Blakewell 2020). Fourteen countries were represented, and the major players included Great Britain, France, Germany, and Portugal. However, no African country was represented at this conference highlighting how Black sub-Saharan Africans were taught to be quiet early on.

Moreover, besides borders, the landscape of the region, including religion and language, was also changed, and colonial powers introduced the principle of divide and rule, which has helped them maintain the status quo until today (Idemudia and Bohnke 2020). The same strategy has worked to maintain existing rivalries among Black sub-Saharan African nations facilitating the outbreak of ethnic wars as they fight over borders (ibid). Unfortunately, this has further underdeveloped the continent, creating poverty and motivating migration. A study by Zhang, Xu, and Kibriya (2021) examining the long-term legacy of the slave trade on contemporary violence and national identity among sub-Saharan Africans in the US concluded that the slave trade has enduring effects on ethnic conflict and national identity. However, it is important to note that this study focused solely on the impacts of the slave trade, but its findings can be extended to the effects of colonialism since both histories often follow similar trajectories (Swan and Raphael 1995; Czyzewski 2011).

The environmental disruptions created by colonial powers while appropriating rich land for their farming projects brought about a considerable amount of disease burden to sub-Saharan Africa and to eradicate this, they adopted the civilise, improve, and develop mandate (Tilley 2016). This involved discarding traditional sub-Saharan African healing practices and setting up governance structures that promoted Eurocentric ideologies in the health sector (Wesseling 1996). Colonial powers such as Britain, France, Belgium, and Portugal viewed their practices as superior and sought to 'civilise' indigenous populations through their imposition. Hence, similar to what colonial powers did with capitalism, where they introduced legal and governance power systems to support capitalist practices (Idemudia and Bonkhe 2020), they established civil and criminal laws to challenge traditional medicines, particularly those that emphasised connections to ancestors and the spirit world (Tilley 2016). Furthermore, the health policies implemented were designed to serve European settlers and the workforce needed for colonial interests rather than those of the local populations (Au and Cornet 2021). This caused harm to the affected indigenous individuals because it undermined and devalued local medical knowledge and practices (Naidu 2021). However, this act of imposing medical practices and public health policies by colonial powers, known as medical colonialism, was not conducted in sub-Saharan Africa alone but in many colonies worldwide (ibid). Therefore, the history of medical colonialism concerns not just sub-Saharan Africa but the world. As such, and due to a lack of resources, colonial powers failed to eliminate traditional medicines, and medical pluralism ultimately remained the norm (Tilley 2016).

However, medical pluralism brought a dichotomous belief in the causes and treatments of mental illness that still exists today (ibid). In their study exploring explanatory models of mental illness in Ethiopia, Teferra and Shibre (2012) found this to be true. While some individuals believe in Eurocentric ideologies, which emphasise biological and psychosocial factors, others believe in the African traditional supernatural and religious factors (Teferra and Shibre 2012). This is supported by the findings of Crawford and Lipsedge (2004) study, which found that the Zulu-speaking people of South Africa locate both the source of mental illness and treatment in the community, while Western psychiatry locates the source of the disease in the person. As such, those subscribing to the former advocate that Black sub-Saharan Africans be treated within the framework of their culture and belief systems (Mosotho et al. 2011), while the latter view this as primitive and inferior, calling for the sensitisation of people to Western knowledge (Sharkawy, Newton and Hartley 2006) and use of modern treatment (Osungbade and Siyanbade 2011). However, being that as it may, medical pluralism may explain the low uptake of mental health services among Black sub-Saharan African communities in England, as some may favour being treated within the frameworks of their culture and belief systems. This supports a legacy study investigating the role of socialisation on current trust levels, which argues that trust levels around vaccination are also shaped by cultural traditions inherited from earlier generations and largely determine whether parents will vaccinate their children (Athias and Macina 2022).

Hence, historical narratives on how indigenous people were treated by colonial powers in clinical experiments may also act as a deterrent to Black sub-Saharan African communities accessing and utilising mental health services from mainstream mental health service providers today. When Europe colonised sub-Saharan Africa, it was at a time when germ theories of disease were beginning to predominate various parts of the world and this, combined with the burden of disease brought about by the environmental disruptions mentioned above, called for the production of pharmaceutical treatments and vaccinations (Tilley 2016). To do this, medical experiments had to be conducted, and Europe turned sub-Saharan Africa and many of their colonies into an experimentation arena (ibid). Indigenous people were used as research material without regard for research ethics (ibid). This trend continued for centuries, and as late as 1955, a senior British physician from Oxford University, Smith (1955) described Africa as a vast and rich source for clinical research, reflecting colonial-era scientific attitudes (*n.p.*). It is said that during this period, some clinicians and researchers deceived, manipulated, coerced, and even threatened their research subjects to achieve their investigative goals; if diagnostic tools and treatments caused pain or permanent disabilities, they were still used (Graboyes 2015). Furthermore, individuals adversely affected during these campaigns had no access to care or assistance and relied on their families and communities for support (ibid).

One good example of medical colonialism is the Tuskegee Syphilis Study that was conducted in the United States 1932 – 1972 (Jones 1993). African American males were used in a long-term experiment to study the effects of syphilis without their informed consent, illustrating a profound disregard for their well-being and autonomy (Reverby 2022). What is disturbing is that they were deliberately left untreated to study the progression of the disease and that researchers allowed the experiment to run for 40 years when treatment (penicillin) was discovered 10 years into the experiment (Jones 1993). Similarly, a poor farmer, Henrietta Lacks, had her cancer cells taken without her knowledge or consent at Johns Hopkins Hospital to become the HeLa cell line, a crucial resource for medical research today (Wolf 2011). This exemplifies the exploitation of marginalised individuals to advance medical science (Skloot 2010). In a White House ceremony on 16 May 1997, President Bill Clinton apologised for the racism shown by the American Health Services in the Tuskegee Syphilis Study (Gamble 1997). It is not difficult to imagine how narratives like these once communicated to Black people are crystallised in their minds creating fear and mistrust of healthcare services, especially seeing how some of these scientists are openly glorified today. Reminders of the atrocities are almost everywhere in the form of statues and writings glorifying medical professionals who performed them such as, American gynaecologist Marion Sims who has a marble colossus in New York's Central Park, adjacent to New York Academy of Medicine paying tribute to him for his contribution to gynaecology. Part of the marble colossus reads:

> *"…. whose brilliant achievement carried the fame of American surgery throughout the entire world".*

Sims, also known as the father of modern gynaecology, is famously known for his contribution to gynaecology (Mitchell 2005). He, however, is infamous (at least to Black people and their allies) for trialling his vesicovaginal repair fistula treatment on three Black women, where he performed approximately 30 painful operations on each with no anaesthetic (ibid). Seeing tributes being paid to people like him, who caused so much pain and suffering to individuals of Black heritage must be frustrating to them as evidenced by the removal of many paying tributes to slave traders, colonialists and racists across the UK following the Black Lives Matter protests in 2020 (Graham 2022). The memories of the ills of slavery and colonialism must be hard for Black people to shake off and manifest as lack of trust for Eurocentric healthcare services.

However, some researchers argue that it is not only individuals of Black heritage but people from all ethnicities who consciously or unconsciously carry ancestral baggage of history

(McKenzie-Mavinga 2009). This probably explains why the research director at the French National Institute of Health and Medical Research, Inserm, Dr Camille Locht was overheard in a conversation, regarding the production of the COVID-19 vaccine with the Head of the intensive care unit at Cochin Hospital in Paris, Dr Jean-Paul Mira, as saying:

> *"If I could be provocative, shouldn't we be doing this study in Africa where there are no masks, no treatment, no intensive care, a little bit like we did in certain AIDS studies or with prostitutes" – (*BBC 2020).

Dr Camille Locht apologised for this and said he was misunderstood (BBC 2020). However, to Black sub-Saharan African communities, whose history narrates similar trajectories, utterances like these may negatively affect their perception and use of healthcare services, including mental health services. Besides, there is some truth in him saying that AIDS and prostitute studies were conducted by Europeans in sub-Saharan Africa (Pisani 2009), making it difficult for Black sub-Saharan Africans to dismiss this as just a rumour.

The Vaughan (1991) book has an interesting take on the Western view of sub-Saharan Africans. Referring mainly to British dependencies in East and Central Africa in the late 19th to the mid-20th century, it co-constructed their superstitiousness as mad or bad. This gave them power to dominate over them and impose their Western health frameworks and treatments. Medical colonialism in mental health practices established asylums, for example in India, to manage what they saw as the 'madness' of the local population often ignoring the indigenous understandings of mental health (Ernst 1991). European psychiatrists focused on social control rather than therapeutic care and dismissed local beliefs about mental illness as superstitious or irrational (McCulloch 1991). Hence, instead, they imposed Western diagnostic categories and treatments, sometimes exacerbating the distress of the individuals they were meant to help (ibid). In Canada and North America, indigenous children were forcibly removed from their homes and placed in residential schools, where they were subjected to cultural assimilation and psychological abuse (Truth and Reconciliation Commission of Canada 2015). The trauma from these experiences has had long-lasting effects on the mental health of Indigenous communities.

The lasting impacts of the cases mentioned above are worth adding to this background context, as the legacy of medical colonialism has contributed to a deep-seated distrust of medical institutions among marginalised communities. This mistrust is evident in the hesitancy of some populations to participate in medical research or vaccination programmes (Petryna 2005). Evidence in the literature shows that current levels of trust are linked to cultural traditions inherited from earlier generations (Bisin and Verdier 2001; Athias and Macina 2022). In a study conducted in the US on the impact of slavery on the uptake of health interventions, researchers examined the relationship between ancestors' exposure to the slave trade and children's vaccination against measles. They found that children whose mothers had ancestors exposed to the slave trade were less likely to be vaccinated compared to children living in the same area whose mothers belonged to an ethnic group that was free from the slave trade experience (Athias and Macina 2022). While the study was carried out on the effects of the slave trade, its findings can be extended to the impact of colonialism since the histories often follow similar trajectories. It shows how the effects of racism have been passed from generation to generation causing intergenerational trauma.

Sadly, the legacy of colonialism and the intergenerational trauma it comes with was found to be a recurring theme in the exploration of race and ethnicity across the world (Lankelly Chase Foundation 2013; Swan and Raphael 1995; Czyzewski 2011). The discipline is gaining momentum in America and experts in race-based traumatic stress define it as the emotional and psychological trauma caused by discrimination and racism, eliciting responses similar to those associated with post-traumatic stress injury (Carter 2007). This can be expressed through anxiety, anger, rage, depression, low self-esteem, or shame, and it may manifest as depression, fatigue, disease such as high blood pressure or diabetes, or mental disorders (ibid). This is supported by Joy DeGruy (2005), whose work defines post-traumatic slave syndrome as, 'a condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continues to experience oppression and institutionalised racism' (Sobers 2023). This is said to impact collective mental well-being, identity, and self-esteem and manifest in second and third generations as self-doubt, aggression, stress and several other psychological and interpersonal relationships (ibid). This may be the case for Black sub-Saharan Africans in the West Midlands of England, UK.

Unfortunately, white supremacy cannot be relegated to historical contexts (Bonds and Inwood 2015) as it continues to be employed today as subtle forms of systemic violence that uphold the privileges that white populations, consciously or unconsciously, enjoy at the expense of Black communities (Binagwaho, Ngarambe and Mathewos 2022; Czyzewski 2011). This has led to the establishment of a system that offers improved access to education, healthcare, security, housing, loans, and a fair justice system, among other benefits (Binagwaho, Ngarambe and Mathewos 2022). Reports in the literature show that some groups are disempowered, leading to social defeat and demoralisation, a lack of trust in mainstream services, social exclusion, and a lack of political influence: this is evident in global majority populations worldwide, particularly those who are from former colonies (Bhui, Halvorsrud and Nazroo 2018; Czyzewski 2011).

Besides, colonialism was followed by a period of neo-colonialism where colonialists continued to hold power over sub-Saharan Africa. Neo-colonialism describes the indirect control and influence exercised by former colonial powers and other developed nations over developing countries, often through economic and political means (Ferro 1994; Helland and Lindgren 2016). Various factors of colonial relations that have produced and continue to reproduce unfavourable conditions and environments have been identified to include capitalism which in the first decades of the twentieth century replaced free competition to become a monopoly (Kemp 1967). This was characterised by the integration of banking and manufacturing capital into finance capital organised and owned by multinational corporations linked to colonial powers (Vickers 2010). This created a scenario in which multinational organisations grew wealthier from returns on capital invested in poorer countries, while the latter became increasingly impoverished and dependent on the former (Lenin 1975; ibid), establishing patterns of migration and settlement that persist today. Between 1997 and 2007, Britain's overseas assets increased more than threefold, reaching £6,357.9 billion—more than four and a half times its GDP (Yaffe 2006; Madden 2009; Vickers 2012). This shows exploitation on the part of Britain and may explain why the UK is struggling with immigration today.

In the 1980s, globalisation put intense pressure on developing countries including those in sub-Saharan Africa resulting in increased unemployment, reduced social spending, and a decline in living standards (Idemudia and Bonhke 2020). To mitigate against these problems, they were sold by the World Bank and International Monetary Fund, economic structural adjustment programmes which proved to have an opposite effect pushing those countries that adopted them further into poverty and debt (Allison 2018). Repayments to the loans have, on average, tripled as a percentage of national expenditure for many countries, from 4% in 2013 to a massive 12% in 2017 (Idemudia and Bohnke 2020). A good example of poor countries depending on colonial power capital investment is Ghana, who the International Monetary Fund present as one of their 'success stories'. Since gaining independence in 1957, Ghana has not been able to break away from its dependency on cocoa exports and by 1990, having completed sixteen structural adjustment programmes from the institution and the World Bank, her external debt stood at USD5.3 billion. To try and recover financially, she diversified and opened herself for timber extraction reducing her tropical forest to a quarter of its original size, which destroyed wildlife that provided food to most of the population and the trees which were relied upon for fuel and medicines.

Thus, from the narratives above, it can be seen that although England and other European colonial powers have mostly granted sovereignty to their former colonies, coloniality has persisted (Poesche 2019). The distinction between the two lies in that colonialism involves one state exerting economic and political control over another nation through direct colonial administration, often imposed against the latter's will. In contrast, coloniality pertains to a social order established on the enduring power structures and hierarchies stemming from colonialism (Kaltmeier 2016; Ndlovu-Gatsheni 2012). As previously mentioned, upon independence, colonies gained direct political control, while economic control remained firmly in the hands of colonial powers. Prime agricultural land, rights to mineral exploration and extraction, and overall ownership were concentrated in multinational corporations based in the home countries of these colonial powers (Kyriakides and Virdee 2003). Moreover, except for southern Africa, colonial rulers were replaced by local elites aligned with colonial powers' interests, thereby perpetuating colonialism (Ferro 1994; Helland and Lindgren 2016).

The narratives also show that a combination of factors have created and maintained poverty and unemployment in sub-Saharan Africa, making it the poorest region in the world (Juju et al. 2020). This high incidence of poverty denies millions of sub-Saharan Africans a decent livelihood solidifying inequalities and injustices. Africa is blamed for slowing down the commitment to eradicate poverty by 2030, interfering with the Sustainable Development Goal (SDG 3) adopted by the United Nations member countries in 2015 (Schach and Lakner 2020). In 2018, 40% of the region's population lived below the poverty line, accounting for two-thirds of the global impoverished population (Asongu and Le Roux 2018). Before the Sustainable Development Goals era (2015-2030), a tremendous global poverty reduction of 50% was achieved from what it was in 1990, through the Millenium Development Goals (2000-2015) but its effect on sub-Saharan Africa was insignificant (Anyanwu and Anyanwu 2017). As a result, the region remains the poorest in the world, having surpassed Asia in this regard in 2019. Its development levels are extremely low across nearly all indicators. In 2009, thirty-one of its countries were ranked among the bottom thirty-three in the Human Development Index, which measures income, literacy, and life expectancy (UNDP 2009).

Besides chronic poverty, there are ongoing humanitarian crises across sub-Saharan Africa, and its health systems are too limited in coverage (Idemudia and Bohnke 2020). The region has also been subjected to severe stress through HIV-AIDS, Ebola and most recently, Covid-19. The legacy of colonialism has maintained the region in a perpetual state of challenges such as, the genocide in Rwanda, ethnic wars in Sierra Leone, Liberia and Congo, and the disintegration of Somalia (Addison, Pikkarainen, Ronkko and Tarp 2020) caused by the legacy of colonial borders that were drawn to mark colonial conquests (Idemudia and Bohnke 2020). This has resulted in grievances over scarce or unevenly distributed resources, coupled with frustration at the diminishing ability of states to ensure socio-economic security, which has led to ethnic conflicts, and in turn, migration (Idemudia and Bohnke 2020; Bilger and Kraler 2005; de Bruijn et el. 2001; de Haan and Rogaly 2002). These may be some of the reasons why Black sub-Saharan Africans leave their home countries to go and seek a better life elsewhere, including in England. This further under develops the region, maintains poverty, and motivates migration.

In summary, it can be seen that the historical relationship between sub-Saharan Africa and England as part of the European countries that invaded the region, was one of dominance and exploitation where the latter benefitted from plundering the former's labour and resources. Europeans used the white supremacy mindset to dominate over sub-Saharan Africa. This is an ideology that supports racial hierarchies and believes that white populations and their cultural, political, and economic ideologies are superior to those of non-white populations. They took away power and left them with limited influence and decision-making authority and in turn, introduced capitalism to exploit the region through exportation of sub-Saharan Africa's natural resources and at the same time, erected financial institutions that were designed to serve European interests. Similarly, in delivering health services, they set up governance structures that promoted Eurocentric ideologies and challenged sub-Saharan African healing practices, concluding that sub-Saharan Africans needed civilisation in this area. In addition, they used them as research material with no regards for research ethics and ignored to compensate them where pain and permanent debilities were experienced.

Unfortunately, the trauma from these experiences has had lasting effects on the mental health of sub-Saharan African communities, a recurring theme observed in the exploration of race and ethnicity worldwide (Rich 1986; Back and Sholomos 2009). White supremacy continues to be used today, both consciously and subconsciously, as subtle forms of systemic violence that maintain the privilege of white at the expense of Black populations (Binagwaho, Ngarambe and Mathewos 2022; Czyzewski 2011). Colonialism was followed by a period of neo-colonialism where colonial powers continued to hold power over sub-Saharan Africa by having multinational organisations operating in the region, using its resources, including labour, at low cost, thereby enriching themselves while sub-Saharan Africans became poorer and more dependent upon Europe (Lenin 1975; Vickers 2010). As such, this continued dominance over sub-Saharan Africa through the use of power that produced knowledge, identities, and social realities that shape the way its indigenous people understand themselves and the world, motivated the use, in Chapter 5, of the Critical Race Theory to interrogate the influences of race, racism, and power dynamics in making decisions to seek help for poor mental health by Black sub-Saharan African communities in the West Midlands of England in the UK.

The high incidences of poverty across sub-Saharan Africa have, among other things, ignited political instability, environmental degradation, and public health issues, motivating migration as individuals move to look for more decent livelihoods. While most of them move within the region, a fraction tend to gravitate towards territories of their former colonial powers. The next section briefly discusses the migration challenges they face to reach Europe as it gives an overview of the social environment they reside in England.

2.4 The Social Environment Resided by Black sub-Saharan African Communities in England – An Overview

The Silences Framework and the Critical Race Theory propose that the social environment experienced by marginalised groups be considered when conducting health research with this cohort (Serrant-Green 2012; Graham 2011). The argument being that sometimes the root causes of the health problems being experienced emanate from their social environment and not attending to them may hinder opportunities for recovery (Serrant-Green 2012; Graham 2011). For example, in this study, the social environment resided by Black sub-Saharan African communities in the West Midlands of England, UK, may be the one negatively affecting their decisions to seek help for poor mental health, resulting in their low uptake of mental health services. Grasping this concept will help strategise and design ways and means that support easy access and utilisation of interventions that meet their mental health needs. In light of these assertions, this section explores the social environment resided by Black sub-Saharan African communities in the West Midlands of England, UK. In addition, the effects of the UK immigration policies will also be explored to see how they impact their integration processes and in turn their decisions to seek help for poor mental health.

As mentioned in Section 2.4, England's history is intertwined with that of sub-Saharan Africa, with historic ties dating back centuries. This has influenced migration patterns from the region, with the first wave occurring during the colonial era and individuals coming to England as students or political exiles (Olusoga 2016). However, they became more visible in the run-up to the new millennium (Bilger and Kraler 2005), making up 0.8% of the population in 2001 compared to 0.4% in 1991 (Scottish Government 2004; Hansard 2000). Their rate of migration to England has more than tripled (UK Government 2022), with later waves being driven by factors such as poverty, environmental degradation and/or natural disasters, the global capitalist economy, and political instability in the region (de Bruijn et el. 2001; de Haan and

Rogaly 2002). Of England's 14.4% global majority communities, 2.5% are said to be of Black sub-Saharan African origin (UK Government 2022).

Additionally, there is an unaccounted number of thousands of undocumented global majority individuals living in England, estimated at 1.2 million (Pew 2019). Therefore, the number of Black sub-Saharan African individuals living in England is unknown. Undocumented migrants, also known as, ‘Illegal migrants’ are individuals who cross international borders without the necessary authorisation or who enter legally but subsequently remain in the country after their visa or residence permit expires, failing to renew or return to their home country (Agiomirgianakis and Zervoyianni 2001).

The significant number of undocumented migrants can be blamed on the EU member states and England’s immigration policies. Migration to Europe became increasingly politicised around the mid-70s when institutional practices designed to control migration were introduced. Previously, the Commonwealth Immigrants Act had been introduced in 1962 to control immigration from the Commonwealth using employment vouchers. The 1968 Act was introduced to control UK and colonies citizens who had no substantial connection to Britain. In 1971, the Immigration Act was introduced to grant citizenship to individuals with a family relationship – that is a father or grandfather born in the UK and entering Europe became increasingly difficult after the recruitment of foreign labour policies implemented in Western Europe following World War II were abruptly halted due to the oil crisis of 1973-1974 (Castles 2006; Beauchemin et al. 2020). In the late 1990s, similar policies were introduced by the UK and other European countries to attract highly skilled migrants (Castles 2006). These initiatives were so widely accepted among EU members that they were formalised as European policy in 2009 (Kanu 2020; Beauchemin et al. 2020).

The EU Directive introduced the Blue Card to allow highly skilled non-European migrants to work in Schengen member countries (Lucas 2014; Beauchemin et al. 2020). However, for all other migrants, be it for family reunion, study, or asylum, entering Europe has remained difficult (Gnisci 2008; Rea 2007). Since then, UK immigration policies have been amended several times, putting measures in place to limit both their entries and length of stay (Castles 2007; Travis 2013; Beauchemin et al. 2020). The most targeted seem to be those of Black sub-Saharan African heritage (Finotelli and Sciortino 2013): for example, the period 2005-2009 saw 0.4% of visa applications for travel to Europe from Black sub-Saharan Africans and 0.8% from other non-African developing countries (Lucas 2014). However, the refusal rate was higher for Black sub-Saharan Africans at 16% against 6% for the latter: this is more than double for other non-African developing countries (ibid). Similarly, in a 2015 relocation scheme designed to move asylum seekers with a 75% success rate from Greece and Italy to Northern Europe, Black sub-Saharan Africans were excluded with the exception of Eritrea putting forward individuals from Syria and Iraqi (ibid).

In the same vein, when Russia attacked Ukraine, England, together with the European Union and its member states decided to activate the Temporary Protection Directive to offer Ukrainian refugees immediate and effective protection but continued to deny Sudanese refugees a safe and legal route to travel to Europe (Heschl 2023). Thus, while the network society fosters shared sovereignty among some states, those from sub-Saharan Africa are often excluded (Bowling and Westenra 2020). Because of this, as well as the requirement of a visa 100% of the time when travelling to Europe from sub-Saharan Africa, these communities have resorted to using irregular and unsafe means such as trekking the Sahara desert using trolleys, dinghies, and cargo ships to cross the Mediterranean Sea (Idemudia and Boenke 2020). This has caused death in some and health problems in others (ibid) and has shown how, while migration has become a common feature in the world today, motivated by globalisation, the global capitalist economy and in some cases ethnic wars and poverty, those from sub-Saharan Africa continue to struggle with migration to super economies (Bowling and Westenra 2020). The use of unsafe means to travel have caused some migrants to become victims of human trafficking, where they are subjected to physical and sexual abuse, forced labour and debt bondage (The Centre for Social Justice 2020).

As new arrivals, regardless of routes taken to reach England and what immigration statuses they have, Black sub-Saharan Africans are met with a less affluent community experience ibid). This is characterised by a myriad of challenges such as, racism, discrimination, different kinds of abuse, imprisonment, daily apprehension of deportation and other hosts of hostile life situations including, unwelcoming local communities, making it challenging to integrate into their new communities (Patel and Fatimilehin 1999; Acheson 1998; Nyashanu, Mbalinda and Madziva 2024). Some academics have blamed this on how migrants are presented to the

English public as the causes of negative social changes, such as the decline in the welfare state and unemployment (Bromley 2015; Weber and Bowling 2008). Bridging social relations, which refer to social relations between migrants and their host communities, is highly recommended in policy as enhancing migrants' connectedness with places in which they settle (Casey 2016; Commission of Integration and Cohesion 2007).

Positive bridging social relations lead to positive outcomes and opportunities for later generations. Hence, their lack thereof sets the tone for how Black sub-Saharan African communities experience the English social environment. Luckily, they have on their side wisdom from the Black Caribbean community who had experienced this environment before them: they came to England at the end of the Second World War at the invitation of the British government to come and help working in the manufacturing and transport industries (Wardle and Obermuller 2019). Therefore, this group paved the way for the integration of Black communities in England, and their experiences and struggles played a crucial role in shaping the broader discourse on integration, race relations, and multiculturalism (Keating 2002). However, the opposing social challenges they experienced back then, including poverty, housing, education, crime and policing, and access to health services still remain today (Lubian et al. 2016). New social control methods continue to be added to the mix making it harder and harder for Black communities to enter and live in the UK and can be best described by Fabre (1992)'s analogy who likened the situation to the limbo dance performed by captives on the slave ships of the Middle Passage. The dancer moves under a bar that is gradually lowered until a mere lit remains through which they pass spider-like, this served as an expression of their predicament and the capacities they needed to deal with their situation (Fabre 1992).

The social challenges faced by Black communities in England have been blamed mainly on the UK immigration policies, also known as the 'hostile environment', whose intention is to force migrants into destitution thereby deporting themselves with minimal cost to the UK (Weber 2019). The policies were introduced in 2012 to reduce net migration by reducing arrivals and increasing removals (Kirkup and Winnet 2012). As such, the policies are marked by detection, capture, punishment, detention, and deportation of criminalised migrants (Aas and Bosworth 2013; Bosworth et al. 2017). They work by creating an environment which makes it almost impossible for undocumented migrants, also known as ‘illegal migrants’, to access public services and stay in the country (Webber 2019). The policies involve increased immigration checks and enforcement in various areas of everyday life, such as employment, housing, healthcare, and education (Travis 2017a; Times Higher Education 2015; Liberty 2018).

While they were designed for all undocumented migrants, they have affected mostly Black communities with and without legal documentation (Griffiths and Yeo 2021). This is because a social construction of illegality relying on racialised practices, such as skin colour and suspicion, is used to identify undocumented migrants (Bowling and Westenra 2018). This has led to discrimination and exploitation. Their negative side was highlighted in the scandalous ‘Windrush Generation’, which saw the Black Caribbean community violently disrupted, with many legal migrants denied healthcare, detained, and deported, with grave consequences for some (Wardle and Obermuller 2019). Sadly, individuals affected struggle to access legal advice to navigate the complex immigration processes, and because of the complexity of the current immigration legislation, it has now become increasingly difficult for people to maintain their lawful immigration status due to increased immigration application costs, inflexible rules, Home Office data errors and grounds of appeal (Yeo 2020).

How the hostile environment policies are structured has connections to and are parallel to the English criminal justice system (Bowling and Westenra 2020). Their characteristics of detection, capture, punishment, detention, and deportation of criminalised migrants (Aas and Bosworth 2013; Bosworth et al. 2017) mean that criminalisation can be for trivial things such as arrival without travel documents, something that may be difficult to acquire in a case where one is fleeing persecution, and breaching visa conditions (Bowling and Westenra 2020). There now is a corresponding criminal offence for almost every immigration law breach (UK Government 2010). This has increased the rates of policing and racial profiling which have now become one of the biggest challenges faced by populations of Black heritage in England. Statistical evidence shows that in England, they are over-represented in the criminal justice system (Crown Prosecution Service 2023). According to the 2021 census, individuals of Black heritage make up only 4% of the general population, but in 2020, they made up 13% of the adult prison population (ibid). A 2023 study investigating charging decisions conducted by the University of Leeds with commissioning from the Crown Prosecution Services found disproportionate prosecutions for global majority populations for similar offences, white suspects were charged at 69.9% against 79.5% for Black African suspects. Black Caribbean suspects had a higher rate at 81.3% (ibid).

Similarly, individuals of Black heritage are more likely to be stopped, questioned, and searched than any other ethnicity, particularly under Section 60 of the Criminal Justice and Public Order Act 1994 (Salisbury et al. 2021), and 7.7 times more likely to have Conducted Energy Devices such as tasers used on them by the police than white populations (Busby 2020). This has been viewed by some researchers as a catalyst for reinforcing Black populations' profound legacy of mistrust in the police force (Salisbury et al. 2021). The mistrust comes from historical wrongs performed by the state and police against Black people, such as the racist stop and search programme (ibid). It was the racist stop and search programme that sparked the Brixton uprisings in 1981 and also played a key role in the 2011 uprisings (ibid). Section 60 allows police officers to stop and search anyone in a defined area for a limited period without requiring any 'reasonable suspicion' (Liberty 2020). Government data show that in April 2021 – March 2022, there were 27.2 stop and searches for every 1000 Black people compared to 5.6 people in white people in England and Wales (UK Government 2023). However, the figure for Black people could be an underreport as the figure for Black people labelled under 'Black other' was slightly above 100 stops and searches in every 1000 people (ibid) meaning there were much more Black people stopped and searched in that period. However, even though the practice continues today, evidence has shown that it does not reduce violent crime (Bradford and Tiratelli 2019).

The over-representation of Black people in the criminal justice system cannot be divorced from the broader context of socioeconomic inequalities. However, while impoverished communities are more susceptible to crime due to limited resources, the way the criminal justice system deals with them exacerbates and perpetuates the cycle of poverty and incarceration. As mentioned above despite constituting only 4% of the population, Black individuals are disproportionately impacted by poverty. A Racial Disparity Audit commissioned by Mrs Theresa May in 2017 revealed racial disparities in various areas, with individuals of Black origin being the worst affected (Racial Disparity Audit 2017). They were said to occupy positions of disadvantage and experience inequalities across all indicators of economic and social wellbeing, including inadequate access to and delivery of health care services (Racial Disparity Audit 2017; John Rowntree Foundation 2017).

In the period 2017-2020, they were said to be twice as poor as their white counterparts, with a poverty rate of just over 45%, which has been consistent for the last 25 years (John Rowntree Foundation 2022). This is 23% above the national average (John Rowntree Foundation 2022). In comparison, during the same period poverty rates for the Bangladeshi and Pakistani communities (populations among the most deprived) were found to be declining (ibid). The west midlands, England, UK, where this research is taking place, is the most deprived area in England after London and has a poverty rate of 25% (John Rowntree Foundation 2022). Interestingly, it is also the most diverse population in England after London (ibid). This seems to imply that diversity is synonymous with poverty. However, while London's poverty rate is declining (down 2% to 27%), the West Midlands was the only English region to register an increase at 2%, its highest in 20 years (ibid). Taking into consideration the fact that poverty is linked to mental health problems (lund et al. 2010), it is not a surprise that individuals of Black heritage are reported as experiencing higher than average mental health problems.

The high rates of poverty are partly caused by high rates of unemployment among communities of Black heritage. In 2018, Black workers were said to have the highest unemployment rate at 9% against 4% of mainstream communities (The Centre for Social Justice 2020). When employed, they work in the lowest-paid jobs, on non-permanent and zero-hour contracts, and are overrepresented in working night shifts (Fernandez-Reino and Rienzo 2022). Working the night shift is known to have a negative impact on physical health and mental performance due to the effects on sleep and circadian timing. In 2020, during the COVID-19 lockdowns, Black sub-Saharan African communities were among the unemployed migrants who were said to be less likely to claim unemployment benefits compared to UK-born unemployed workers (ibid). Also, the 'hostile environment' imposes restrictions on individuals under immigration control to access employment. The legislation requires that employers check the immigration status of job applicants, and where an employer is found to employ someone with no right to work, they are punished heavily (Qureshi, Morris and Mort 2021). Similarly, individuals working without proper documentation may face penalties, including deportation (ibid). This pushes individuals without proper documentation into working illegally, thereby increasing their vulnerability to unscrupulous employers who may exploit their status (Bloch et al. 2014; Lewis et al. 2017). The exploitation comes in the forms of underpayment, poor working conditions, and a lack of employment rights. The policies' emphasis on immigration enforcement may deter even those with legal status from engaging with employment-related services and seeking support, including support for their mental health for fear of deportation.

Unfortunately, unemployment motivates homelessness as with no earnings individuals are not able to pay for their boarding. Reports say that Black individuals in England are more likely than their white counterparts to be homeless, particularly those aged between sixteen and twenty-four, and also that financial institutions' criteria in assessing the status of Black people when applying for loans to use on private housing is more rigid (Bowling and Westenra 2020). More than a quarter of global majority communities are said to spend over a third of their earnings on housing compared to 10% in white individuals (ibid). Furthermore, workers from global majority populations in lowest-paid occupations are far more likely to face unaffordable housing costs than their white counterparts in the same occupations or white workers on average (John Rowntree Foundation 2022; Race and Ethnic Disparities Report 2021). The 'hostile environment' legislation also introduced the 'right to rent' policy, which requires private landlords to perform immigration checks on prospective tenants, their families and anyone else who looks like a migrant (Bowling and Westenra 2020). In a Home Office-commissioned assessment of the 'right to rent' pilot, findings revealed that landlords frequently make discriminatory comments and disproportionately require individuals who appear to be migrants to prove their immigration status (UK Government 2015).

Similarly, a poll of landlords conducted by Shelter, found that half of them would not rent out to people who appear to be migrants, another half of landlords reported being less likely to rent to foreign nationals, and 58% said they would refuse individuals from a global majority background without British passports (Shelter 2016). In April 2020, a court of appeal held the 'right to rent' scheme lawful even though it agreed that it causes landlords to discriminate (Griffiths and Yeo 2021). As such, these tough rules and regulations may render some Black sub-Saharan Africans homeless becoming a barrier to them seeking help for poor mental health. Besides, when individuals are struggling to meet their basic needs, addressing mental health concerns may take a backseat as survival becomes the primary focus.

Access to education has also been highlighted as a challenge for Black sub-Saharan African communities in England. While the Commission on Race and Ethnic Disparities Report 2021 confirmed the presence of 'immigrant optimism' among students of Black sub-Saharan African heritage and reported a better performance compared to their white counterparts when socio-economic status was considered, the 'hostile environment' made it difficult for them to access education. In June 2015, the Department for Education reached an agreement with the Home Office to share information from the school census, enabling the detection, detention, and deportation of families residing in the country unlawfully (Webber 2019). Besides creating an atmosphere of fear and uncertainty, which can lead to increased stress and anxiety, negatively impacting the educational outcomes of the children affected (ibid) this environment may also cause them not to access mental health services. In addition, the children of undocumented migrants are denied access to free student loans for further education, and their fees are pegged at international fees, which most cannot afford. Therefore, it becomes difficult for them to stay in education, and as mentioned earlier, the emphasis on immigration enforcement may deter even those with legal status from engaging in education.

Moreover, those facing deportation may experience disruptions in their education if they are taken into detention, which is usually the first step towards deportation. In addition, new arrivals on visas other than refugee status are often awarded restricted immigration statuses of two and half years, which is not long enough to complete a degree programme in England: most degrees are, on average, three years and hence, this becomes a barrier to accessing education. As mentioned earlier, the fear also extends to that of using other social services, including mental health services, which may be the reason why Black sub-Saharan Africans are overrepresented in experiencing mental health problems and have the lowest rate of mental health treatment.

As can be seen in the above narratives, racism and discrimination seems to be the biggest challenge for Black sub-Saharan African communities in England. While the 2017 Racial

Disparity Audit confirmed its existence and highlighted its disproportionate effect on Black populations (UK Government 2017), another investigation commissioned by the then Prime Minister, Boris Johnson, in 2020, following the Black Lives Matter protests, disputed racism had much impact on life chances (UK Government 2021). The cross-government commission acknowledged that racism was still a force in the UK but blamed family, geography, culture, religion, and class as being the culprits. Part of the report read:

> *"Put simply, we no longer see a Britain where the system is deliberately rigged against ethnic minorities. The impediments and disparities do exist, they are varied, and ironically very few of them are directly to do with racism. Too often 'racism' is the catch-all explanation and can be simply implicitly accepted rather than explicitly examined"* – (UK Government 2021).

However, some mental health research experts argue that both social circumstances and racism are to blame for individuals' life chances and the inequalities in mental health service delivery. A brief on the relationship between racism and mental illness published by a national initiative, the Synergi Collaborative Centre, to consider ethnic inequalities in mental health and deprivation, suggested that fear of racism and racist attacks can lead to chronic stress (Bhui et al. 2018). In addition to being harmful on its own, it is said to weaken parental resilience and negatively impact the mental health of their children (ibid). The authors also mentioned the existence of a growing and compelling body of evidence demonstrates that individuals exposed to racism are more likely to experience psychosis, depression, substance misuse, and anger (ibid).

Above all, the experiences of Black sub-Saharan African communities in England reflect a longstanding struggle against systemic racism rooted in historical injustices and perpetuated through structural inequalities. Some migration researchers believe that the 'hostile environment' situation is evidence to an ongoing expression of the colonial system of racial hierarchies and condemn it for legitimising and encouraging discrimination by those it deputises (El-Enany 2020). Besides causing untold suffering in migrants, the 'hostile environment' is yet to achieve its intended goal, as net migration has continued to rise. In 2023, net migration was unusually high at 685 000 compared to pre-pandemic levels of between 200,000 and 300,000 (The Migration Observatory 2024). However, the increase was said to be due to non-EU arrivals coming to England to study and to take up work in the health and social care industry (ibid). In a 2020 study conducted to investigate the impact of policy changes on migration, findings showed an increase in behaviours towards taking concrete steps to moving out of Africa and stable probabilities of out-migrating (Flahaux and de Haas 2020). The researchers analysed data from the Determinants of International Migration (DEMIG) and Migration between Africa and Europe (MAFE) projects focusing on migration from sub-Saharan African countries of Ghana, the Democratic Republic of Congo, and Senegal to European countries of Belgium, France, Italy, Spain, the Netherlands, and the UK. This behaviour was attributed by some researchers to the "now or never" effect whereby potential migrants prepare their departure in advance of even more restrictive stances being implemented (de Haas et al. 2019). Nonetheless, once in England, the discriminatory immigration policies lead them to occupy all positions of disadvantage such as, poor housing, exploitative conditions of employment, lower levels of education and isolation rendering them invisible, with 'silences' around their situations little explored. As a result, they experience mental health problems and their decisions to seek help are negatively affected, perpetuating their mental health problems. The following section gives an overview of the mental health system in England before presenting what other researchers have found out around the topic.

2.5 The Mental Health System in England – An Overview

In England, statutory health care services, including mental health care, are provided by the NHS. The organisation was set up after the Second World War (Bochel and Daly 2020) based on the principles of universality, free at point of delivery, and equity (Delamothe 2008). It was first proposed to parliament in the 1942 Beveridge Report as part of a welfare reform designed to eliminate socio-economic issues such as unemployment, poverty, and illness and to improve education (Beveridge 1942; Fraser 2009). Initially it disadvantaged women and migrants due to its insistence on full employment. Women were viewed as caregivers and hence missed out on social benefits after their careers were interrupted due to childbearing and caregiving responsibilities (O'Brien 2010; McKay and Rowlingson 2022; Eseonu 2024). Similarly, migrants struggled to access to same level of social benefits as white citizens, particularly those coming from commonwealth countries who were often encouraged to work in essential sectors of the economy (ibid). The organisation has survived numerous political and organisational changes and continues to be paid for by tax revenue and national insurance contributions (Grosios, Gahan and Burbidge 2010). Rights for NHS users are summarised in the NHS Constitution and among them is the right to access care without discrimination and within certain time limits for specific categories, such as emergency and planned hospital care (Department of Health 2015).

Mental health services are free on the NHS to service users ordinarily resident in England. To be ordinarily resident, individuals who require immigration control need to have a settled status of indefinite leave to remain (UK Government 2019). People seeking asylum, humanitarian protection, and temporary protection under the UK immigration rules, and victims of human trafficking and their dependents are also eligible to receive free mental health services (Department of Health 2015). In contrast, individuals visiting England for more than six months, including students, must pay a health surcharge, and the amount is dependent on the kind of visa one is holding and whether they are applying from inside or outside England. The surcharge payment allows them to access NHS services on the same basis as individuals ordinarily resident in England (Buswell 2022). If someone finds themselves needing to access healthcare but is not eligible for the service, and does not have any medical insurance, they are charged 150% of the NHS tariff unless they are coming from a country with a reciprocal healthcare agreement (ibid). Nonetheless, the same individuals can access free treatment in an Accident and Emergency department and for certain infectious diseases. Undocumented migrants are treated under these rules.

The Parliament, the Secretary of State for Health, and the Department of Health fulfil the role of health legislation and general policy. NHS England, an arm's length, a government-funded body independent from the Department of Health, is responsible for its day-to-day running (NHS England 2024). It has different responsibilities for various parts of the health system, including managing the NHS budget, overseeing clinical commissioning groups, commissioning different types of care, setting strategic objectives, and working toward objectives issued by the Secretary of State for Health. Their priorities include improving mental health services and preventing/tackling health inequalities. They hope to achieve this by addressing health inequalities, improving mental health services, and investing in their workforce (NHS Confederation 2021). Health Education England supports them by training the NHS workforce and planning effectively.

Reports in the literature say there is a lack of diverse cultural understanding within the current NHS workforce because they do not reflect the population makeup of specific geographical areas (Kline et al. 2017). This increases the likelihood of both implicit and explicit bias in decision-making. Having a representative workforce is crucial, especially regarding treatment decisions that impact detention under the Mental Health Act 1983, which is known to disproportionately affect individuals of Black heritage (Barnet 2019; Bhui 2003; Singh 2007; Audini 2002). However, the NHS is known for having a good record of employing individuals from diverse communities. 21.0 % of its workforce are of a global majority heritage, but they make up only 10.3% of very senior managers and 13.2% of board members (NHS 2021). Many of the most senior leaders and decision-makers in the NHS are white (NHS 2021; Carter 2020). Important to note is that among the global majority doctor population, 66% are South Asian (UK Government 2020; General Medical Council 2019), leaving Black sub-Saharan African communities with less cultural representation at this level. While South Asian doctors may have a shared experience of perceived racism with individuals of African heritage, they may have little in common with them culturally (Wessley 2018). Again, being from a racialised majority does not in itself reduce the likelihood of behaving in a discriminatory way towards other racialised communities (ibid). Hence, the lack of individuals of Black heritage at the decision-making level in the NHS may mean that less attention is paid to the challenges faced by this group (ibid). Reports also say NHS staff from a global majority background face inequalities at work. They are more likely to report workplace discrimination from a manager or colleagues (17% compared to 6.8% of white staff) and are 1.14 times more likely to enter the formal disciplinary process than their white counterparts, underscoring the inequalities they face (Kline et al. 2017). A 2019 NHS pay guide revealed a pay disparity by ethnicity among workers and showed that individuals of Asian heritage were the highest paid, followed by white populations, with the least paid being individuals of Black populations (NHS Digital 2019). For example, the average monthly basic pay (full-time equivalent) was £3,864 for Asian populations, £3,145 for white populations and £2,646 for Black populations (NHS Digital 2019). However, it has to be noted that the amounts could have been affected by the position one was on the pay grade continuum.

Mental health services offered by the NHS range from mild to severe mental illness care. Mild illnesses such as depression and anxiety disorders are treated at the primary care level (General Practitioners), while those requiring more advanced care and treatment, such as inpatient care, are treated at the secondary care level (specialist mental health trusts). However, there is a growing body of evidence showing that community-based interventions such as art activities, social groups and nature-based activities are effective in reducing symptoms of mental illness and improving positive psychological well-being (Hanson and Jones 2016; Houlden et al. 2018; Jenkinson et al. 2013; Hui et al. 2019; Sextou and Smith 2017; Iancu et al. 2014). As such, there has been increasing emphasis to integrating biomedical and psychological approaches in managing and treating mild mental illness (Baxter and Fancourt 2020). Integrating community-based interventions into a portfolio of options for individuals experiencing mental illness is expected to help address the increasing demand for mental health services (Baxter and Fancourt 2020). These services often meet the mental health needs of marginalised groups as they are delivered by not-for-profit voluntary organisations and community groups that usually share the cultural background of the people they support and allow the use of non-medical models (Fernando 2005). However, these organisations often face challenges such as lack of funding which lead to high staff turnover, as most, especially the smaller community groups, do not receive statutory funding (Whitelaw et al. 2017). The next section explores the way in which access to and utilisation of mental health services among global majority populations has been explained by different scholars.

2.6 Barriers to Access and Utilisation of Mental Health Services

For almost half a century, the literature has accumulated evidence of persistent inequalities in pathways to mental healthcare services among the global majority population in England. A longitudinal study conducted in England to monitor detentions effected through the Mental Health Act legislation 1999 – 2016 found that the detentions were associated with the economic recession, change in legislation and the impact of austerity measures on health and social care (Smith et al. 2020). However, these factors are often intertwined and vary among individuals and communities. This section highlights what other researchers have discovered regarding this topic, and as mentioned in Section 2.0, it will include studies conducted with global majority communities inside and outside England.

A naturalistic study with 1,024 community individuals case managed by London Early Intervention Services supports the point that individuals of Black heritage access mental health services when already in crisis. The study found that, unlike Black communities, white populations presented to primary healthcare services earlier and, thus, were less visible in crisis mental healthcare services (Ghali et al. 2013). This supports a systematic review and meta-analysis of research investigating ethnic inequalities in pathways to care for adults with psychosis in England (Halvorsrud 2018). The review was conducted as part of a national programme to tackle ethnic inequalities, and the findings revealed elevated rates of detention through coercive mental health legislation and less involvement with general practitioners for individuals of Black Caribbean descent (ibid). Similarly, a gendered research study also conducted in England found a higher percentage of involuntary admissions and significantly lower access to community mental health services among Black and other global majority women in the perinatal stage compared to their white counterparts (Jankovic et al. 2020).

As previously mentioned in section 1.3, for over five decades, the Black Caribbean population in the UK has been over-represented in experiencing mental health problems and in not taking treatment for their illnesses, and this position has now been assumed by Black sub-Saharan African communities (Mayston et al. 2020). Since the latter only became more visible in England towards the new millennium (Bilger and Kraler 2005), while the former have been around for over seven decades (Wardle and Obermuller 2019), it can be assumed that the overrepresentation is caused by the challenges individuals experience while trying to navigate their social environment. Hence, since the Black Caribbean population has been around longer, they have gained skills to navigate the social environment better. Socioeconomic status, including income and access to health insurance (payment for health in USA studies), is said to affect an individual’s ability to access mental healthcare services. Similarly, this can be the case in the UK for undocumented migrants who must pay for healthcare services in advance (Steele et al. 2014). Here, an outstanding NHS debt of £500 can be used as basis for the refusal of the right to remain application and can lead to deportation (UK Government 2016; NHS Digital 2017). Hence, having a lower socioeconomic status can limit access to quality healthcare. Gajwani (2016) identified social determinants of health as leading to a higher rate of serious illness, which can lead to people of Black origin being detained under the Mental Health Act 1983.

In a study conducted in the US investigating the role of acculturative stress factors on mental health and help-seeking behaviour among Black sub-Saharan African communities, Orjiako and So (2014) found that a higher level of education, as well as good English language proficiency, increased the level of help-seeking. However, while the study was conducted ten years ago, its findings are old but may still hold considering findings from Morgan et al. (2017)'s study, which showed that individuals accessing mental health services over an extended period of up to 10 years still faced the same disparities as when they started. The researchers, who performed a quantitative analysis of AESOP-10 outcome data, found that Black Caribbean patients diagnosed with psychosis had worse clinical, social, and service use outcomes compared to the white British population, not only at their initial presentation to services (Morgan et al. 2006) but also over the 10-year follow-up period (Lawrence et al. 2021).

Besides, studies conducted later than Orjiako and So (2014)'s study realised similar findings: Memon and colleagues (2016) found that having little or no understanding of English added anxiety to participants and prevented them from accurately articulating their problems. They also felt that mental health practitioners took a generalised approach when working with them and were unable to listen to their concerns and needs (Memon et al. 2016). Similarly, Kang, Tom, and Farrington (2019) discovered that most asylum seekers and refugees find navigating and negotiating primary health care services in the UK onerous. They also named inadequate interpretation services, prescription fees, transport to appointments, perception of discrimination relating to race, religion, and immigration status, and a lack of awareness of the structure and function of the NHS as barriers to them accessing primary care services (Farrington 2018). However, their findings cannot be generalised since they looked into asylum seekers' and refugees' experiences, which may not be the same for other migrants with different statuses and British-born individuals from migrant backgrounds. Another study conducted in Norway with Filipino migrants, which identified educational background as a barrier to seeking help for poor mental health from general practitioners, can also not be generalised since it was conducted on women using a post-colonial feminist perspective (Straiton, Ledesma and Donnelly 2018).

A study conducted in the Southeast of England to understand the perceived barriers to accessing mental health services among the global majority communities identified personal and environmental factors such as social stigma and negative perceptions of mental health services, and factors that affect the relationship between service users and health care providers such as, long waiting times and imbalance of power among, and authority between service users and providers as barriers (Memon et al. 2016). However, the study was limited in that it was conducted using university graduates in the Southeast of England and half of the participants did not indicate what their ethnicity was. However, being that as it may, a legacy study conducted in the London Borough of Hackney with a homogeneous sample of Somali refugees posted similar findings (Palmer 2006), confirming the validity of Memon et al. (2016)'s results. Even further afield in the US, similar findings were realised. In a systematic review of 30 studies conducted to explore differences in perceptions of mental health services among Black American populations (Black African, Black Caribbean, and Black American), two themes emerged: perceptions that influenced service use and another related to barriers to mental health help-seeking (Gaston et al. 2016). Unfortunately, besides being an old review, it failed to identify any themes for Black African and Caribbean groups, citing the paucity of information on this cohort in the literature (ibid). However, it was essential to include it in the literature review as the studies used acknowledged the importance of cultural differences and perceptions among diverse populations, including subgroups of Black African descent, in mental health care delivery. This confirms the need for this study, which seeks to add to the board of knowledge, the social factors that influence decisions to seek help for poor mental health among Black sub-Saharan African groups.

Nonetheless, some researchers identified the lack of initial access as the main issue causing disparities in mental health service delivery (Le Cook, Manning and Alegria 2013; Cook et al. 2014). A study conducted in the US to investigate disparities, including the initiation of care in mental health care, found that compared to White communities, Black and Latino communities had less initiation and adequacy of care (ibid). The researchers used the Medical Expenditure Panel Survey (MEPS), a dataset commonly used to examine various aspects of healthcare utilisation, such as doctor visits, hospitalisations, medication usage, and other healthcare services, to assess disparities at the beginning, middle, and end of episodes of care (ibid). They analysed panels 9 – 13, which measure, among other things, health conditions, healthcare utilisation, and risk factors. However, this study was conducted almost ten years ago, so the data and conclusions are outdated. Nonetheless, they may still hold considering reports which insist that little change has occurred regarding racial disparities and mental health care in the US since the 2014 Secretary General's Report (Meyer et al. 2015, Bailey, Makonogho and Kumar 2019). Similar findings were realised in a more recent study conducted in the US with a similar group of participants using MEPS data, highlighting the robustness and reliability of Cook et al. (2014)'s findings. Henry et al. (2020) found that even with a mental health disorder diagnosis, Blacks and Hispanics, as opposed to white communities, were less likely to seek mental health treatment voluntarily. This underscores the importance of addressing the factors that drive these disparities. A systematic review conducted by Aggarwal and colleagues (2015) found that low treatment initiation and high treatment discontinuation among Black and Latino communities were related to them perceiving mental health services as not addressing the understanding of their illness, care, or stigma. Working in this way can lead to misdiagnoses and wrong treatments, which can be catastrophic for patients. Using the researchers' recommendations, which call for using simple language when working with these groups and tailoring communication to patient preferences, discussing differences and demonstrating positive affect can help mitigate against these problems (Aggarwal et al. 2015).

The above argument seems to support the issue of assessment tools used to ascertain whether mental ill health requires treatment, put forward by some researchers who argue their validity, citing cultural and ethnic differences factors in the presentation of particular symptoms (Chakraborty, McKenzie and King 2002; Palmer 2006; Karlsen et al. 2005). The importance of an accurate diagnosis cannot be overemphasised as it leads to accurate treatments being offered and, ultimately, recovery. Similarly, the importance of cultural intelligence in mental health assessments to produce a precise diagnosis is required. Individuals from diverse cultural backgrounds and traditions are believed to define and experience reality differently, including their perspectives on mental disorders (Okello and Musisi 2006). For example, it was found by Crawford and Lipsedge (2004) that Zulu tradition places the source of individual psychological distress, as well as the responsibility for its treatment, within the community, while Western psychiatry models locate both the source of psychological disturbance and its therapy within the individual. Because of this, some researchers argue that it would be wrong to use the same assessment tools for diverse cultures when assessing mental illnesses.

Furthermore, the literature shows that Black communities are more likely to be prescribed anti-depressants as compared to talking therapies (Memon et al. 2016). Hence, there also is debate around the use of psychotropic medicines such as antidepressants and antipsychotics, whose side effects lead to the discontinuation of medicines by patients, putting them at risk of severe mental illness (Achtyes et al. 2018; Francois et al. 2017; Semahegn et al. 2020). As such, some researchers advocate that Black African people be treated within the framework of their culture and belief systems (Mosotho et al. 2011), such as, using herbal medicines which are widely used in other parts of the world, including Africa, Asia, and South America (Ramirez-Tagle et al. 2016; Iwanaga et al. 2017; Jidong et al. 2021a).

Experiencing poor outcomes from mental healthcare services was also identified as a barrier to seeking help for poor mental health. In a study of Black faith groups, Codjoe et al. (2019) suggested that poor outcomes from healthcare services would lead to a cycle of mistrust, leading to late presentation or inadequate access to early interventions. This was also confirmed by the previously mentioned AESOP-10 project, which found that experiencing mental health problems over some time and facing persistent inequalities in accessing mental health inequalities can lead to a mistrust of services (Lawrence et al. 2021). Findings showed that the experiences of Black Caribbean individuals were dominated by powerlessness compared to those of their white counterparts (ibid). This highlighted how negative expectations and experiences with mental health services build up over time, leading to a damaging cycle of disempowerment and mistrust (ibid). This, in turn, leads to individuals of Black heritage not accessing mental health services.

Another factor identified as a barrier to accessing mental health services among global majority groups was their underrepresentation in participating in health research. Because of this, mental health services are said to be developed for dominant cultures who give their input through research participation (Fernando 2005). More so, for Black sub-Saharan African communities in England who, as previously mentioned gained greater visibility in the lead-up to the new millennium (Gill et al. 2008). A lack of participation in research precludes the understanding of their health needs to allow for the development of adequate interventions that meets them (Rukgasa and Canvin 2011). For this reason, mental health practitioners are said to respond to mental health problems among global majority populations in line with established Western medical models, disregarding the needs of the global majority populations. There is support for this in some migration research experts who accuse mental health professionals with little understanding of the migratory journey of 'box ticking' to provide a recognised and statistically significant diagnosis when working with refugees (Watters 2001). In addition, it is said an intergenerational loss of social and cultural identity among migrants exists when they join new communities. Research has shown that individuals who feel disconnected from their cultural identity may struggle to seek help for poor mental health due to the sense of isolation this brings (Leong, Wagna and Tata 1995; Haslam et al. 2009). In a legacy study conducted with Asian Americans, the findings showed that individuals who felt culturally alienated struggled to seek help for their mental health compared to those who had a strong sense of identity (ibid). Similarly, another study conducted by Haslam et al. (2009) showed that individuals who lack a strong sense of belonging to a social group often experience higher levels of stress and are less likely to seek help for their mental health highlighting the importance of maintaining a social and cultural identity.

The literature also highlighted how cultural beliefs about the causes of mental health illness, stigma and religion can also act as barriers to accessing mental health support. According to Bhui et al (2003), cultural differences exist when seeking help for mental health. A study conducted in 2018 by Gopalakrishnan identified how cultural diversity could affect the way people access help for their mental health, as well as how explanations of the illness and ways to manage it were influencing what and how the communities seek relevant and accessible help. Cultural beliefs are also said to be a breeding ground for mental health stigma, which can also prevent individuals from seeking help. Corrigan (2004) researched and confirmed how, in some Black African communities, mental illness may be stigmatised due to cultural beliefs and misconceptions about mental health.

A similar study was conducted by Ward and Hiedrich (2009) to investigate African American women's beliefs about mental illness, preferred coping behaviours and whether stigma was associated with help-seeking. The women endorsed low levels of stigma, and their coping strategies included praying and seeking medical support. However, considering the low levels of treatment highlighted in the literature, it may mean that they use prayer more. Prayer was also highlighted as a coping mechanism in another study on African American individuals (Harries 2020). Shame, secrecy, and reluctance to seek help are a constant theme in UK research (Mantovani et al. 2017). The embarrassment of being mentally ill can lead to a desire to distance oneself socially and become disconnected from people. Many researchers suggest playing a role in the church or community will enable people to continue getting out of bed, thereby reducing the deterioration of their mental health (Clement 2015; Giscombe et al. 2016; Codjoe et al. 2021). Clement (2015) reinforces the context that stigma and discrimination against Black people will affect the access to mental health services as set out in UK policy, whereas approaching a community church is more accessible and less stigmatising for some. Very few studies have explored how many Black African and Afro-Caribbean people ensure their well-being by having a positive relationship with their faith rather than a medicalised view of their care and this is not within the scope of this literature review so cannot be put forward as a sound theory.

The reproduction of stigma at the community level was also found to be a factor influencing mental health help-seeking (Mantovani, Pissolati and Edge 2017). Moreover, people felt those experiencing mental illness were viewed as dangerous and incapable (Harris et al. 2020). Research carried out in the US to investigate 'the superwoman' schema's influence on coping and health found the female participants felt an obligation to present an image of strength and hence would not seek help for their mental health but relied on their religion instead (Giscombe et al. 2016). This shows how intertwined stigma and religion are. Unfortunately, as mentioned above, a place of worship is not recognised as first access to mental health services. Recognising and acknowledging this fact may help develop working interventions. The Fripp (2017) research with 129 African Americans seeking counselling for their mental health added to the notion of stigma and help-seeking. Its findings showed that stigma, including internalised stigma resulted in a reluctance to seek help for poor mental health.

Codjoe et al. (2021) discussed how the inequalities were evident immediately, with the pathways to accessing help being very difficult for Black people in the UK.

The researchers suggested the utilisation of ‘bottom-up’ development approaches and mental health champions for effective interventions. They recommended coproduction and partnership working as key to developing an acceptable and accessible intervention (Codjoe 2021). In a study carried out in the US investigating perceived and personal mental health stigma, De Freitas and colleagues (2017) found that African American college students had higher stigma than Latino college students. They suggested that interventions aimed at reducing stigma in college students should target specific global majority groups and focus on issues particularly salient in those communities. However, this seems to suggest that Black people are homogeneous, which they are not, as reported by Clift, Jones and Corrigan (2013), who called for anti-stigma interventionists to take care not to undermine the strengths of Muslim attitudes towards mental illness.

Other studies about Black faith groups and mental health services, such as Codjoe et al. (2019), actually suggest there should be a partnership between health and spirituality. This is because religion plays a significant role in the lives of many Black sub-Saharan Africans and as such, some individuals may prefer spiritual guidance or their religious leaders' assistance over mental health professionals. This is in line with researchers such as Mantovani et al. (2017), who believe that the weakness or moral failing of having poor mental health is only understood by culturally appropriate community help.

The role of family and community in decision-making about mental health treatment is significant. Family and community members can have both positive and negative impacts on individuals’ decision to seek help for their mental health. A systematic review working to synthesise evidence on behavioural and attitudinal patterns as well as barriers and enablers in Filipino formal mental health help-seeking across seven countries found that social stigma attached to mental health disorders hindered their decision to seek help (Martinez et al. 2020). This was worsened by concerns about loss of face, shame, and adherence to Asian values of conforming to norms where mental illness is considered unacceptable (ibid). Although this study was conducted on Filipinos, its findings can be extended to Black sub-

Saharan African communities whose African values also view mental illness as a weakness. However, on the other hand, teachers and parents were viewed as both barriers and facilitators to mental health help seeking (Radez et al. 2020). Another systematic review exploring barriers and facilitators to mental health help-seeking in young people and adolescents found this group was likely to seek help if they perceived the decision as their own choice and not their parents' or teachers' choice (ibid).

However, whatever the barrier, delay in the uptake of mental health services is known to have problematic consequences, such as worse outcomes in psychosis, bipolar disorder, and major depressive and anxiety disorders (Boonstra et al. 2012; Dell'Osso et al. 2013). This may explain why people of Black African and Caribbean heritage are more likely to receive a schizophrenia diagnosis compared to other groups, are highly represented in being detained under the Mental Health Act 1983, are held by the police for observation for mental illness, and access mental health services through the criminal justice system (Care Quality Commission 2022; NHS Digital 2021; Bignall 2019; Audini 2002). Unfortunately, there seem not to be many studies documenting the experiences of Black populations being detained under the Mental Health Act 1983. A 2019 review conducted in the UK to synthesise qualitative evidence on patients' experiences of assessment and detention under various mental health legislation found no study was done on the detention experiences of global majority communities (Akhter et al. 2019). However, its findings can still not be considered as the review included studies conducted in different settings using different legislation, which may give distorted results. Nonetheless, it at least provides a pathway for follow-up studies investigating the experiences of individuals detained under mental health legislation.

All in all, there seems to be consensus in the literature confirming the inequitable access to mental health services in the UK and as mentioned earlier, the inequalities have been consistent across generations for over half a century (Bagley 1971; Cochrane and Bal 1989; Halvorsrud et al. 2019; Harrison et al. 1988; Kiev 1965; King et al. 1994; McGovern and Cope 1987; Pinsent 1963; Van Os et al. 1996). They have remained stubbornly in place even after more resources and numerous policy interventions were introduced to reverse the sad statistics (Sachidaran 2003; Department of Health 2005). This has led to some researchers suggesting that mental health services themselves were discriminatory, and this stands in the way of the majority of global populations accessing them (Bhui et al. 2018; Nazroo et al. 2020). In their argument, Nazroo et al. (2018) blame the ways in which institutions respond to factors that act as barriers to accessing mental health services, which they say are shaped by processes related to racism and, therefore, make the services racist. As such, together with other researchers they claim that ignoring this fact and continuing to emphasise other factors will perpetuate these disparities (Bhui et al. 2018; Nazroo et al. 2020). This supports the application of the Critical Race Theory to analyse this study's findings in order to understand how race and racism influence decisions to seek help for poor mental health among Black sub-Saharan African communities.

2.7 Efforts Employed to Reduce Barriers to Access and Utilisation of Mental Health Services

As can be seen in the above section, over the decades, there has been increasing recognition of the disparities in mental health service provision for racialised minorities communities in England, particularly for global majority populations (Bhui et al. 2008; Nazroo 2003). Early efforts to address these disparities were primarily centred on policy reform and institutional initiatives aimed at improving accessibility and ensuring equal treatment. The Mental Health Act (1983), revised in 2007, represented a significant milestone in this effort, as it sought to standardise care while protecting against discrimination (Department of Health 2007). Subsequently, the introduction of the Equality Act (2010) and the NHS Constitution reinforced the legal framework for tackling discriminatory practices and promoting inclusivity in mental health care (UK Government 2010).

In the 1990s, the issue of cultural competence began to receive more focused attention. Training programmes for health professionals started to emphasise cultural awareness, recognising the diversity of the British population and the importance of providing culturally sensitive care to the needs of racialised communities (McGibbon and Etowa 2009; Leichsenring 2011). This shift was accompanied by an increased representation of individuals from global majority populations in mental health advocacy groups, which played a critical role in raising awareness and advocating for policies that would bridge the gap between mental health service providers and the communities they served (Fernando 2010; Mclean et al. 2003).

However, while these reforms have made significant strides in improving access to services and reducing overt discrimination, the power dynamics within mental health services remain largely unaddressed. The hierarchical nature of healthcare institutions, often compounded by implicit biases and institutional racism, has created an environment where the voices of racialised minorities are frequently marginalised (Kirk and Kutchins 1992; Hall 2018). Even when cultural competence is prioritised, the power imbalance between healthcare professionals and patients often leads to a lack of trust and effective communication, leaving many patients feeling unheard or disrespected. This results in a sense of alienation and reluctance to seek mental health support among racialised groups (Smaje 1995; Williams et al. 2014).

In response to these issues, various grassroots and community-led initiatives have sought to address the gaps left by institutional efforts. These include peer support networks, community mental health education, and advocacy organisations focusing on racialised groups specific mental health lineups (Sue et al. 2019; Runnymede Trust 2017). These initiatives emphasise the importance of empowerment and representation in overcoming systemic barriers to care. By providing culturally relevant information, offering peer-led counselling, and encouraging engagement with healthcare systems, these initiatives have empowered individuals and tackled some of the underlying barriers to service utilisation.

Despite these advancements, one critical gap remains: failure to fully address the power dynamics within mental health services. Power imbalances between healthcare professionals and racialised individuals persist, often manifesting in the form of implicit bias, cultural misunderstandings, and a lack of genuine engagement with the experiences of racialised patients (Sue et al. 2019; Williams and Mohammed 2009). Even with policies, the broader institutional culture in healthcare has yet to evolve significantly to foster an environment of mutual respect and shared decision-making (Dutton et al. 2013). For meaningful change to occur, it is essential to recognise and dismantle these power structures, creating a more inclusive and equitable mental health system (Fernando 2010; Hall 2018).

2.8 Identifying a Research Gap

The gap in the literature is that mental health service providers have failed to explore how they can engage Black sub-Saharan African communities. The literature shows low evidence for effective mental health interventions for this cohort. The medical model of health would encourage social prescribing when people's environmental factors are used as vital information. However, a medical model of health where peoples' own life choices are used to explain their illness will not work for Black sub-Saharan African communities who have many inequalities in their lives. The exclusion of their cultural and religious beliefs means the social policy in England and the design of services do not accept a place of worship as the first access to mental health services. A considerable section focuses on having churchgoers influenced by the services currently in the UK. This is a tokenistic approach with a medical model that assumes all Black people attend church and all Black people need a leaflet or information about the services that focus on medicines and talking therapies. Available research focused on lived experiences misses out a tool to intercept and assess need. In terms of identifying stigma and determinants of health, the studies can evidence inequalities in Black families, but there could be a tendency then to class all Black patients as being poor and in low-paid jobs.

There also is a homogony of treating Black individuals as one case study which is a real failure of the literature. Much of the policy and literature covering the uptake of mental health services has either amalgamated all global majority populations or Black sub-Saharan African and Black Caribbean communities as a sample. This presents a distorted image of the phenomenon since culture influences the way mental health symptoms are expressed, understood, and ultimately diagnosed (Earl et al. 2014). Various cultures of global majority populations need to be acknowledged when researching these communities. Besides, in the UK, global majority populations (Black, Asian and Minority Ethnic - BAME) communities are quite diverse; identifying as one can include a heritage of Asian, Black African and Caribbean, and Chinese background (Office for National Statistics 2013). Also, the studies lack direct or formal engagement with the patients, sometimes just dealing with their paperwork or case notes.

In conclusion, the literature gap is clear: few studies on this topic highlight the need for further research. Existing studies are outdated, necessitating more current evidence. Additionally, many of these studies utilised a quantitative design (Morgan et al. 2006; Cook et al. 2014) to explore lived experiences. Qualitative research on the subject (Memon et al. 2016) focused on the Black, Asian and Minority Ethnic populations, grouping non-white individuals rather than explicitly examining Black sub-Saharan African communities. Given the historical context and the specific characteristics of the target population, no existing research has investigated access to mental health services through the combined lenses of The Silences Framework and Critical Race Theory. As such, the concept of this thesis is designed to fill the gap in academic research by approaching individual real people and finding out what silences they hold.

Chapter 3 - Methodology

"To truly understand the diverse tapestry of human experiences, we must amplify the voices of those marginalised and silenced. Our methodology is not just a means to an end but a commitment to justice, empathy, and the pursuit of a more equitable world" – O'Byrne.

3.1 Introduction

This methodology chapter outlines the process and methods used to conduct the research, highlighting the validity and reliability of the study. The chapter follows the typical stages of research questions, ontological and epistemological position, research design, recruitment procedure, data collection, and data analysis and concludes by giving ethical considerations and a summary of the key points.

This section briefly introduces the chapter by referring to the literature review in Chapter 2 and explaining the importance of the methodology. For example, it can be seen from the analysis of previous work on barriers to seeking mental health service access among global majority populations that most studies used surveys and medical notes to conduct their research such as, Morgan et al. (2008) and Lawrence et al. (2021) who both used data outcomes from the Aetiology and Ethnicity in Schizophrenia and Other Psychoses – 10 (AESOP-10) 10 year follow up study, and Cook et al. (2014) who used the Medical Expenditure Panel Survey (MEPS) a dataset commonly used to examine various aspects of healthcare utilisation. A few relied on empirical data or one-to-one consultations and when they did, they combined global majority populations as participants (Memon et al. 2016; Barnett et al. 2019) which unfortunately, presents a distorted image of the phenomenon as culture is said to influence the way mental illness symptoms are expressed, understood and diagnosed (Earl et al. 2014). The scope of this thesis was much more focused on the participants' voices, and the objective of using this type of methodology was to answer the question on what stops individuals of Black sub-Saharan African heritage from seeking help for poor mental health. Hence, to answer this question, the study explored their lived experiences using the qualitative Interpretative Phenomenological Analysis (IPA) methodology.

On the overall, this doctoral-level research endeavours to illuminate the Black sub-Saharan African communities' unique narratives and strategies employed to navigate their complex terrain of sociocultural and economic positioning, and how this influences their decisions to seek help for poor mental health. In doing so, it aspires to contribute not only to the academic discourse but also to the development of informed policies and interventions that address these communities' mental health needs and aspirations in a more culturally sensitive and equitable manner. In the subsequent sections of this chapter, the researcher will dig deeper into IPA's theoretical underpinnings, explaining its suitability to answering her research questions and applicability to studying the lived experiences of Black sub-Saharan African communities. The research design will be outlined, as well as, the methodologies, and ethical considerations guiding this comprehensive investigation. Through this rigorous exploration, the aim is to shed light on the profound richness of their lived experiences, fostering a deeper understanding of the challenges and opportunities faced by this cohort in today's globalised world. However, before doing this, the chapter will start by stating the aims and objectives of the study and the researcher's ontological and epistemological positions.

3.2 Study Aim and Objectives

This study is entitled, 'Barriers to Mental Health Service Access and Utilisation: A case of Black sub-Saharan Africans in the West Midlands of England'. It received ethics approval from the Nottingham Trent University's Schools of Business, Law and Social Sciences Research Ethics Committee. As expressed in the ethics application, its aim was to explore the beliefs and perceptions towards the uptake of mental health services among Black sub-Saharan African communities in the West Midlands of England, UK. The study's key question was, 'Why is the uptake of mental health services low among Black sub-Saharan African communities in the UK'. To answer this question, the study was designed to examine participants' lived experience of the social environment they reside and aligned the following objectives to the overarching question:

1. What sociocultural and socioeconomic factors influence the uptake of mental health services among Black sub-Saharan African communities?

2. What beliefs and perceptions do Black sub-Saharan African communities hold towards the uptake of mental health services?

3.3 Ontological and Epistemological Position

The ontology in this study respects relativism, which proposes that realities exist as multiple, intangible mental constructions, which in effect means that no reality exists beyond the subjects (Moon and Blackman 2014). For this study, this means that each participant can provide knowledge about their own reality. This stance is in line with anti-essentialist viewpoints which functions as a guide to the screaming silences concept which was adopted by The Silences Framework (Williams and May 1996; Serrant-Green 2011; Phoenix 2013) partly guiding this thesis. Its viewpoints posit that reality is constructed in given societies based on experiences and contexts (ibid) which is one of the reasons why The Silences Framework was chosen to guide the research process and presentation of this thesis.

In this thesis, the epistemology identifies how knowledge was created, which can be labelled as constructionism, meaning that the outcomes, or the knowledge, were created from the interplay between the participants and their lived social experiences. In other words, the participants constructed their realities of seeking help for poor mental health based on their experiences of racism, exclusion, and other unfavourable power dynamics. The theoretical perspective regarding the researcher’s belief was that knowledge acquisition is experiential, value-laden, and contextually unique. For this reason, it was important for her to consider the participants’ experiences, who in this case were Black sub-Saharan Africans, the period in which the study was taking place, which happened to be 2020 – 2024, and the context, which was the UK.

3.4 Research Design

This section details how the study was designed. In the ever-evolving landscape of academia, research methodologies continue to adapt and expand to meet the diverse needs of understanding complex societal problems. Among these methodologies, IPA stands as a robust and nuanced approach that enables researchers to dive deep into the subjective worlds of individuals, allowing for a rich exploration of their lived experiences. Previous work has reported how the interplay of cultural, social, and economic factors significantly impact marginalised communities the world over, particularly those within the sub-Saharan African diaspora (Fernando 2005; Halvosrund 2019; Zubrick et al. 2004; Lee-Tauler 2018; Henry et al. 2020; Gajwani 2016). Black sub-Saharan African communities have long struggled with the complexities of inhabiting socio-cultural and economic positions shaped by historical legacies of colonialism, systemic discrimination, and economic disparities (Fernando 2005). As such, a qualitative research approach rooted in IPA becomes indispensable to understanding their experiences and strategies to navigate their various challenges. It offers a phenomenological lens that supports the exploration of individuals' detailed narratives and subjective realities and at its heart lies a commitment to investigating meaning-making processes (Larkin, Eatough and Osborn 2011). This emphasises the significance of context, culture, and individual subjectivity in shaping experiences. Its idiographic nature is advantageous to the research process as it recognises the importance of understanding the complexities of individual experiences within a broader social and cultural context (Larkin, Flowers and Smith 2022). By employing this approach within a doctoral research context, the researcher aimed to thoroughly investigate how Black sub-Saharan African communities perceive, interpret, and respond to their socio-cultural and economic positions.

However, for this study, IPA was chosen after consideration of other qualitative approaches with similar characteristics that could have answered the research question, such as ethnography, narrative analysis, and grounded theory. Ethnography would have been appropriate because of its holistic approach. More so, for its requirement that the researcher understand the culture of the group they are researching into and consider various aspects of their lives, including social structures, rituals, language values and daily practices (Hammersley and Atkinson 2007). Hence, the researcher being of Black sub-Saharan African heritage and working with global majority populations who include Black sub-Saharan African communities, it would have been advantageous to use this approach.

However, the researcher decided against using ethnography due to the vast data collection required by this approach. Her fear was that sorting through enormous amounts of data, field notes, interviews, and observations could be overwhelming. Apart from this method, narrative analysis is another one that could have answered the research question but was opted against and IPA was chosen instead. All the approaches mentioned here focus on the subjective, which was suitable for satisfying the goal of exploring how Black sub-Saharan African communities perceive and interpret their socio-economic and sociocultural environment. However, the decision to choose IPA was heavily influenced by the researcher's background in psychology. This is because the research method was initially developed in psychology, and hence, she guessed her experience of studying psychology at undergraduate level would be advantageous for grasping the concepts quicker. She also appreciated how the methodology was used in another PhD research study to explore 'Black men's experiences of mental ill-health and oppression' (Brown 2020).

Nevertheless, IPA has its limitations. It is a time-consuming research method that can be labour-intensive, and the analysis process can be complex and challenging as researchers navigate the interconnected aspects of participants' experiences. Recruiting willing participants to share their experiences and feelings can also be challenging. IPA's focus on individual experiences makes it difficult to generalise findings to larger populations and replicating IPA research can be demanding as the analysis often involves multiple levels of interpretation. These limitations do not, however, undermine its value and can be mitigated against by providing, for example, detailed documentation of the researcher's analysis process to allow other researchers to replicate their studies. However, as mentioned in the previous paragraph, the researcher could have used other research methodologies for this study but opted for IPA because she could mitigate against most of its limitations. For example, she had a pool of individuals willing to participate in the research from her practice at Inini Initiative, with whom she had built trusting relationships. She also had the opportunity to use clinical supervision for the participants and herself from a counselling therapist experienced in working with Black sub-Saharan African communities residing in the West Midlands of England, UK if the need was to arise.

IPA requires that the researcher takes a reflective stance when using the methodology to conduct a study (Biggerstaff and Thompson 2008; Larkin, Eatough and Osborn 2011). This concept emphasises that researchers are not separate from their research; they are embedded in it. Their presence, actions, and biases can influence the study, making it crucial for them to engage in self-reflection. Green and Thorogood (2011) stress the importance of critically examining one's role in the research process, alongside the subjects under investigation, to maintain ethical and methodological integrity. This practice ensures that the researcher remains aware of how their perspective, decisions, and interactions might shape the research outcomes. Thus, a reflective stance requires that they acknowledge their influence on the research process and how the same process influences them in return (Finlay 2002; Shaw 2010). The next section shares the approach the researcher employed on her journey through the various stages of the research process.

3.5 Insider/Outsider Perspective

In qualitative research, the importance of researchers disclosing their identity, stance, and the ways in which they may have influenced their findings is widely acknowledged (Langdridge 2007; Serrant-Green 2011). This concept is referred to as positionality, often explored in the literature through the contrasting notions of etic (outsider) and emic (insider) perspectives (Doucet and Mauthner 2008; Huberman and Miles 2002), which mark the opposite ends of the positionality spectrum. The etic perspective adopts a detached, objective stance, aiming to produce findings that are broadly generalisable (Green and Thorogood 2014). This aligns with the principles of the dominant positivist and empirical approach to knowledge (Kahuna 2000). In contrast, the emic perspective is subjective and immersive, where the researcher becomes personally involved and deeply connected to the subject matter (ibid), seeking to offer an interpretation from within the group (Charmaz 2004). A researcher adopting an emic approach often claims cultural membership within the group being studied (Pelias 2011) or identifies shared identities with the participants (Green and Thorogood 2014). Structuralism infers the source of meaning comes from the formal structure found in language and can apply to all aspects of human culture (Moon and Blackman 2014). In this work, interpretivism is used to understand the insider position because interpretations of reality are culturally derived and historically situated (Sturrock 2008). In addition, symbolic interactionism indicates that the researcher must take the position of those researched (interaction) by sharing language and other tools (symbols) (ibid).

However, having said the above, researchers are said to move backwards and forwards on the positionality continuum during the research process, and some scholars warn of the danger in doing this as the two sides may collide, causing what is known as researcher identity crisis (Arber 2006; Serrant-Green 2002; Kahuna 2000). This often occurs when a researcher seeks to balance involvement and detachment, aiming for the ideal stance of 'marginal positioning', which lies at the intersection of insider and outsider boundaries (Kahuna 2000). Corbin-Dwyer and Buckle (2009) acknowledge the insider/outsider dichotomy but argue that researchers can safely occupy both roles by utilising the space between these two extremes, referred to as the 'silence'. They suggest that the researcher's identity, cultural background, and relationship with participants can be navigated and maintained within this intermediary space. Positionality depends not only on the researcher's perspective but also on those involved in the research, such as study participants and other collaborators (Arber 2006). This means that researcher reflexivity is needed throughout the research process, from the planning stage to execution, to ensure any presumptions the researcher may hold that could influence the research findings are laid bare and put aside during the research process (Asselin 2003).

The Silences Framework is a proponent to the above views and suggests that to help the reader understand the researcher's perspectives, experiences, and thought processes that motivated the work, the researcher needs to identify themselves (Serrant-Green 2011). In this study, there were aspects of my identity that I felt would have a particular impact on the research such as my experience of being on the asylum process mentioned in Chapter 1, Section 4. Because of this, I may have entered the research field with preconceived ideas of what socio-economic and socio-cultural experiences influence decisions to seek help for poor mental health among Black sub-Saharan African communities. Furthermore, to a certain extent, my refugee background and identity as someone of Black sub-Saharan African heritage mean that I continue to face similar challenges to those experienced by participants in navigating the social terrain of the West Midlands of England, UK.

My personal and professional experience mean that I was both an 'insider' and 'outsider' in this study. I conceptualised the survey from both perspectives. I was an 'outsider' because of my professional background. My work requires advocating and facilitating that global majority communities, including Black sub-Saharan African communities, receive adequate, continuous health and social care support. This means that I must liaise and collaborate with mainstream agencies, such as local authorities, NHS Partnership Trusts, the West Midlands Police, and other organisations providing social services to this client group. As such, I may be viewed as someone who may be advancing the views of these organisations. In addition, because I facilitate that this cohort receives social support, the power dynamics involved, where I am the facilitator and the receiver, makes me an 'outsider'.

Nonetheless, the same position can also have me viewed as an 'insider', since I can be viewed as a group member who understands the group's needs and goes outside to source resources that satisfy these needs and bringing them back to the group. In addition, my migration journey and identity as someone of Black sub-Saharan African heritage also make me an 'insider'. However, being female and Zimbabwean makes me an 'outsider' to participants who identify as not female and those who come from other parts of sub-Saharan Africa. Hence, I had vital perspectives from both sides of the positionality continuum, and as such, I constantly reflected on the research process to avoid having my perspectives influence the findings.

Being an 'insider' or 'outsider' has its pros and cons: 'Insiders' have the advantage of establishing relationships with the participants and, therefore, can engage better with them (Kerstetter 2012). However, the downside is that they may struggle to detach their personal experiences and biases (ibid). On the other hand, 'outsiders' may maintain greater objectivity and emotional distance from participants, but they often face challenges in gaining access to participants and encouraging them to open up fully during interviews (ibid; Muhammed et al. 2015). To ensure a smooth interview process, I began by acknowledging both the similarities and differences between myself and the participants, including factors such as age, gender, socio-economic status, immigration status, and education level. My primary concern was the difference stemming from my role as a resource facilitator for many of the participants, as they were service users of the Inini Initiative. They often look up to me for support and may have agreed to participate in the research as a way of returning a favour. Furthermore, they know what my standpoint regarding the challenges brought about by the socio-cultural and socio-economic environment in which they reside and may have aligned their responses with that. However, on the other hand, my role may have made it easier for participants to open up about their experiences because they were familiar with me and the interview setting. This may have made them feel comfortable discussing difficult conversations with me and trusted me.

Most had approached me seeking support for various challenges and already discussed difficult personal stuff with me. Hence, they must have found it easier to discuss difficult conversations as they had built their trust with me. However, it was confusing to some when during the interview sessions, I asked sensitive, personal information which they had provided during support sessions, such as immigration status or reasons why they were not employed. This was made worse by the fact that I was recording the interview sessions. Such incidents disrupted the flow of conversation, which initially affected rapport and made them doubt my trustworthiness. Sometimes, I had to stop and explain to the participant why I was asking these questions and reassured them that it was okay and safe to answer them truthfully. For example, when I was interviewing Agbo, who is undocumented, about his migration journey, he became restless and apprehensive. I could tell he was confused about why I was asking him for sensitive information when he had already given it to me when he was seeking support from me. This could have been caused by the fact that I had only known him for less than a month, and to make matters worse, I was recording the conversation. I had to stop and say to him:

> *"Don't worry about the questions. I have other questions. I know you've told me these things […] for when I'm doing the report".*

Fortunately, my experiences of direct involvement with Black sub-Saharan African communities and individuals struggling to regularise their immigration statuses in my profession made it possible to get back on track. However, I became more conscious about how I approached the conversation and used my counselling skills to monitor his responses and body language. Luckily, he later warmed up and gave a rich narrative of how he struggled to navigate his social terrain. As recruitment continued and I interviewed more participants, I made it a point to make them aware, ahead of the interview, that I may ask them for information they had already given.

3.6 Methodological Perspective

This thesis used critical theory research because of its focus on power structures to reveal how they perpetuate inequalities and domination. Political and political agendas are accounted for in this work. The emphasis was on praxis, or the practical application of theory to bring about social change as theory and practice are seen as intertwined and mutually informing. In-depth interviews were employed in this research to understand complex social phenomena and the lived experience of individuals. The next section highlights the comprehensive participant selection process and inclusion criteria that served as a foundation for the study's purposive sampling strategy, which ensured a diverse and representative cohort was recruited.

3.6.1 Inclusion/Exclusion Criteria

Participant sampling is a critical aspect of research design. IPA posits that to understand better the overall perception among participants, a research study needs to have participants with similar lived experiences of the phenomenon being studied (Creswell 2013). As such, the study purposively recruited adult participants of Black sub-Saharan African origin to ensure that the sample was homogeneous enough to represent the issue under investigation. Purposive sampling meant that participants selected were most likely to provide rich relevant data for the research questions that involved interviewing this cohort to understand how their social environment influenced their decisions to seek help for poor mental health. Recruiting for participants was very straightforward since the researcher worked with global majority populations, including Black sub-Saharan African communities at Inini Initiative, and was connected with various community groups and places of worship who also work with this cohort. By surveying the clients, this made a readily accessible sample.

The study was introduced to this convenient sample through their leadership, and only those interested were contacted. Those from the Inini peer support group were selected based on their availability and willingness to participate. By carefully choosing the appropriate sampling methods and considering the research goals, population characteristics and ethical considerations, the researcher enhanced the quality and impact of this study. This is because the sampling method directly influence the validity, reliability and generalisability of the research findings. Since the study required participants to provide detailed descriptions of lived experience, which may have evoked traumatic experiences leading to psychological or emotional distress, a risk protocol questionnaire was developed whose aim was to identify and exclude individuals experiencing acute emotional distress. This contained four questions to collate the mental health profile of participants. It probed them to share information that could confirm if they were experiencing acute mental health problems or not. The questionnaire asked if they were receiving mental health support, have been detained in a mental institution recently or recently gone through any traumatic experiences that could make participation risky. The risk protocol questionnaire can be viewed in Appendix vi.

The inclusion criteria for recruiting the sample were:

- Participants must have been of Black sub-Saharan African heritage living in the west midlands of England, UK for at least a year. Since the study was seeking to interrogate the lived experience of the English West Midlands social environment, this period was factored in to allow participants to time to experience navigating its social environment.
- Participants must have been 18 – 65 years old. This age range was chosen because it represents adults who are more likely to have navigated multiple roles and responsibilities, thereby having a range of life experiences.

To create a supportive and ethical research environment, a list giving comprehensive information on the Mental Health Support Services available in the West Midlands, England, UK was compiled and given to participants at the end of the interviews. This proactive approach was an acknowledgement that talking about their lived experiences may have triggered them and evoked emotional challenges during the research process, making them want to access mental health services. Hence, giving them mental health support services information was a way of empowering them to seek help if needed. In addition, a counselling therapist of Black sub-Saharan African heritage, known to most participants was recruited to be on standby in case they needed support immediately.

3.6.2 Sample

A purposive and snowballing method was used to recruit 21 participants of Black sub-Saharan African heritage with the following demographics:

- Female – 8
- Male – 13
- Age range 23 – 60 years old
- All participants had gone through the migration process, from sub-Saharan Africa except one born and raised in England to migrant Black sub-Saharan African parents. 18 had travelled straight from sub-Saharan Africa, 2 had stayed briefly in other European countries before coming to England, and 1 was born in England.
- 18 participants were recruited from the Inini peer support group. 17 had been members of the support group for at least 6 months before the interviews, while 1 had only been to the peer support group for less than a month. Two were mental health practitioners to refugee/migrant communities, including Black sub-Saharan African communities, and one was a church reverend in a Black congregation church.
- The participants had different immigration statuses; 6 were naturalised British, 7 were asylum seekers still awaiting a response from the Home Office, 2 had indefinite leave to remain, 5 were undocumented, and 1 was British born to migrant parents.

3.6.3 Pilot Study

A meticulous pilot was conducted with three participants to refine and validate the research approach. The intent was to assess the feasibility and appropriateness of the study's design, risk protocol questionnaire, semi-structured questions, and data collection methods. The pilot allowed for the identification of potential challenges, cultural nuances, and areas of improvement in the data collection process. It also facilitated for the observation of how participants interpret and respond to questions and assess the potential emotional impact of questions and helped refine follow-up or probing techniques. Feedback from the pilot study was used to fine-tune the structure of the interview plan and provided an opportunity to assess the logistical aspects of participant recruitment. The process improved the study's strength and demonstrated a commitment to conducting the main study in an ethically sound and culturally responsive manner.

3.6.4 Data Collection Instruments - Semi-Structured Interview Question Guide

Participants who met the inclusion criteria were administered semi-structured interview questions from an interview guide prepared in advance. This was to help guide and facilitate the flow of the conversation (see appendix iv). Semi-structured interviews were suitable for this research because they allow for open-ended and exploratory discussions, which assist in uncovering rich and detailed information about the experiences and perspectives of individuals (Scanlan 2020). Moreover, they can be adapted to become culturally sensitive, which is invaluable when researching communities such as Black sub-Saharan African groups with diverse cultural beliefs and world-views (Okeke-Ihejirika et al. 2020). However, their subjective nature can have interview interpretations dependent on the researcher’s biases and perspectives influencing the study's outcome (Vogl, Schmidt and Zantler 2019). Participants can also provide responses they believe to be socially acceptable, and language can become a barrier (Seamark and Gabriel 2018). To mitigate against this, as mentioned in section 3.6.3 a pilot study was conducted to check for any potential biases and to see if the questions were clear enough and practical to answer the research questions.

To develop the interview guide, qualitative research relating to barriers and facilitators of accessing mental health services among Black ethnicities and global majority populations were reviewed. The semi-structured interview questions development process was also influenced by conversations conducted in the Inini peer support group and considered The Silences Framework and Critical Race Theory principles. This supports the critical thinking before researching and knowing what areas need covering called for by Smith, Flowers and Larkin (2022). Additionally, the meetings with the researcher’s supervisory team helped develop an interview schedule that answered the research questions and aligned with the principles of IPA. The interview plan ended with seven themes as follows:

- Migration journey and immigration status
- Housing
- Employment
- Health and well-being
- Mental health awareness
- Mental health service access
- Cultural perception of mental illness and its treatment

The interview guide can be viewed in appendix iv.

3.6.5 Data Collection

Once the study design and data collection tools were deemed appropriate, the interviewing of participants began. All interviews were carried out on a one-to-one, face-to-face basis at the Inini offices in Coventry except one which was carried out at the participant's house. Before the start of the interviews, participants were given the Risk Protocol Questionnaire to assess their fitness for the interview. Once they passed this, the researcher and participant engaged in a warm-up discussion to reduce interviewee tension and to get them ready to discuss more sensitive and personal issues (Pietkiewicz and Smith 2014). At this point, the researcher used their basic counselling skills and work experience in community development to build rapport with the participants and to gain their confidence. She also removed all preconceptions regarding this topic as required by IPA (Smith et al. 2009). Once the conversations were flowing and the participants appeared comfortable, they were asked to re-read the Participant Information Sheet and verbally repeated its contents to the researcher who encouraged them to ask any questions they may have had. Once they confirmed their satisfaction with the information and were willing to proceed with the interview, they were asked to complete, sign and date the consent form. Fortunately, all participants were willing and fit to proceed. Following this, the researcher checked the consent form, and once satisfied that it was completed, printed her name, signed, and dated it. Participants were issued a Mental Health Support Services Information list in case they needed support later.

While IPA recommends that research questions be pitched at abstract level, so they are answered at analysis level (Smith, Flowers and Larkin 2022), this was sometimes not possible, particularly for those participants who were not fluent in English. Translation from an indigenous sub-Saharan African language to English is usually direct and pitching questions at abstract level may have left them meaning something different. Hence, in such situations, the researcher used her experience of working and communicating with global majority populations, including Black sub-Saharan African communities and devised a way of asking the questions in a way they understood. However, though the first question was about their migration journey to England, the rest were not asked in any particular order and allowed enough space and flexibility for original and unexpected issues to arise which were investigated in more detail with further questions. The interviews lasted, on average, one hour for each participant. Recruitment and interviewing of participants continued until a point of saturation was reached. With participants' consent, they were audio recorded using an Olympus digital recorder, and verbatim transcriptions were produced. The researcher noted any initial thoughts, comments, and points of potential significance during the transcription period before moving on to the analysis phase.

3.6.6 Data Analysis

IPA demands that participant and researcher interpretations of phenomena be considered when analysing data (Pietkiewicz and Smith 2014). It is a requirement that the researcher immerse themselves into the participants' shoes (ibid). The researcher's Black sub-Saharan African heritage and lived experience of the migration/integration process made it easier to conduct this study. Given IPA's idiographic commitment (Smith, Flowers and Larkin 2022), the data was analysed on a case-by-case basis before looking for patterns of similarities and differences across the interviews to create group experiential statements. To allow for a thorough examination of the data, hermeneutics, phenomenology, and idiography were used to shape the interpretive lens through which data analysis was approached. This ensured that findings went beyond description and delved into complicated meanings and experiences. Hermeneutics contributed by emphasising the importance of understanding the context and the interplay of meanings embedded in the data. This acknowledged the role of preconceptions and biases in influencing the interpretation of data and, ultimately, the findings. On the other hand, phenomenology guided the analysis by focusing on the essence of experiences as they unfolded in the data. This was complemented by idiography, which highlighted the uniqueness of each case and emphasised the richness of details and nuances within the data.

Within this, an intertwined perspective of descriptive, linguistic, and conceptual analyses created a robust framework for understanding and interpreting the data. The foundation was laid by descriptive analysis, which systematically detailed and summarised the key features and characteristics that was present in the dataset. Doing this provided a solid base for further investigations. On the other hand, linguistic analysis contributed by scrutinising the language and discourse used in the data. Hence, connotations and communication patterns were highlighted. Doing this acknowledges that language is a powerful medium through which meanings are constructed and conveyed. The conceptual analysis dealt with the underlying ideas, themes and theoretical constructs, which identified and illuminated the broader concepts and relationships, contributing to a deeper understanding of the theoretical framework underpinning the phenomenon being studied.

The procedure followed is outlined below.

1. The transcript was read at least once while listening to the audio recording to get the interview's overall ‘feel’.
2. A copy of the interview transcript was printed and re-read. Using a coloured pen, semantic content and language use were examined and recorded on an exploratory level. Notes were made on the left-hand margin on observations and reflections regarding the interview experience and anything of particular significance. Attention was paid to things like repetitions, pauses, symbols and metaphors. The goal was to create a thorough and detailed collection of notes and comments on the data.
3. Next, the exploratory notes were reviewed, frequently referring to the original interview text and constructed experiential statements, which were noted on the right-hand margin using a different coloured pen. According to IPA, this process represents one manifestation of the hermeneutic circle (Smith, Flowers and Larkin

2022). The term ‘experiential statements’ refers to what was initially described as emergent themes (ibid). They have been re-named to this because they directly relate to the participant’s experiences. That is, their experience of trying to understand what happened to them.

4. Following this, a three-column table with the headings, experiential theme, interview content, and exploratory notes was produced to represent the stages in point 3 visually. An extract of this can be viewed in appendix vii.
5. Once finished, the researcher went through the table, focusing on the experiential themes and grouped them into clusters depending on how closely they were aligned. Page numbers were noted next to the quotes for easy reference in case there was need to look for them on the transcript. These were titled according to their characteristics. An extract of this can be viewed in appendix viii.
6. The process was repeated for each participant, and the analysis was concluded by examining patterns of similarities and differences across personal experiential themes to create group experiential themes.

3.6.7 Ethical Considerations

Ethical considerations are important when researching communities to protect their well-being and rights (Banks and Brydon-Miller 2018). This enhances the credibility of the research. For this study, an application to conduct the research was made to and approved by Nottingham Trent University’s Schools of Business, Law and Social Sciences Research Ethics Committee. This was only the first step to satisfying ethical considerations, as the way research is conducted is another and equally important way of satisfying ethical requirements. Hence, in continuing to explore the ethical considerations for this study, the researcher also considered how participants were recruited, confidentiality, the researcher’s, and their well-being. The study recruited only participants who could give valid consent. A Participant Information Sheet (PIS) detailing the study was circulated to potential participants through their leadership. It gave information on what participation in the study involved, including that it was voluntary and that their confidentiality would be maintained. It also informed them that their responses and findings to the study may be published, and some of their quotes may be published. The participants were also made aware that access to data was restricted to only the researcher and their supervisory team and that all personal information provided for the research would be stored securely and kept private. It would be processed according to the NTU RDM Policy, Data Security – Portable Devices and Media Policy, Information Classification Policy, NTU Records Retention Policy and NTU Research Ethics Policy. Interview recordings will be kept on the secure NTU Data Store. They were also informed that they could leave the interview at any time, without explanations or repercussions, if they changed their minds. The PIS also told them that if they decided to withdraw from the interview, their answers would not be used. However, this was only valid if they did this within seven days of the interview, after which it was impossible to withdraw their answers. Before the interview, this information was repeated to the participant before signing the consent form.

3.6.8 Participant Well-being

The well-being of all participants is a priority when conducting research. More so when participants are required to provide detailed accounts of their lived experiences. Having read widely on how unethical research was conducted on Black communities historically (Tilley 2016), the researcher was aware of the trauma inherent in this community regarding participation in research. Therefore, she ensured the whole process, from recruitment to interviewing, was reassuring. Since the interviews used for data collection may have evoked traumatic experiences leading to psychological or emotional distress, she engaged her counselling skills and experience as a mental health specialist to monitor how they were affecting the participant. This helped determine when participants were avoiding talking about specific issues, starting to feel awkward, ashamed, or becoming emotional so the interview could be stopped to check if they were okay to continue or otherwise stop the interview altogether. Additionally, as previously mentioned, a qualified, BACP registered counselling therapist, experienced in working with global majority populations, including asylum seekers, refugees and migrants of Black sub-Saharan African origin, was recruited and on call during interviews in case support was needed immediately. Participants were also issued with an information sheet detailing mental health services, including 24-hour helplines, text, and online mental health support.

3.6.9 Researcher's Wellbeing

The Research Governance Framework requires that, besides considering the health and safety of research participants, that of the researcher conducting research should also be considered (DH 2005). Thus, I did not overlook my health and safety while conducting this research. Throughout my research journey, I frequently experienced mental distress and emotional upset. At one point, my supervisory team suggested I engage in clinical supervision. However, after much reflection and consideration, I decided against it because I realised, I was still carrying traumas caused by previous personal experiences and engaging in clinical supervision at this moment might have triggered them and hindered the progress of the study. Instead, I relied on my study journal and focused on support from family, friends, and my supervisory team. I sometimes removed myself from the study to escape the emotional labour encountered and immersed myself in my community development work. Advocating for mental health equity, providing solutions and hope to our Inini Initiative clients made it all worthwhile, especially when the outcomes were positive: sometimes, just seeing a smile on our Inini Initiative clients brought me joy, and gave me enough strength and courage to continue. I also embarked on regular long nature walks when the weather was good and used the gym, my research journal, listened to feel-good music, and watched documentary films on Netflix often.

3.7 Conclusion

In conclusion, this chapter has outlined the steps involved in conducting the research. It reviewed the foundational theoretical assumptions of IPA and explained why it is suitable for addressing the study's aim. The researcher has also provided transparency regarding the recruitment of participants and the development of the interview schedule, along with detailing the approach to data analysis. This chapter demonstrates how the study was conducted with integrity, critical reflection, and a strong commitment to addressing the research questions in an honest, respectful, and ethical manner. The next chapter will present the results of the IPA analysis, showcasing the study’s findings alongside the researcher’s interpretations.

Chapter 4: Findings

"There is no such thing as a single-issue struggle because we do not live single-issue lives" —
Audre Lorde

4.1 Introduction

This chapter presents the findings of the study, organised using IPA as the method of analysis. The results are grouped into two key superordinate themes: Struggle and Oppression and Medical Colonialism, which are explored in sections 1 and 2, respectively. These themes capture crucial aspects influencing participants' decisions to seek help for poor mental health and their use of mental health services. As described by Smith, Flowers and Larkin (2022), these themes reflect the process of contextualisation. Each superordinate theme summarises critical and foundational experiences shared by participants, illustrating the widespread and deeply ingrained struggles faced by Black sub-Saharan African communities in the West Midlands of England. While individual circumstances vary, the overarching themes of systemic exclusion, financial hardship, bureaucratic obstacles, and mental health challenges appear to be pervasive and intergenerational rather than isolated cases. This is evident in the almost identical experiences shared by Kudzayi and Akusoa in section 4.2.1, despite them belonging to different generations. Also, the use of a snowball sampling technique reinforces the communal nature of the participants' experiences, as they frequently reference peers with similar backgrounds and struggles to participate in the research.

The two sections are closely connected, with significant overlap between them. The sections are structured to address both the challenges participants face in deciding to seek help for mental health issues and the obstacles they encounter when navigating mental health services after seeking help. Hence, section 1, Struggle and Oppression, outlines the experiences of challenges faced by participants while trying to navigate their social terrain and highlights how these negatively influence their decisions to seek help for poor mental health. Section 2, Medical Colonialism, outlines the experiences of challenges of navigating mental health services by participants who managed to break the barriers and proceeded to seek help.

4.2 Superordinate Theme 1 – Struggle and Oppression

This section presents the first superordinate theme revealed from the study's findings. The theme represents a key and significant aspect of the participants' socio-cultural and economic experiences in the environment in which they reside and how this influences their uptake of mental health services. It captures their experiences and challenges while trying to navigate their social terrain in the West Midlands of England, UK. The section describes the environment and paints a vivid picture of how, within this environment, their lives are dominated by such factors as struggle, fear, social exclusion, discrimination, and racism as they try to integrate into their communities. The perspectives participants hold towards the uptake of mental health services are explored alongside how their lived experiences influence them. The sub-themes overlap and intersect and highlight how the experiences of challenges faced by participants in trying to integrate into their communities create barriers for them to seeking help for their mental health. The chapter presents the exact words used by the participants allowing the reader to check their understanding against the data adding to its reliability.

4.2.1 Regularising Immigration Status

A sad feature of the description of the socio-cultural and socio-economic environment experienced by the participants was the sense that everything was a fight. This was articulated in a few ways across participants. In the first two almost identical statements, Kudzayi and Akosua, summarised the types of challenges faced by participants and mentioned how trying to overcome these affected their mental health. Kudzayi said:

> *Everything is a fight—to get food, to get housing, to get everything, to get anything. And then it's, you know, your mental health as well, especially battling with things and trying to get status, trying to get a job, and trying to sustain a livelihood.*

> Kudzayi, Female, 27

By saying ‘status’, Kudzayi was referring to having an immigration status that allows one to access all the services she listed in her statement, including health and social care, employment, and education. In almost the same words, Akosua also said:

> *Everything is a fight, you know, to get food, to get housing, to get wants, to get sheltered, to get anything and then it's, you know, your mental health as well, especially battling with things like papers and trying to get status and you know, trying to get a job, trying to sustain a livelihood. That could bring up a whole host of mental health issues as well […].*
>
> Akosua, Female, 59

In saying ‘papers’, Akosua refers to the same eligibility needed to access essential social services mentioned by Kudzayi as ‘status’ above, as the two words are usually used interchangeably to refer to regularising immigration status. Hence, by saying ‘papers’ and ‘status’ in one sentence, she is emphasising the importance of regularising one’s immigration status as it is the one that unlocks the eligibility to access services and employment and, thus, holds the power to overcome the challenges she mentioned in her statement. However, having a regularised status does not guarantee access to services as rules and regulations change often affecting the accessibility of services. Almaz, whose family moved from sub-Saharan Africa to a European country outside the UK but moved to England for education due to language barriers had the following to say:

> *I had a letter from the European Union that confirmed I am qualified as a European student. So, the first year at uni, I paid European fees. My second year going to my third year, they wrote me a letter and said you're not qualified […]. So, you have to pay international fees. I couldn't afford so I had to defer my course […]. I got my five years and after the indefinite. I went to xxxx university, […] qualified one year for me to progress and that time too the same fees thing came in again. So, I had to also stop*

> *and the third time I went to xxxx uni again […] when I was starting, they say you can't, you have fees of £2000 to pay when you were at xxxx University […]. They wanted that money even after 10 years.*
>
> Almaz, Male, 38

What Almaz is saying is that due to the frequent changes in policy his studies were constantly disrupted, and he ended up with an unnecessary bill for a course he did not even complete because of something that was not even his fault. This narrative shows how the eligibility to use services is not clear to individuals which may be the reason they avoid mental health services fearing to end up with an unwanted bill. Nonetheless, not having a regularised immigration status is worse. In the narrative below Jabu described how this made him feel:

> *[…] Immigration is like a, a disability almost […] I feel stuck and disabled socially to do many things that people would do normally to survive […].*
>
> Jabu, Male, 35

In this statement, what Jabu is saying is that his lack of legal immigration status takes away his freedom to participate in the economic arena.

As the interviews progressed, participants revealed the depth of their social challenges by revealing points in their lives when they encountered different demands and challenges, highlighting how difficult their lives were. Almaz described the difficulty of regularising one’s immigration status below:

> *You know when you come to the UK, it's very tough, especially as a foreigner. Even when you have to pay your applications […] going through the one-year route or two-year route paying huge amounts. It's tiring. It is tiring, the lawyers: with my indefinite, I was rejected the first time. And had to appeal. It's not easy. It's very hard. Because I've seen people where there's you, there's your wife, or you have just two kids. And you need to renew for the four of you.*

Almaz, Male, 38

The challenge Almaz is talking about here is affordability to pay for the visa application and solicitor fees because they are high and need to be paid every two and half years in some instances until one is granted indefinite leave to remain. More so, those submitting applications for more than one person or, if the first application is refused, are not eligible to work and earn any income. By repeating the phrase, ‘t’s tiring’ and using two different statements with the same meaning, ‘it’s not easy’ and ‘it’s very hard’, one after the other, Almaz is emphasising the difficulty of the immigration process. Akua describes how she managed to submit for further submissions in the extract below:

> *I’ve put in what they call further submissions again. I put in 2020, and I’m waiting for a decision from the Home Office. It has been over one year now. So, my solicitor is a pro bono solicitor because I can’t afford to pay solicitors […].*
>
> Akua, Female, 49

By saying that she has submitted further submissions again, it means Akua’s asylum application and first further submissions were refused, that she was destitute and had no recourse to public funds, including access to social and healthcare services. Unfortunately, she must stay in this situation until the Home Office decides, which takes a long time. Long as it is, the waiting time can be scary and frightening, as mentioned by Setorwu below:

> *In the beginning, it was very scary and frightening […] But you keep thinking, giving yourself hope […]. I think I waited about twelve years, but then it got to a point where I started getting to know other people who were in the same situation as me.*
>
> Setorwu, Female, 43

The fear brought about by waiting for a decision for Setorwu comes from not knowing if her application will be allowed or if she will be deported. It also was difficult for her to keep hope for twelve years, but relief came from knowing others were in the same situation. However, for Lobengula, who, besides waiting, was moved from place to place during the Covid-19 lock-downs and ended up in a detention centre, the process traumatised and left him with mental health problems. He narrates his story below:

> *I applied for asylum immediately when I arrived in London, but they took one year without any response at all until the last day of leaving xxxx. I had to stay at xxxx for another three weeks, you get it, when they were putting in my application for subsistence allowance. So, for them, because xxxx could not keep me anymore. They picked me up and took me to the detention centre, you get it? Where I spent two months, you get it? Remember that time COVID was high? You get it? […]. The situation worsened, and that is why when I arrived in the Midlands, you get it, the GP had to refer me to what they call ICPT.*
>
> Lobengula, Male, 34

By saying the situation worsened, Lobengula was referring to his mental health, which deteriorated. Hence, the GP referred him to AIPT. Sadly, the immigration process and the amount of time spent trying to regularise one's stay often lead to challenging situations, as narrated by Almaz:

> *I was homeless for nearly two years. Hardly to get food to eat […]. I didn't know who to help, or where to go. I went even to the council, and they wouldn't help me.*
>
> Almaz, Male, 38

By saying even, the council would not help him, Almaz confirms the difficulties of living in England without the correct immigration status. The council could not help him because he was not eligible to access social services.

Kodjo's interview extract below, which he used to conclude his own interview, sums up the experiences of challenges faced by participants:

> *The last point I wanted to make, like Last, this is a hard situation to overcome because these challenges are still there every day. You have to think of them. You go to bed, Last, I can't have a proper sleep in this country, now for maybe about eight years. You know how I sleep? I sleep with stream sounds. Nature sounds. That's what I rely on to sleep. It's a shame. I rely on nature sounds to sleep because under normal circumstances, if I lie on the bed, I won't sleep.*
>
> Kodjo, Male, 35

The narratives presented highlight the deep interconnection between different socio-economic and socio-cultural challenges experienced by participants. The overarching theme that emerges is one of systemic hardship, where barriers to immigration status, employment, education, housing, and mental well-being are intertwined, creating a cycle of exclusion and struggle.

One of the strongest links across participants' experiences is the idea that ‘everything is a fight.’ Kudzayi and Akosua articulate this in nearly identical terms, reinforcing the idea that survival itself, whether securing food, housing, or employment, feels like a constant battle. This struggle is further compounded by the precarious nature of immigration status, which is not only difficult to obtain and maintain, as Almaz and Akua describe, but also subject to unpredictable policy changes. These bureaucratic and financial hurdles prevent individuals from accessing the very services that could support them, including mental health care, as Jabu highlights when he likens immigration struggles to a form of social disability.

Additionally, the emotional toll of uncertainty is a unifying thread in these narratives. Setorwu’s experience of waiting for twelve years and Lobengula’s account of the distress caused by detention during the COVID-19 lockdowns illustrate the anxiety and trauma associated with prolonged immigration processes. The fear of rejection, deportation, and the inability to build a stable life contributes significantly to mental health deterioration. Kodjo’s closing reflection on his inability to sleep without the aid of nature sounds underscores the psychological distress caused by these systemic barriers, reinforcing the far-reaching consequences of immigration struggles.

4.2.2 Fear of Deportation

This sub-theme explores the link between fear and the uptake of mental health services. Participants spoke about how fear influences their responses to their various challenges. In her narrative below, Setorwu describes how a loud knock, referenced as the ‘police knock’ induced fear:

> *The knock, you remember like if, if, the postman knocks […], the police knock. And people here knock like that. I had an English friend where I had to say to him, I swear if you knock on the door like that, I will never open the door for you […]. You need to stop knocking that knock. We laugh about it now, but it’s not funny […]. Everything, everything was so scary […].*
>
> Setorwu, Female, 43

In this extract, Setorwu shows how the challenges she faced have embedded fear into her so much that a loud knock would trigger her and leave her unsure of how to respond to situations, as narrated below:

> *You never sometimes knew how far you could go; you know. Somebody will abuse you on the streets you can't say anything back. You've got to hold your tongue. You got to. When you go to work, you've got to really behave yourself. You've got to make sure like them, they were the right, the papers are right, the right NI the right everything you don't want to be called […].*
>
> Setorwu, Female, 43

In this extract, Setorwu highlights the intensity of this ‘fear’ and how it prevented her from reacting in situations, even in instances where she was abused. She strives for perfection because she does not want to get into any conversation that may lead to any talk about her immigration status. This shows how fear can act as a barrier to accessing services, including mental health services. In the extract below Kodjo narrated how he ended up being operated on because he did not seek help early enough:

> *At one point I was really scared of going to the hospital […]. I just had that, um, perception that the hospital is like a no, no, due to your immigration status […]. I can say maybe for a couple of years, I was just staying away from hospitals […] within that time, I had some symptoms which had to develop in my body […]. I got operated at that time, you know, and it was something which maybe I could have avoided […]. I was almost dying, you know.*
>
> Kodjo, Male, 35

Kodjo was afraid to go to the hospital because of his immigration status, as he was unsure of his eligibility to use health services and fearful of deportation.

Besides deportation, participants shared how they did not want to do anything that might jeopardise their income because they took responsibility for most family members. This is articulated by Mumbi, who, when his health practitioner encouraged him to go and study so he could get a better-paying job, took time to decide because he was afraid of how he and his family members would survive without his income:

> *Because I was quite scared of how to survive, but also scared of how, because I took on responsibility. Most people are here, but they are taking a lot of, almost 80% responsibility back home rather than here, where they are. So, these are all the things that I used to see. How will my mom survive? How will this one survive? How will that one survive? Survive, survive, survive, survive, […].*
>
> Mumbi, Male, 49

Mumbi was confused about making the decision because even though he found his job strenuous and not paying enough and wanted change, he did not want to jeopardise his income flow because of the responsibilities he carried. Similarly, he would go through the same deliberations with himself about stopping to seek help for his mental health.

This sub-theme illustrates the profound link between fear and the uptake of mental health services. Participants' accounts demonstrate how fear, rooted in their precarious immigration status and financial responsibilities, significantly influences their ability to seek help, whether for physical or mental health concerns.

Setorwu's experience with the 'police knock' highlights how fear becomes deeply ingrained, triggering anxiety in everyday situations. Her hesitance to respond, even in the face of abuse, reveals how fear constrains individuals, compelling them to stay silent to avoid exposing their immigration status. This need for constant vigilance extends to other aspects of life, as seen in Kodjo's case. His reluctance to seek medical care, despite experiencing worsening symptoms, shows how fear prevents individuals from accessing even critical healthcare services. His perception that hospitals were unsafe spaces due to his immigration status led to severe health consequences, demonstrating the life-threatening impact of this fear.

Beyond health-related concerns, fear also dictates financial decisions. Mumbi's narrative underscores the weight of financial responsibilities that many participants carry, not only for themselves but for family members both in the UK and abroad. His fear of losing his income discouraged him from prioritising his mental health. The repeated emphasis on 'survive, survive, survive' reinforces the overwhelming pressure that many Black sub-Saharan Africans feel, leading them to deprioritise their own well-being in favour of financial stability.

Taken together, these narratives show how fear, whether of deportation, financial instability, or losing access to essential services, creates a significant barrier to seeking support. The sub-theme demonstrates that beyond legal restrictions, the psychological burden of fear plays a critical role in limiting access to care, reinforcing cycles of hardship and vulnerability.

4.2.3 Dealing with Unwelcoming Host Communities

Another feature of the description of the socio-cultural and socio-economic environment experienced by the participants was the unwelcoming communities they had to deal with.

This was articulated in several ways across participants. Setorwu describes her experiences when she first arrived in the area where she resides:

> *In the beginning, it was a very scary place to go […]. From the bus stop to the flats, we would be chased being called names. They would call us niggers. They'd call us Black people. You know, like, all sorts of names, you know. And they will chase us, and they will throw stones at us […]. I remember when my partner then came to be with me, and his car was stripped off. The tyres were removed and the side mirrors […] and then to enable, to help me learn how to drive he bought me a mini Micra's car you know. Like they took it and drove it to the river and set fire on it.*
>
> Setorwu, Female, 43

What Setorwu is saying is that dominant communities made her feel unwelcome. Unfortunately, she could not move to a different area because Black people were treated the same in all areas:

> *All areas were the same. The abuse was the same, so I decided to stay in xxxx. At that time when I looked at xxxx it was worse, when I looked at xxxx, xxxx, xxxx, where would I go at that time, you know […]. One of my friends actually moved from xxxx to xxxx there she went and even suffered worse than with the way she was in xxxx and that put me off.*
>
> Setorwu, Female, 43

Setorwu's narrative shows that she had to stay and face this hostility. It also highlights that this hostility was acted towards Black people in other locations of this local authority.

This was also confirmed by Sankara, who faced hostility from one of his neighbours when he moved into a new area:

> *One of our neighbours was so, so challenging. He didn't understand us. He didn't welcome us […] as soon as we moved into that house, he cut branches and threw them over the fence into our yard just to say you're no welcome.*
>
> Sankara, Male, 60

This narrative shows that Sankara’s neighbour kept provoking him so he could move because he did not want to live next door to a Black family.

But then again, not all neighbours reacted with hostility; participants explained how some neighbours just showed their discomfort by using their body language and leaving it to Black people to find meaning in it:

> *There is no animosity, but you can feel by the way they look at you or just their body language that they […] you can tell that they’re uncomfortable with your presence. So, in what sense and what kind of context, I’m unsure. However, since I am the newcomer and I’ve just moved in, and this is, uh an area, from what I’ve noticed which is predominantly white. I could kind of, perhaps it’s, it’s a form of tribalism.*
>
> Mupezeni, Male, 27

Here, Mupezeni is talking about having that feeling where he knew he was not welcome and by mentioning that the area is predominantly white, he is saying this was happening to him because he was Black.

These quotations highlight the widespread experience of unwelcoming and often hostile communities faced by Black sub-Saharan African communities. The dataset suggests that while the intensity of hostility varied, feelings of exclusion and othering were common among participants, shaping their sense of belonging and safety.

Setorwu’s account paints a harrowing picture of overt racial hostility, including physical threats and violence. Her experience of being chased, verbally abused, and having her property vandalised demonstrates an extreme level of racialised aggression. Her decision to stay despite this treatment, because similar hostility existed in all areas she considered moving to, suggests that such racism was not isolated but systemic within the local authority. This aligns with broader trends in the dataset, where many participants described facing racial discrimination regardless of their location, making relocation an ineffective solution to escaping hostility.

Sankara’s experience provides a more subtle but still damaging example of racial hostility. His neighbour’s actions, deliberately throwing branches into his yard, symbolised rejection and an attempt to make him feel unwelcome. This type of indirect aggression, which seeks to push Black sub-Saharan Africans out of certain spaces without outright confrontation, was echoed by other participants. His experience is representative of a pattern in which Black sub-Saharan Africans encountered both direct and indirect signals of exclusion.

Mupezeni’s account, in contrast, reflects a less overt but equally significant form of exclusion. While he did not face explicit hostility, he could sense discomfort from his predominantly white neighbours through their body language. His uncertainty about the exact cause of their unease but his strong suspicion that it was due to racial difference highlights how exclusion can be communicated through non-verbal cues. This subtler form of unwelcoming behaviour, where white community members do not actively confront Black sub-Saharan Africans but make their discomfort clear, was a recurring theme in the dataset.

4.2.4 Experiences of Racial Discrimination

Racial discrimination and the subtlety of racism were highlighted as one of the significant challenges faced by participants in trying to navigate their social terrain. Participants told of the discrimination they face in the community and at work. There was a unanimous agreement that racism was subtle, as narrated by Punha and Agbo. In her narrative, Punha said:

> *In the UK, there is a lot of racism. I find that a lot of the racism that I encounter isn’t outright people shouting the N-word at me; it's people subtly doing stuff. It’s work; I mean previous jobs being racist, being systematically racist. It’s, you know, people*

> *excluding me from things because of my colour, you know, and it’s uncomfortable because it’s so subtle. You kind of question yourself, are people treating me this way because of my colour or am I kind of making things up and it kind of feels like I am constantly kind of being gas lit by people? It also feels uncomfortable […].*
>
> Punha, Female, 23

Punha knows deep down that she is being racially discriminated against, but because of how subtle it is, she gets anxious from the confusion of not being sure whether she is right or wrong in thinking this.

In support, Agbo, who has lived in a different country in Europe before coming to England, stated:

> *Here, they won't tell you that they don't like you. They will be with you and pretend that they like you because they like the things you do.*
>
> Agbo, Male, 31

Hence, Agbo says it straight to the point, and his words are brought to life by Punha who shared a story about a friend she had for four years and didn’t know she was racist:

> *I was friends with one friend for like four or so years, and then when “Black Lives Matter” happened, she was like to me, ‘It’s not my fault that Black people always appear like thugs’. And that was a four-year friendship, and I didn’t even know that she was like that until then […] when you look at people’s perception of Black people, they either think that we are doing drugs and stuff like that.*
>
> Punha, Female, 23

Punha is confused that she was friends with someone for four years and never guessed they were racist. She, however, agrees people had a negative perception about Black people. This is attested to by Almaz, who says he was perceived as a drug dealer by the police because he was Black and had a car. An extract from this interview is given below:

> *[…] this police officer will always use to stop me, and when he sees me passing to xxxx through xxxx,* (names of residential areas), *he will stop me all the time […] because he thought xxxx - xxxx* (names of residential areas) *there's a lot of drugs, and so every Black guy driving a car is a drug dealer. That's the perception of most police.*
>
> Almaz, Male, 38

Again, Almaz thinks he is perceived as a drug dealer by the police because he is a Black man driving a car. Kamuzu blames the media for instilling this idea into the minds of dominant populations.

> *Observe this. When a black person, especially a black man, is walking, yeah and then a parent with a young, a white parent with a young child or children, they will immediately grab them. It's a subconscious thing because we've been labelled, labelled as aggressive, violent, you know […]. It's about what the media made them believe.*
>
> Kamuzu, Male, 45

And Lobengula, who has cerebral palsy and struggles with balance, experienced the above as narrated in his story below:

> *We are socially discriminated against, Black people. I was coming from an arcade […]. Seeing a person coming in your direction and runs into another direction, you get it, yeah, without talking anything, but the act only, implies a lot, you get it? So, but what to, what to do. You can't complain, you get it? Yeah, you can't complain. Even if you were to complain. Where do you complain?*
>
> Lobengula, Male, 34

Lobengula’s narrative reiterates what Punha, Almaz and Kamuzu said above. He said even if he wanted to complain, there was nowhere to complain because even the police had the same perception towards Black people. Sadly, this behaviour is also present in the workplace. Mupezeni describes his experiences below:

> *Western culture has a certain way that they see Black people. Other managers want to make you feel as, as if you are a slave and you are under them, you see […] I’ve experienced it in eh different, uh, warehouse environments. It’s almost psychological. Like, um, they try to domineer someone, almost trying to make them submit. That’s one of the reasons I find, um, the environment challenging […] because of course, these are my managers, my superiors, so they can talk to me in a certain way they might feel, and they know there wouldn’t be any retaliation because I don’t have any power in the environment […] even if something offensive were to happen and I were to complain about it, there won’t be much done.*
>
> Mupezeni, Male, 27

Here, Mupezeni is saying the power dynamics are skewed against Black people. In saying that other managers want to make you feel like you are under them, Mupezeni is talking about class hierarchy, and because all his superiors are white and side with each other, it is pointless to complain. His thought process is confirmed by Agbo, whose complaints of racism were ignored by his employers:

> *I was already in stress in the company because somebody was racist against me on the job. Then I complained, they pretend they don't see, you understand? I complained again, they still come pretending they don't see it, thinking I'm stupid. I know the guy is acting really racist. So, he dropped a xxxx* (unprintable four-letter word) *in my way that I will get hurt*.
>
> Agbo, 31

Agbo is talking about superiors turning a blind to him being racially discriminated against by a colleague. This problem is not limited to workers in a warehouse or menial job environments only, as attested by Kamal, who worked in a high-powered environment:

> *[…] the workplace is challenging, […]. Your mental health is on the line constantly […]. When you're put in front of clients, they don't generally see a Black man like me as their lawyer to complete a 400-million-pound contract […]. So, when I arrive in the room, and I'm like, okay, I'm, I'm your associate dealing with this contract. They look at each other first […]. It can affect your well-being; you wouldn't be human if you don't feel as if they're trying to undermine you […]. You have to prove yourself.*
>
> Kamal, Male, 35

Kamal needs to prove himself. And Kamuzu talks about how, for Black people, the higher the position, the more subtle the racism becomes:

> *[…] the higher you move professionally, the more, more complex people become in terms of, their racial attitude. The lower you are, the more open and direct they are. The higher you go, it becomes subtle, it becomes like a micro, more of a micro-aggression, yeah, but then the impact on that mentally is huge. I'm trying to find a way to deal with that challenge because if not, you will even stop going to work.*
>
> Kamuzu, Male, 45

What Kamuzu is saying is the same as what Punha was saying regarding racism being subtle, and he feels there is more directed towards him as he moves up the ladder at work. In the extract below, Kamal blames institutions for hiding discrimination behind policies:

> *The discrimination is written into the law. So, it’s like the fabric of what the institutions do […] but the charge of racism, I think it's a difficult one to establish. You can’t point that towards people you don’t know […] who are implementing a policy position, but as to whether they know that the system is discriminating, I think they do.*

Kamal, Male, 35

What Kamal is saying is that because of how subtle racial discrimination is dealt with in England, those who are discriminated against may feel it, but it isn't easy to establish. At the organisation level, it is presented as policy, but the organisation knows fully well they are discriminating. This may be what made Sankara struggle with getting a mortgage even though he had all the required documents. He narrates his story below:

> *So, we managed to put a deposit for the house. And it was also a challenge. Each time we're about to get a house, things didn't work out until one Asian guy who ran a corner shop said, don't you know what's happening? This is discrimination; it's quiet discrimination. You are not gonna get a house. This is what's happening. You can have all the money, but what I suggest is, there is a company, which he is linked with in xxxx* (a different city with a more diverse population). *That's how I managed to get my money. It was through an Asian financial company. Otherwise, every deal was falling through, falling through, falling through. And that's how it was at the time.*
>
> Sankara, Male, 60

Sankara agrees with Kamal that organisations will look for a clause in the policy to justify their discrimination against you. He also thinks it is because those who implement policies do not know much about the social challenges faced by Black communities:

> *I've seen a shift in policy where there is now a tendency to try and promote more or, to be precise, more inclusive […]. The awareness is there, policies are there on the paper […] what tells you that things are still a few years behind, all you need to do is look at the structure of a company. Who is at the top? How many Black people are there? Sometimes, you see nobody. So, who is going to influence that?*
>
> Sankara, Male, 60

What Sankara is saying is that even though policies are now inclusive, it is only theoretical, and this is because the top management responsible for implementing them is all White and, hence, continues to implement policies that favour dominant populations.

This sub-theme highlights the ways in which racial discrimination, both overt and subtle, shaped participants' experiences in their communities and workplaces. The narratives demonstrate how racism manifests in indirect ways, leading to self-doubt, exclusion, and systemic barriers that affect well-being and limit opportunities.

Many participants, including Punha and Agbo, described racism as subtle and difficult to pinpoint. Punha’s account of experiencing exclusion and gaslighting at work was echoed by a majority of participants, particularly younger individuals working in predominantly white environments. Her narrative reflects a broader struggle with microaggressions that leave Black individuals questioning whether they are imagining discrimination. Agbo’s observation that people in England hide their racial prejudices behind politeness was similarly common, especially among those who had lived in multiple countries and had a basis for comparison. His experience illustrates a general trend in the dataset, some participants felt that racism in England was more covert compared to other parts of Europe.

The perception that Black people are viewed as criminals was another prominent theme, reflected in the experiences of Almaz and Kamuzu. Almaz’s repeated stops by police officers based on racial profiling was a pattern seen among male participants, particularly those who were younger and more mobile. Kamuzu’s account of white parents instinctively protecting their children upon seeing a Black man further supports this trend, highlighting how media-driven stereotypes contribute to everyday racialised encounters. Lobengula’s experience of people avoiding him without direct confrontation adds another layer to this, demonstrating how racial discrimination is often expressed non-verbally. His story is particularly significant because, as someone with a physical disability, his experiences illustrate the compounded effects of racial and ableist biases, an issue that was less commonly reported among other participants.

Workplace discrimination emerged as a consistent challenge, affecting participants across different industries and job levels. Mupezeni’s description of managers attempting to exert dominance over Black workers was widely shared by participants in lower-paid, manual labour environments. His sense of powerlessness in these situations was echoed by Agbo, who found that complaints of racism were frequently ignored, reinforcing the feeling that Black workers lacked institutional support. In contrast, Kamal, who worked in corporate law, provided insight into how workplace discrimination operates at senior levels. His account of clients doubting his competence based on his race was representative of a particular subset of highly skilled Black professionals who encountered more nuanced, yet equally damaging, forms of racism. Kamuzu's observation that racism becomes more subtle as one advances professionally was a recurring theme among those in leadership roles, suggesting that while overt discrimination may lessen at higher levels, racial bias remains deeply embedded in workplace culture.

At an institutional level, participants identified policies as a vehicle for maintaining systemic racism. Kamal's assertion that discrimination is 'written into the law' reflects the frustration shared by participants who felt that racial biases were ingrained in corporate and governmental structures. Sankara's difficulty in securing a mortgage, despite meeting financial requirements, exemplifies how institutional discrimination operates in practice. His realisation, only after speaking to an Asian shop owner, that racial bias was the cause of his rejections was a pivotal moment, reflecting a broader pattern in the dataset. Many participants described moments of sudden awareness when they recognised the quiet but persistent barriers preventing them from accessing opportunities. His final observation about the lack of Black people in senior positions within organisations supports a wider finding in the study.

These narratives collectively reveal how experiences of subtle racism and institutional discrimination contribute to a deep sense of mistrust toward dominant cultures and systems. Participants across different backgrounds and occupations expressed frustration with having to prove themselves, fearing they would not be believed if they reported discrimination. The uncertainty created by covert racism, alongside the systemic exclusion from opportunities, intensified feelings of alienation and psychological distress. This mistrust extended to key institutions such as law enforcement, the workplace, and financial services, further deterring participants from seeking support, including mental health services.

4.2.5 Loss of Social and Cultural Identity

Another of the challenges faced by participants was the loss of social and cultural identity, which can trigger and leave them with an identity crisis. This can lead to them needing help to make choices that align with their values and goals contributing to a sense of confusion and indecisiveness. In his narrative, Kamuzu talked about how he contemplated going back to sub-Saharan Africa because moving to England had moved his from a well-respected position in the community to a factory worker:

> *Well, first is the cultural shock. You come here, you lose everything; your identity, professional, personal identity is gone. So, uh, I was comfortable according to the xxxx standard. Yes. Uh, social status, extremely well respected […]. That was the hardest part for me, and uh, at some point I wanted to go back because I've never worked in a factory ever in my life […]. And the people there are not nice at all. They are very nasty people. Yeah. It's ruthless.*
>
> Kamuzu, Male, 45

Kamuzu is saying that coming to England reduced his social status, and sadly, the people he was working with made him feel like nothing. The same sentiments were echoed by Sankara, who also found moving from high profile jobs to a petrol attendant challenging:

> *My first job was working for xxxx selling petrol. And before I go there, I went to the university of xxxx, and I graduated in xxxx with a BSc in Sociology. And I worked as a government labour relations officer in xxxx, then human resources for organisations like xxxx, xxxx xxxx, xxxx […]. So, coming to UK to sell petrol it was quiet, it was so difficult. So, from that job, I worked in a warehouse, so difficult. If I had not come with my family, because I had a return ticket, I promise you, I would have gone on the next plane back home because it was so challenging.*
>
> Sankara, Male, 60

Just like Kamuzu, Sankara also contemplated going back to his home country. He is saying he felt belittled and embarrassed moving from such high-profile jobs to becoming a petrol attendant. Disturbingly, even with a postgraduate qualification obtained in England, it was still challenging to get a job one trained in as narrated by Akua:

> *Although we have our own professions, like I said, I studied for a master's in public health at the university of xxxx so you would want to work in the field that you, you know, but it's hard to get work in the same profession you studied and worked in in your country. Even after further studies on the same profession in this country. It seems like care work is open to everyone […].*
>
> Akua, Female, 49

In her narrative, Akua is saying regardless of what qualifications she has, as a Black person she can only get into lower-paying jobs that are shunned by dominant communities. For Kudzayi, her identity was lost in moving from a big house to a one-bed flat, which she shared with her mother and sister. She says:

> *When we lived in xxxx (home country), you know, we lived in a big house, lots of rooms, huge garden spaces, you know, this was just what we were like, just used to, and we went to really good schools […] but when we moved to the UK, you know, we moved in with our mum, and she was living in this tiny little studio flat in xxxx. […] one small room um with one tiny kitchen, one tiny shower, no outdoor space […] so you know, to kind of move from that to just a shrunken landscape.*
>
> Kudzayi, Female, 27

Kudzayi expresses the shock of coming from a life of comfort to modesty in England, where she had imagined everything to be better than anywhere in her country in Africa.

One of the significant challenges experienced by participants was the loss of social and cultural identity upon migration to England. This transition often triggered an identity crisis, leaving individuals struggling to reconcile their past status and achievements with the reality of their new environment. The sense of displacement made it difficult for them to make choices that aligned with their values and goals, contributing to a state of confusion and indecisiveness. Many participants expressed feelings of frustration, embarrassment, and even regret about their migration, with some contemplating returning to their home countries.

A key aspect of this identity loss was the dramatic change in social status and professional identity. Several participants who had held well-respected positions in their home countries found themselves relegated to low-skilled, low-paying jobs in England, which not only affected their self-esteem but also left them feeling undervalued and disrespected. This was particularly evident in the experiences shared by Kamuzu and Sankara. While their experiences were striking, they were not isolated cases. Their struggles reflected a broader pattern observed among participants, particularly those who had attained higher education and professional success before migrating. Many described how they had to settle for employment that was far below their qualifications, reinforcing their sense of identity loss. Akua, for instance, pursued a master's degree in public health in the UK, hoping that further studies would help her integrate into her field. However, she found that her qualifications did little to improve her employment prospects, as many Black sub-Saharan Africans were systematically pushed towards care work and other low-paying sectors. Her experience was indicative of the frustration felt by many who, despite their efforts to gain UK-based credentials, still faced barriers to employment in their respective professions.

In sum, the loss of social and cultural identity was a profound and recurring challenge among participants, shaping their overall experiences of migration and mental health. The psychological toll of this downward social mobility was profound, affecting their confidence, self-worth, and ability to navigate their new environment. The resulting frustration and disillusionment made it harder for them to seek help for poor mental health, as they struggled to accept and articulate their new reality.

4.2.6 Social Exclusion and Isolation

Another feature of the participants' description of the socio-cultural and socio-economic factors that influence their uptake of mental health services was the sense that they were socially excluded from participating in activities and events happening in their local communities. in his narrative below, Lobengula described why he thinks this happens:

> *[…] at the moment, I’m not included. I really think that because of the situation, the way they take us to be as asylum seekers, we are not notified of what is taking place in the community.*
>
> Lobengula, Male, 34

What Lobengula is saying is that, as an asylum seeker, he is seen as not worthy to give any input into what is happening in the community. The same is echoed by Kamal, who feels ignored by the community:

> *They recently came knocking during the council elections because they wanted to be re-elected, but I'd never seen them before. I don't know where the councillor's office is. If they've got one in the area, it's not visible, at least, I think. I've never actually approached him, either.*
>
> Kamal, Male, 35

Here, Kamal says that local authorities do not recognise his worth except maybe getting a vote from him.

The lack of involvement in community events is a barrier to its new members getting information on services, including mental health services and how they can be accessed. To mitigate against the problem of exclusion and unwelcoming communities mentioned in 4.3, participants tend to gravitate towards residential areas where individuals with similar characteristics, such as culture, religion, and nationality, when looking for a place to stay as confirmed by Setorwu below:

> *You see, the Somalis will be there. The people from other Eritreans will be here. You know, people cluster themselves […].*

Setorwu, Female, 43

Setorwu is saying that individuals will form cliques to feel safe and share information. However, as Agbo narrates, how those without the right characteristics will be isolated.

> *The depress here is that everybody likes to stay with the people they meet first. It's like people already don't know you at the moment, so you're not selected.*
>
> Agbo, Male, 31

Agbo feels isolated because the cliques around him are not open to newcomers.

And, coming from a continent where the culture of ubuntu is almost universal, participants were shocked to witness the English individualistic culture. Akosua, who moved to England to nurse her daughter, who was fighting cancer, narrated her shock of experiencing the individualistic culture.

> *You know how it is out here in the UK. […] It's not about your neighbours, about anyone. It's just you and your own family, […] I've realised it's who the British are; each one minds their own business […] Somebody is mourning next door, you cannot even go and, you know, show your, uh, support in terms of, uh, emotional support […]. For me, it's so awkward because I come from a society where people are people, because you know about your neighbour, you care about your surroundings.*
>
> .
>
> Akosua, Female, 59

Akosua is talking about her shock at experiencing the English individualistic culture. She feels the English are not 'people' because they lack the collective values of ubuntu, which believes in people being intermingled with their environments and hence, if the English were 'people', neighbours would empathise with one another.

The same is echoed by Samora below, who says in England, even families do not commune:

> *[…] but in this country, I find, I think families are so disintegrated, and there isn't much family support. I find it's the way people live in this country. I live in a place as I told you, I don't know who the neighbours are, I don't know what their names are, you know, and sometimes you barely say hello you know. So, in an environment where the community is not cohesive, the community doesn't even commune […].*
>
> Samora, Male, 45

Samora seems to have acknowledged that this is how it is in England and feels disconnected from the community.

However, some participants feel that it is not only the dominant communities who practise the individualistic culture, arguing that Black sub-Saharan Africans also get sucked up into this fragmented English society when they get to England as narrated by Mupezeni who arrived from Zimbabwe as a ten-year-old. An extract from his interview is given below:

> *[…] help is that you have companionship and family. However, it kind of gets convoluted, um, in England because, because society is very fragmented, especially because of, uh, people's professional lives […] everyone is sucked up into their long hours jobs and, uh, other responsibilities that come after […] that cultural feeling or that, that, that cultural understanding is not there among Zimbabweans themselves because of the modern life of England and how it has taken up so much time and energy within their minds. And yes, […] because of that, there is no, there isn't as much of a cultural environment because of the westernisation we go through when we come to England. So, because of that, we don't really have the same methods of dealing with our, um frustrations.*
>
> Mupezeni, Male, 27

What Mupezeni is saying is that, even though sub-Saharan Africans share and practice the concept of ubuntu in the region, it all changes once they get to England, motivated by its challenging social demands and they lose their cultural understanding of living in an interconnected community where they support one another.

The narratives under this sub-theme show that participants were isolated and excluded from what is happening in their communities. Even though some form clusters where they share information, others are not let in because they have different characteristics to the group. Also, the demanding social challenges mean that people keep to themselves as they work to try and overcome them. Unfortunately, it means the sharing of information is limited, and this may affect the way they seek help for poor mental health as they may not be aware of who to approach and where to find them.

This experience of exclusion was particularly pronounced among asylum seekers and recent migrants, who often felt unseen and undervalued. For instance, Lobengula expressed how asylum seekers were systematically overlooked when it came to community engagement, stating that they were not even notified of what was happening locally. His narrative reflects the reality that asylum seekers are often perceived as outsiders who have little to contribute to the community. Similarly, Kamal noted that local authorities only engaged with him when they needed his vote, reinforcing his feelings of being ignored and undervalued outside of political gain. These accounts illustrate the lack of meaningful engagement between migrants and the wider community, which in turn creates barriers to accessing mental health services, as individuals are left unaware of the support available to them.

Beyond exclusion from local communities, participants also struggled with the cultural shock of transitioning from a collective to an individualistic society. Many came from sub-Saharan African countries where the concept of ubuntu, an ethos centred on interconnectedness, collective responsibility, and mutual care was deeply ingrained. Upon arriving in England, they were confronted with a culture that prioritises independence and self-sufficiency, which left them feeling emotionally disconnected and unsupported. Akosua, who had moved to England to care for her sick daughter, was particularly shocked by this lack of communal support. Similarly, Samora described England as a disjointed society where even families do not commune, reinforcing his sense of alienation. His account suggests that social fragmentation is not just experienced at the community level but also within families, making it even more difficult for Black sub-Saharan Africans to find the support they need. This has direct implications for mental health, as it leaves individuals without the emotional support networks that they would have relied on in their home countries.

Interestingly, some participants noted that this cultural shift does not solely apply to dominant communities but also affects sub-Saharan Africans themselves. Mupezeni, who moved to England as a child, observed that even within migrant communities, people become absorbed in the fast-paced and demanding nature of English life, leading to a gradual loss of communal values. His account demonstrates that social isolation is not just imposed by external communities but can also develop within groups as they struggle to navigate life in England.

Overall, the narratives reveal a consistent theme of exclusion and isolation that significantly impacts the ability of Black sub-Saharan Africans to access mental health services.

4.2.7 Decreased Mental Health Awareness

Another theme that came up was how participants were not aware their mental health needed professional support. Setorwu shared how she found out by mistake that she needed support for her mental health. She tells her story below:

> *The first time I ever went to the GP […] I didn't go to him like I was seeking mental health support. I was going to him like, please help me write a letter. Yeah, please help me write a letter to anybody, a lawyer, or anybody I can find. And then he said, xxxx* (participant's name) *do you realise that you […] this is more than just writing a letter, because you're crying, you're sad, you're really down? This is affecting your mental health. Do you know that? And he sent me to xxxx hospital.*
>
> Setorwu, Female, 43

Setorwu was focused on trying to find solutions for her problems. She did not even realise she needed support for her mental health.

However, Akua felt something was not right but did not know what it was until by chance, she found some literature on mental health in the library and approached an attendant who referred her to a GP. She said:

> *I wasn’t aware, you see, initially […] and that’s how I was prescribed medication at that time because I didn’t know, um, the support services that I could access.*
>
> Akua, Female, 49

This point was supported by Kodjo who expressed in his interview that he had never had anyone talk about mental health until he started coming to the Inini peer support group where he learned about it and how to support his peers when they were going through difficult times. An extract to his interview is given below:

> *[..] the first place I ever heard of mental health problems was in ININI, where it was being spoken. Um, no one had ever spoken that to me, you know, it was at ININI. […] It’s really important because we see many of our friends, loved ones going through, you know, a lot. And sometimes we just ignore them because we can't, we can't help them […] people don't really want to listen […]. I've, I've made statements like, I don't need to hear your problems. I got my own.*
>
> Kodjo, Male, 35

What Kodjo is saying is that, before joined the Inini peer support group, he did not have any information on mental health and could not identify it in himself and others making it difficult to support them.

Nevertheless, while others are aware they are experiencing psychological distress and know which mental health services to approach, they still prefer to turn to their religion as opposed to accessing mental health services. When asked what treatment he would prefer for mental illness Tafadzwa responded:

> *I'll go to God, […] cause God takes care of me. I would go to God. Like for, um, for I'll just go open in the Bible mm-hmm, because everything is there.*
>
> Tafadzwa, Male, 42

What Tafadzwa is saying is that the bible teaches us that it is God who takes good care of us and hence, when overwhelmed psychologically, he will turn to prayer and meditate on God's word.

Tafadzwa's comments are supported by Afolabi who also believes that God takes care of people's problems. An extract from her interview is given below:

> *I saw my GP about it once. And I was given some happy pills. I tried them twice; I stopped it. I said no, I cannot use this and become dependent on it. These are only problems and they're not my problems […], they are God's problems.*
>
> Afolabi, Female, 49

What Afolabi is saying is that using drug treatment for her mental health will leave her dependent on it, so she would rather turn to her faith in God for healing instead. Her fears are confirmed by Punha, who when she prescribed antidepressants was told she would be on it for only two years maximum, and has been on them five years now:

> *My GP was like, yeah you are depressed, and they gave me antidepressants and they were like, yeah you will only be on them for two years or so, and it is five years later, and I am still on them.*
>
> Punha, Female, 23

What Punha is saying is that she now cannot function without the antidepressants.

Unfortunately, others lose all hope and start using recreational drugs and other distractions to numb their pain:

> *It really affects your mental status, and you are, at the end of the day, maybe on drugs, maybe on this, so that you try and forget.*
>
> Akosua, Female 59

According to Akosua, the challenges faced by participants are way too much and induce mental health problems. Hence, people turn to drugs to escape their realities, and anyway, if one does not know they need help for their mental health, they will not seek help for it.

The narratives reveal that many participants were unaware they needed mental health support, while others, despite recognising their struggles, chose to rely on faith or alternative coping mechanisms rather than seeking professional help. Setorwu and Akua's narratives highlight how mental health struggles often go unrecognised within Black sub-Saharan African communities due to a lack of information and awareness. This illustrates how some individuals may only recognise their mental distress when pointed out by others. Kodjo's experience reinforces this idea, as he had never heard discussions about mental health until he joined the Inini peer support group. His admission that he previously ignored friends' problems due to his own burdens reflects a broader cultural attitude where mental health is often deprioritised in favour of more immediate concerns. This lack of awareness prevents individuals from identifying distress in themselves and others, making it more challenging to provide or seek support.

However, for those who do recognise their psychological distress such as Tafadzwa and Afolabi, many prefer to rely on religion rather than professional mental health services. This perspective reflects a strong faith-based approach to mental health, where prayer and spiritual guidance are seen as the primary sources of healing. Also, there is a fear of becoming reliant on medication as expressed by Punha and Afolabi which may contribute to the reluctance by some individuals to seek professional mental health care. Unfortunately, for those who neither recognise their mental health struggles nor turn to faith, some resort to unhealthy coping mechanisms.

These accounts illustrate a pattern in which many Black sub-Saharan African individuals lack awareness of mental health issues, and even when they do, often reject conventional treatment in favour of spiritual or alternative coping strategies.

4.2.8 Lack of Familial and Community Support

Another sub-theme from the findings was the lack of family and community support, particularly for individuals facing health problems. In the extract below, Akosua, who nursed her daughter to health when she had cancer, said:

> *Some people have gone out of it because usually issues to do with mental health is excessive stress on you. And you need some people that help you to, you know, get out of it, and support you and, you know, make you feel better.*

What Akua is saying is that mental illness is caused by excessive stress, but if a person has human interaction and support, they will recover. She can attest to this as she saw the results when she nursed her daughter:

> *She started to respond to medicine because she was >pause< she said she got sick in January. When I came here in October, she was not responding to medication. Each time they tried to do this; she would just get worse […].*
>
> Akosua, Female, 59

However, participants spoke openly about the lack of family support. Samora said:

> *In this country […] it seems everybody is busy living their lives to care for anybody who's unwell. So, when people get unwell, they just, it seems they're just dropped into the system, you know. Once they are in, the relatives and friends, once the person is in care*

> *setting, they believe they are getting the help they need, and yet the care the person gets within a care setting, whether in a mental health unit is, is more about medication and managing the behaviour.*
>
> Samora, Male, 45
>
> Samora believes the challenges families experience trying to navigate their social terrain leave them no time to care for their loved ones, and they think it is best if they go into the hospital, but the care there lacks the human touch.

Almaz supported this and claimed that families even exaggerated their relatives' symptoms to get them into hospital, which may lead to wrong diagnoses and treatments. He narrates a scenario in which he was involved with one of his church members:

> *Some of the problems we go through as Black people sometimes is generated by our brothers and sisters because of their inability to take proper care of us. They exaggerate sometimes our conditions. I was called to go to xxxx* (city in England) *a young Black girl, 19 years old, was detained in the hospital for mental health she didn't really have any mental health, and they kept her for three days […] and I went in, spoke to her, prayed with her and guess what, the next day they took her out. Up to now this girl […] they are doing so great in life. Probably, she was trying, she needed somebody to the point they even thought she was losing it. So, they wanted to put her in psychiatric […]. Look, if I didn't go from here to xxxx, that girl will be in a mental home now… she was going to start having injections for something she wasn't sick of.*
>
> Almaz, Male, 38

Almaz believes the amount of time participants take to find solutions to their challenges does not afford them time to care for their relatives, and they are happier for them to get this in the hospital.

On the other hand, the lack of know-how on how to support someone with an illness they are not familiar with makes families and friends distance themselves from the individual. This happened to Setorwu, who removed herself from a friend because she did not know how to support her:

> *And you know, having a child here, it’s not the same as back home. And we, at that time, never took it seriously. We didn’t know what post-natal depression was. And you know, and she kept on, and we were thinking come on, you know you have a child and you know the child needs you and you know, people come and see you from time to time […] but then when she was there, then you, you didn’t also know when you go to visit, how you, you visit, what would you say to her, well, how would you? I mean, how do you explain this issue? I mean, you are just confused […]. So, you don’t know how you can help. And you can go slowly, and then you lose contact because you don’t, you also don’t know your place. You don’t know how to act.*
>
> Setorwu, Female, 43

Setorwu did not know what post-natal depression was and what the correct way of supporting someone experiencing something like that was, so she decided to distance herself from her.

Cultural norms may also become a barrier to family support, as narrated by Setorwu, who told how her male cousins failed to support her when the father of her children was abusing her:

> *I remember when we, I broke up with the father of my children, I went through a really tough time […] then domestic violence also happened and, and even you know things are happening and I didn't know what to do, where to go, who do I engage with. And you talk to […] you reach out to some of my cousins because it's […]. So, you will hear from the men it will be like, ‘What are you doing or what are you not doing that is causing you […] Because in that time as well, my ex had papers, and I didn’t, and he took the children away from me […]. That's when I lost it; I properly lost it […].*
>
> Setorwu, Female, 43

Setorwu is saying she failed to get support from her male cousins because they had the patriarchal mindset, which says it is mostly the woman’s fault that causes her to be abused.

Participants also spoke about family members who arrived in England first withholding information on services to control them. Afolabi became a victim of this when she threatened to return to her home country after finding out that her husband had lied to her about his immigration status and life circumstances:

> *[…] I remember where I was living, I could stand outside my door or on my window. I can see the Co-op. I can see Tesco and I can see the, the main road. I don't know how to get to Tesco, not knowing that there is a subway I need to get into […].*
>
> Afolabi, Female, 49

Basically, what Afolabi is saying is that the lack of information disabled her.

Participants also mentioned how they struggled to build community networks because they were moved often or those in their circles were busy trying to overcome barriers to care about building relationships. In the narrative below, Akua narrates how she was uprooted from a community she had known for seven years:

> *[…] when I claimed asylum, I was living in xxxx. I had a community there at the time. Like I used to go into xxxx church and we, I had a lot of xxxx friends and family there, but when I claimed asylum, I was told initially that, because I had lived in xxxx for about seven years at the time, Home Office would consider me to be given a house, an asylum house in xxxx […]. But when the day came, when we were moving, I didn’t even know where they were taking me until we arrived in xxxx, that’s when the driver said you are now in xxxx. So, to me that whole journey was very stressful.*
>
> Akua, Female, 49

Akua was moved from a familiar place with familiar people to a new place where she did not know anyone, which stressed her. More so because the house was dilapidated, and her new house-mates were also struggling with their mental health:

> *The house was very, very dirty […], and because the water was running 24/7, therefore there was no water to flush the toilet […]. Plus, seeing people that I was living with, even people struggling with their mental health issues, it's always not easy to live in that environment where you see that other people are also struggling and nobody cares.*
>
> Akua, Female, 49

What Akua is saying is that the house she moved into was dilapidated, and it was not easy to form any friendships because her housemates were experiencing mental health challenges.

The above narratives show how participants struggled with their mental health with no support because either their families were busy trying to earn a living or were also experiencing mental health problems themselves. This acts as a barrier to accessing mental health services as individuals lack trusted individuals to offer them emotional support.

The narratives illustrate the significant lack of family and community support that many Black sub-Saharan African communities face, particularly when dealing with health challenges. This absence of emotional and social support contributes to increased stress, isolation, and barriers to accessing mental health care. Akosua highlights the importance of social support in overcoming mental health struggles when she describes how her daughter who was not responding to treatment began to improve when she provided her with emotional support. In support of this point, Samora, echoed his frustrations of how the challenges faced by Black sub-Saharan African communities make it difficult for them to care for unwell relatives as they work to overcome them. This is further supported by Almaz who argues that some families even exaggerate their relatives' symptoms to get them into hospital care, so they can free their time to go to work.

On the other hand, a lack of knowledge about mental health also plays a role in distancing individuals from their loved ones as seen in Setorwu who shared how she withdrew from a friend experiencing post-natal depression because she did not understand the condition or know how to offer support. Her experience reflects a broader issue where mental health conditions are not widely understood, causing isolation instead of compassion. The same goes for cultural norms which she says after experiencing domestic violence and losing custody of her children, her male cousins failed to help her. This is a response rooted in patriarchal beliefs and is common in individuals of Black sub-Saharan African heritage. Unfortunately, without trusted individuals to turn to, those experiencing mental health problems face significant challenges in accessing mental health care, reinforcing cycles of isolation and distress.

4.2.9 Mental Health Stigma

Participants also spoke openly about mental health stigma and revealed how family and friends reacted to individuals experiencing mental health problems. In the extract below, Setorwu narrates how her peers shut down the idea of seeking help for one’s mental health:

> *[…] engaging with a GP about mental health? Never […] and then there was this thing, like, you know, big Black people don't crack […] come on, you're not the only one, you're not the only one who is suffering […] And then when people started leaving xxxx* (name of her home country)*, and then my friend went to America […] and they will tell you the challenges they're facing. You think okay, we are not alone. To me, come on, it was >pause< never did I think of engaging the GP for mental health.*
>
> Setorwu, Female, 49

What Kudzayi is saying is that the mantra among her friends and family is that Black people across the world face social challenges day in and day out and have normalised this way of living. Therefore, seeking help for one’s mental health was not necessary. Similarly, Kudzayi describes below how her own family did not take mental health seriously:

> *[…] I can only speak from a person who is African who grew up in an African family, raised by Africans. Like mental health is not an issue. It's something that's overlooked. Particularly, in my family we have this attitude of you've just gotta keep it moving, whatever it is, […] my mother just said, well why would you get counselling, what is it going to do […]? What I have seen is people just sweeping things under the carpet. It's like, this has happened, let's move on because we can't stay in the tragedy, there's no transitional period of like, okay hold on, still trying to figure out what is going on. You appear soft in that way. Yeah, so um, pretty much just, sweeping it under the rug […].*
>
> Kudzayi, Female, 27

In this narrative, Kudzayi is saying that in her family, traumatic experiences are part of life, and taking time out to evaluate and understand them is seen as being weak. Punha encountered stigma from her own parents when she decided to access mental health support for depression, anxiety, and bulimia. She says:

> *I also feel like when it came to accessing therapy and support, there was just a lot of stigmas. There was a lot from my parents: you are not crazy, you're fine, you're fine, and like they did not understand that you could be mentally ill and not crazy […] because I am quite vocal about my mental health and my struggle, they were like no, no, no, people don't need to know. It's okay, yeah, like, they are very embarrassed […] yeah, by my mental health and stuff.*
>
> Punha, Female, 23

What Punha is saying is that besides stigma, her parents did not view illnesses such as mild depression and anxiety as mental illness, but schizophrenia and major depressive disorders, and they are happy for those experiencing it to seek mental health support. However, those experiencing this level of mental illness are viewed as weak, and derogatory terms are used on them as described by Samora in the narrative below:

> *[…] people will use names, derogatory names to somebody suffering with mental health issues. And sometimes people, like even close families and relatives, want to remove themselves from that individual.*
>
> Samora, Male, 45

Samora is saying that because of the stigma, people do not want to be associated with those experiencing severe mental illness. As such, for fear of rejection, those experiencing mental illness will deny it, both to themselves and the world as narrated by Jabu below:

> *I'm not being stereotypical, but Black people don't like to admit sometimes that they, there's something wrong with them […] and the stigma. So, we have that culture of stigmatising people when they're vulnerable.*
>
> Jabu, Male, 35

What Jabu is saying is that because of the stigma, Black people will not admit that they are experiencing mental health difficulties. They will in turn, lose their self-confidence, making it difficult for them to seek help, as mentioned by Lobengula below:

> *So, I find myself in the situation whereby even my esteem of doing something, you know, is low.*
>
> Lobengula, Male, 34

In the narrative, Lobengula says he is exhausted from it all and lacks the drive to do something to help himself.

These above narratives show that participants, their friends, and families are sensitised to traumatic experiences and believe that as a people, they are strong enough to soldier through difficult challenges. Those who develop serious mental illness are viewed as weak and, as such, are rejected and excluded as they are said to bring shame to their family and friends.

This motivates them to conceal their illnesses and hence, is a barrier to seeking help for poor mental health.

The narratives highlight the deep-rooted stigma surrounding mental health within Black sub-Saharan African communities, revealing how cultural beliefs, societal expectations, and family attitudes discourage individuals from seeking professional help. This stigma leads to denial, isolation, and a reluctance to acknowledge or address mental health struggles. In her narrative, Setorwu explains how her peers dismissed the idea of seeking mental health support, reinforcing the notion that Black people are inherently strong and must endure challenges without complaint. The belief that suffering is universal among Black people, regardless of location, discouraged her from viewing mental health support as a viable option. The same can be seen in Kudzayi's narrative where her family's mindset of 'just keep moving' discouraged any form of reflection or emotional processing rather encouraging the, 'sweep things under the rug' mindset. Similarly, Punha experienced direct stigma from her parents when she sought therapy for depression, anxiety, and bulimia because they were embarrassed about her illnesses. Samora notes that individuals with mental health issues are often given demeaning labels, leading even close family members to distance themselves from them. Jabu adds that because of stigma, many Black individuals refuse to admit they have a mental health issue. The fear of being labelled weak or an outcast prevents them from acknowledging their struggles. This denial can lead to a loss of self-confidence and make it even harder to seek support. Lobengula describes how the societal pressure to endure hardships without showing vulnerability has left him feeling exhausted and lacking the motivation to take steps toward improving his situation. This demonstrates how stigma does not just prevent people from seeking help but also drains them of the will to advocate for their well-being.

Collectively, these narratives reveal that within the participants' communities, trauma and hardship are normalised to the extent that seeking help is considered unnecessary or even shameful. Those who experience serious mental illness are perceived as weak and are often excluded from their social circles. This rejection forces individuals to conceal their struggles, making stigma a significant barrier to accessing mental health support.

4.2.10 Conclusion

All in all, the narratives from all the sub-themes show how the experiences of Black sub-Saharan African communities pose challenges for them to access mental health services. The different sub-themes are deeply interconnected, painting a broader picture of how Black sub-Saharan African communities face multiple barriers to accessing mental health services. Each challenge reinforces the others, creating a compounded effect that makes seeking support for mental health incredibly difficult. At the core of these struggles is the issue of immigration status, which directly affects nearly all aspects of life. The financial burden of regularising immigration status means individuals are focused on affording visa fees and legal representation, leaving little room for prioritising mental health. This financial strain, combined with the fear of deportation, creates an environment where individuals are afraid to engage with official services, including mental health support, for fear of exposure to authorities.

The stress of navigating immigration systems is further compounded by experiences of racial discrimination and unwelcoming communities. Participants described how racism, both subtle and overt, eroded their sense of belonging, leaving them hesitant to seek help from services they feared might be just as unwelcoming. This is reinforced by the feeling of social exclusion and isolation, where participants found it difficult to integrate into the English social fabric, making them more vulnerable to mental health challenges without any supportive networks to turn to.

A key consequence of these experiences is loss of identity, as participants struggled with the shift from respected professionals or community figures in their home countries to being in low-paying, unfulfilling jobs in England. This loss of status contributed to low self-esteem and reduced confidence in seeking mental health support. Additionally, decreased mental health awareness meant that many did not recognise the extent of their distress or understand that professional help was an option. Even those who were aware did not know where to go or whether they were eligible for services.

The lack of familial and community support further exacerbates these issues, as individuals in these communities are often too occupied with their own survival to care for struggling family members. Those seeking asylum, who are frequently moved by the Home Office, found it even harder to establish stable support networks. This lack of support, combined with mental health stigma, made it even more difficult for individuals to acknowledge their struggles and seek professional help. Cultural beliefs that ‘Black don’t crack’ reinforced the idea that seeking help was a sign of weakness, pushing many to suppress their struggles rather than address them.

These barriers do not exist in isolation: rather, they build upon one another to create a vicious cycle where systemic, social, and personal factors reinforce each other. Immigration struggles create financial and legal stress, which fosters fear and isolation. This, in turn, makes individuals more susceptible to discrimination and exclusion, leading to a loss of identity and confidence. Without support or awareness, mental health issues go unaddressed, and stigma further discourages help-seeking. Despite these challenges, some individuals managed to break through these barriers and went to seek mental health support. The next section explores their experiences, shedding light on how they navigated the mental health system and what can be learned from their journeys.

4.3 Superordinate Theme 2: Medical Colonialism

While in the previous section, the findings highlighted how the social challenges experienced by participants negatively influenced their decisions to seek help, this section captures the experiences of those who managed to rise above the barriers and went on to seek help when experiencing poor mental health. Seven sub-themes emerged from this superordinate theme, highlighting how barriers to mental health service utilisation are created for this group. Similar to section 4.1, the sub-themes overlap and intersect, highlighting the reasons why participants struggle to utilise and stay engaged with mental health services.

4.3.1 Not Being Believed by Mental Health Practitioners

This theme describes how, after overcoming barriers and having gone to seek help for their mental health, participants are faced with further challenges. They spoke about not being believed by mental health practitioners when they present themselves to mental health services. Below is an extract from Lobengula, who, while experiencing mental health problems, struggled to get support for it until he was detained in the hospital for his physical health:

> *Actually, we the Black people, so many times they don't believe in us at first, until the situation worsens. So, what it means is, if I wasn't admitted in hospital, I wouldn't have been given the support.*
>
> Lobengula, Male, 34

Here, Lobengula is saying that had it not been that he was detained in hospital for a physical ailment, he would not have received the mental health support that he needed because services did not believe he needed it. The same feelings were expressed by Samora, who was refused support because mental health professionals did not believe he would know if he was unwell and that he had not followed the correct referral process anyway. He narrates his experiences below:

> *There used to be a mental health unit just less than three minutes from where I lived. I went, and I knocked on the door. I buzzed and they said, we can't. You can't come in. The referral process is this: call this number. I called the number, and they referred me to say, oh, can you get to this place? I went to that place. And they said, um okay, we recognize you've used mental health services before. What is the issue? So, I told them, look, I realise that I'm unwell. Like how can you tell? So, I explained to them, then they said, but you're not a professional? I said, I'm an individual who understands when certain things don't add up and right now this is how I feel. They sent me back home.*
> *They said, we will send a team to come out. And this team didn't come for four days […]. When they finally came, the day they came, the state of my room; the moment they get in the house they called the police. The state of my room, I was unwell. I'd been aware and I went to seek for help. By the time I get the help it's almost a week. […]. The next thing within the half hour, I was in the same unit that I'd knocked to say I need some help […]. I was detained.*

Samora, Male, 45

What Samora is saying is that he understands when he is not well but is not trusted to do this by practitioners who also demand that he use the correct referral procedures even though they are equipped to support him, and he is likely to end up in their service anyway. His demeanour when he said, “I was detained”, displayed a combination of defeat, disempowerment, and hopelessness.

Their points are supported by Punha, who, when she approached mental health services, felt she was not taken seriously by practitioners who felt she was not ill enough to require their services as individuals, they normally supported were so ill they could not even come out of bed:

> *And also, I kind of feel like, because I pass as high functioning, because I am able to do stuff, I am not taken seriously. […]. So, I feel like they just don’t know how to interact with me. I feel like a lot of it is they didn’t necessarily understand that actually, I didn’t have time to just stay in bed all the time, like I didn’t, I couldn’t. […]. If I were like, ok, I can’t do any of this. I need to take time out of university, I would not have had financial support. I wouldn’t have been able to go home, I wouldn’t have been able to work, I wouldn’t have been able to actually afford to live. So, it was, they did not necessarily get that me not having to do lots of stuff was about surviving. And it didn’t mean that I wasn’t struggling. It just means that I was doing what I had to do to survive.*

Punha, Female, 23

In her narrative, Punha was saying that she was mistaken by practitioners as being ill enough to need professional support because she was still able to complete basic tasks when the reality was that she had no choice but to complete them to survive.

These extracts highlight how participants who approached mental health services were not taken seriously until their mental health had deteriorated. Unfortunately, denying individuals support when they need it is teaching them not to seek help until their mental health has deteriorated. It also shows how dangerous a lack of understanding of the challenges faced by Black sub-Saharan Africans by mental health practitioners can be and how this affects the way they utilise mental health services.

These extracts illustrate a broader pattern within the dataset, where Black sub-Saharan African individuals seeking mental health support are often not taken seriously until their condition has significantly worsened. Lobengula’s experience represents a common theme among participants who felt that their struggles were not acknowledged until they were admitted for physical health issues, suggesting that practitioners often fail to recognise mental health concerns early.

Similarly, Samora’s narrative highlights systemic barriers in accessing mental health services, particularly the rigid referral processes that create delays in care. His story is not an isolated case but rather reflective of a wider issue where individuals are not trusted to assess their own mental well-being, despite having prior experience with mental health difficulties. His experience of being dismissed until his condition visibly deteriorated aligns with the broader trend of delayed intervention seen across the dataset.

Punha’s account sheds light on another dimension of this issue, how those who appear ‘high functioning’ are often overlooked for support. While her experience may not represent the majority of participants, it highlights a crucial subset of individuals who are struggling yet remain undetected by traditional mental health assessments. Her story underscores the danger of equating functionality with well-being and demonstrates how practitioners' lack of understanding can lead to exclusion from essential services.

Together, these narratives reveal a troubling pattern in which Black sub-Saharan Africans face scepticism, dismissal, and unnecessary delays when seeking mental health care. Rather than being exceptions, their experiences illustrate systemic failures in recognising and addressing mental health concerns in this community. The reluctance of services to provide early intervention reinforces a harmful cycle where individuals learn not to seek help until their condition has worsened, further entrenching disparities in mental health care access and outcomes.

4.3.2 Long Waiting Times

This sub-theme describes how those who are lucky enough to be believed endure lengthy referral periods. Lobengula, who was referred from one practice to another, said it took a year for the specialist service he was referred to get back to him. He shared his feelings below:

> *So, if you tell me the GP refers you to another person, another person refers you to another person you get it, all the time taken, you get it. That time increases your problems. The time-scale, yeah, the time-scale is too long. Actually, xxxx* (the name of the specialist organisation) *called me in November this year after one year.*
>
> Lobengula, Male, 34

What Lobengula is saying is that the period it took for him to get to the right support was lengthy, and his mental health deteriorated in the process, causing him more problems. This was seconded by Punha, who has struggled with her mental health since she was a child. She also had her mental health deteriorate while waiting to get into therapy. In the extract below, she explained what happened:

> *What happened is, I had to wait a year to get into therapy and in that year I got worse. So, it would have been better if I had support from when I was like, look I'm struggling um, it would have been better if I had support growing up as a child really, um, and it would have been better, and if they actually have engaged with me as if I was a person as opposed to kind of a robot.*
>
> Punha, Female, 23

What Punha is saying is that she would have been in a better place with her mental health if she had been listened to early on and offered support when she asked for it. Not being listened to adds more anxiety to one's mental illness, and by the time they get support, it may be too late, as narrated by Samora, who also asked for better referral methods:

> *I think there can be, there has to be better referral methods* that are swift *and that are decisive because anything would have happened during the period of me self-referring and actually being admitted and I was sectioned.*
>
> Samora, Male, 45

What Samora is saying is that not getting support because the mental health system believes in a rigid, inflexible referral pathway is not correct. The deterioration of his mental health could have caused him to harm himself and/or others, complicating things even further.

The above narratives highlight the need for swift action to providing mental health services and flexible referral methods when participants present themselves. As previously mentioned, each time help is delayed when individuals ask for it, it is teaching them not to ask for it until they are in crisis.

This sub-theme highlights a significant issue within the dataset: even when individuals are believed and referred for mental health support, the lengthy waiting periods often lead to further deterioration of their condition. This experience is not an isolated incident but rather a recurring challenge for many participants.

Lobengula's experience of waiting a full year to hear back from a specialist service exemplifies a broader trend within the dataset. Many participants described being caught in an extended cycle of referrals, where one service would pass them on to another, prolonging their suffering rather than providing timely intervention. His frustration with the drawn-out process reflects the structural inefficiencies that contribute to worsening mental health conditions.

Punha's narrative reinforces this pattern, emphasising how the delay in accessing therapy led to a significant decline in her well-being. While her experience may not apply to all participants, it represents a subset of individuals who have struggled with mental health issues since childhood but were not taken seriously until their condition worsened. Her account underscores how the failure to engage with individuals as people, rather than as cases to be processed, can exacerbate their distress and erode trust in mental health services.

Samora’s testimony further highlights the dangers of rigid and bureaucratic referral pathways. His perspective reflects the concerns of many participants who felt that inflexible systems failed to prioritise their urgent needs. His mention of being sectioned after a long referral process illustrates the very real risks associated with delayed care: by the time help arrives, individuals may already be in crisis, which could lead to more severe interventions, such as involuntary hospitalisation.

Collectively, these accounts demonstrate that delays in mental health referrals are not just logistical issues but have serious consequences for individuals' well-being. The dataset reveals a widespread pattern of delayed intervention: as previously mentioned, each time help is delayed when individuals ask for it, is teaching them to not ask for it until they are in crisis.

4.3.3 Inadequate Assessment Tools

Another theme in analysing the research data was the inadequacy of assessment tools used which led to the failure by mental health practitioners to diagnose. A diagnosis reassures the patient that their mental health practitioner understands what the causes of their symptoms are and is providing appropriate treatment to prevent illness progression. Lobengula, who was prescribed therapy before a diagnosis and, on review, had the medication changed with still no diagnosis, had the following to say regarding this:

> *So, if I have gone there frequently, I have communicated to you frequently, if I have met you frequently […] now why do you ask me every time, you get it. If the GP understands that the main cause of the mental health illness of this person is depression, you get it. That is the main cause, you get it. So, we work on depression. If it’s anxiety, work on anxiety, yeah. If it is bipolar disorder, you work on that, you get it, yeah […].*
>
> Lobengula, Male, 34

What Lobengula is saying is that when he is put on drug treatment and has not been given a diagnosis, and each time he visits the practitioner for a review, he is asked about his symptoms and at times, his medication is changed, he gets the impression that the practitioner does not understand his illness and is just trying different medication to see if they can find one to manage his symptoms. This leaves him anxious and worried that the disease may progress in the process, or the medication may have damage effects on him. Continually asking a patient about their symptoms without giving a diagnosis can be confusing, particularly for those with a language barrier who, if they express this kind of treatment from their mental health practitioners may change the way they describe their symptoms, assuming they are not clear enough, which may eventually lead to a wrong diagnosis and treatment. Commenting on this issue, Sankara said:

> *It starts with language. If you don't understand the person you're communicating with, how do you come up with a diagnosis? It's very difficult.*
>
> Sankara, Male, 60

What Sankara is saying is that participants with a language barrier end up with wrong diagnoses because they lack the language to describe their symptoms, and practitioners may misunderstand their descriptions of symptoms and give wrong diagnoses. This is supported by Kamal, a community leader of Black sub-Saharan African heritage, for a group supporting refugees and migrants, who, in his comments, questioned the eligibility of assessment instruments. In the extract below, he describes what he witnessed at a point of assessment when he acted as an appropriate adult for two members of his group who are also of Black sub-Saharan African origin who had gone to seek help for poor mental health.

> *[…] had I not been there, objecting to what the system was trying to do, I think they might have actually taken these people to xxxx* (name of mental institution) *and given them a bed and put them on medicine, but I challenged the diagnosis and asked how certain they were that that was the most appropriate action, and whether the other methods couldn't be tried […]. What I object to is a one-size-fits-all type of system,*

> *which is like a tick-box exercise. I've ticked eight out of 10 boxes; I think you should be put into the xxxx* (name of mental health institution).
>
> Kamal, Male, 35

Here, Kamal says that assessment tools should not be treated as universal as they may not be adequate for other cultures, considering that individuals and groups attach different meanings to mental health symptoms and that a difference exists in the way they perceive their realities. Using the same assessment instruments for everyone seems to imply that individuals from diverse cultures and backgrounds have universal characteristics and when they behave differently, it means they are experiencing mental illness.

Kwame's points are supported by Kamal who advocates for those experiencing mental health problems be allowed to design their own treatments with support from mental health practitioners.

> *[…] but the thing is, when it comes to mental health, rather than approaching the person who is suffering from any kind of mental health, as if, uh, the therapist or any other person know, how to, how to fix that person. Um, in my opinion, uh, I think the person, uh, the people who suffer from mental health should be allowed, uh, to devise a strategy as to how they want to heal themselves. Uh, earlier I was talking about, uh, um, um, resilience, I, I, one way or the other, I think everyone has it. Uh, but for that to work, uh, we, we, we need to, uh, facilitate some, uh, things, let let's say, okay, I know what makes me feel better. I know what makes me feel down, uh, because I live my life. Nobody has lived my life. I am the experiencer of my own life. […] I think, um, the mental health approach, uh, should be, uh, tailored individually, uh, by, uh, allowing and facilitating someone to do something.*
>
> Kwame, Male, 54

Kwame is saying that, the one size fits all kind of treatment does not work for everyone because individuals face different challenges and have solutions to their problems but lack the means to implement them. Hence, what mental health practitioners need to do is to assess the needs of each individual and support them by facilitating that those needs are met.

A one size fits all kind of treatment was also argued by Agbo who said this will make some individuals to end up with wrong diagnoses, leading to wrong treatments. In his interview he said, he witnessed friends of Black sub-Saharan African background taken into mental hospital for simple stress and coming back with a severe mental illness. An extract of this interview is given below:

> *They just get some stress and behave somehow. They just took them, tell them some they are not correct. Um, bring them, they come back square […] it's that, basically medicine will take time; go slowly, slowly, slowly until you will become addicted on it and when you are addicted on it that mean you are already sick.*
>
> Agbo, Male, 31

What Agbo was saying is that his friends were admitted into mental institutions for simple stress, and the drug treatment they were prescribed caused them serious mental illness as a side effect.

The issue of Blacks experiencing mental health problems being over-emphasised was also mentioned by Almaz, who believed that statistics showing them as having a higher rate of experiencing mental health problems than white populations was not correct. Below is an extract from his interview:

> *I don't know how they get that figure […] I think it’s just stigma. That is a stereotype. Yes, we have issues, but I think we are overrated or highly rated as people with mental health issues […]. I think white people in this country […] they have issues when it comes to mental health which they are struggling to deal with than we, I think ours is over emphasised.*
>
> Almaz, Male, 38

What Almaz is saying is that there is a stereotype among mental health practitioners perceiving Black people as mentally ill, thereby giving them a wrong diagnosis. This could also cause them to refuse individuals talking therapy treatment thinking what they are experiencing is beyond its remit. In her interview Kudzayi narrated how she struggled to get a talking therapist to attend to her:

> *[…] for the longest time, I have kind of been on this wheel of you know, just keeping it moving, keeping it going, but unfortunately, I had an event in my life that caused me to just stop and freeze and forced me to just finally find ways of dealing with my emotions in a health way. […] I was phoning a lot of these services trying to speak to a counsellor […] and after trying about three or four, you know, going through this assessment of you know, are you suicidal, like that was like the starting point and I've had like two counsellors say to me, there isn't, like I am not really qualified to deal with what you are going through right now, so they then referred me to another place and that's how I kept calling place to place […] I was just at breaking point where you let everything go, and you know […], it wasn't until I was referred to the services with Inini that I was offered that lifeline […]*
>
> Kudzayi, Female, 27

Kudzayi is saying that, the assessment tool used, made it look like what she was experiencing was way outside what counselling therapists could do. However, she was able to find support through a culturally sensitive mental health service provider run by and for Black people.

All in all, the above narratives highlight the point that assessment instruments used are not adequate for Black sub-Saharan African communities and that not giving a diagnosis within reasonable times causes participants to doubt the ability of the mental health practitioner to manage their illness and this may cause them to disengage from mental health services. In addition, language barriers can lead to patients not being able to describe their symptoms leading to them receiving wrong diagnoses and wrong treatments. The narratives also highlight how stereotyping by mental health practitioners where they perceive Black individuals as having mental illnesses also lead to misdiagnoses and wrong treatments whose side effects actually induces mental illness.

This theme highlights a critical issue within the dataset, the inadequacy of assessment tools used by mental health practitioners, which leads to misdiagnoses, incorrect treatments, and a lack of trust in the mental health system. Participants repeatedly expressed frustration with the rigid and often inappropriate diagnostic processes that failed to account for their lived experiences, language barriers, and cultural differences.

Lobengula's experience is representative of a wider pattern in the dataset, where individuals were prescribed treatment without a clear diagnosis. His frustration stems from the fact that, despite repeated visits and medication changes, he still had no clarity about his condition. His account reflects the broader concern among participants that practitioners do not fully understand their illnesses, leading to anxiety and a fear that their mental health could worsen due to trial-and-error prescribing. This issue is exacerbated for individuals with language barriers, as Sankara points out. His statement highlights how the inability to effectively communicate symptoms can result in misdiagnosis, further reinforcing the inadequacy of standard assessment methods for Black sub-Saharan Africans.

Kamal's experience as a community leader further illustrates this issue from an external perspective. Acting as an advocate, he observed how assessment tools functioned as rigid, one-size-fits-all frameworks that failed to consider cultural differences. His testimony reveals how individuals from Black sub-Saharan African backgrounds may be placed into mental health institutions based on a checklist approach rather than a holistic understanding of their conditions. This concern is echoed by Kwame, who argues that mental health support should be tailored to the individual, allowing those experiencing mental health issues to have a say in their treatment. His view represents a subset of participants who felt that mental health services should empower individuals to take an active role in their own healing, rather than imposing standardised treatments that may not be effective.

Agbo's account provides further evidence of the risks associated with inappropriate mental health diagnoses and treatments. His testimony suggests that individuals experiencing temporary stress were admitted to mental health institutions and prescribed medications that ultimately worsened their conditions. His perspective aligns with a broader concern in the dataset that some participants felt over-medicated, leading to a distrust of mental health services.

Almaz raises another key issue, the perceived over-representation of Black individuals in mental health statistics. His view, while not necessarily shared by all participants, points to the concern that systemic biases may lead practitioners to diagnose Black individuals with mental illnesses at a higher rate than white individuals. This perceived stereotype could result in Black individuals being denied access to appropriate talking therapies, as illustrated by Kudzayi's experience. Her struggle to access counselling services demonstrates how assessment tools can classify certain mental health issues as too complex for therapy, leaving individuals to navigate an already difficult system on their own. Her eventual success in finding support through a culturally sensitive, Black-led service highlights the importance of alternative, community-based approaches to mental health care.

Taken together, these narratives emphasise the limitations of standardised assessment tools in diagnosing and treating Black sub-Saharan African individuals. The dataset shows that delays in diagnosis lead to distrust, language barriers contribute to misdiagnosis, and systemic biases can result in inappropriate treatments. Additionally, the rigid application of assessment criteria may prevent individuals from accessing the right kind of care.

4.3.4 Drug Treatment

Mental health treatment and how it is prescribed to patients is another theme that came out of the data analysis. Participants candidly shared their opinions and experiences on treatments, medication dosages, and their perceived side effects. Kudzayi, who is open to accessing mental health services but not keen on taking prescribed medicine, gives her reasons below on why this is:

> *I would definitely try and seek help, um, in terms of maybe speaking to a licensed therapist or counsellor. I personally do not really believe in taking medicine, like prescribed medicine […]. I've seen members of my family that have had prescribed medicine. In some cases, it becomes fatal, or you know, for the most part, when you*

> *prescribe something, that medication then gives you a side effect, so you end up with a prescription for something else. So, then it becomes this nonstop, you know, um, taking of medicine and pills, and you know, surviving on pills […].*
>
> Kudzayi, Female, 27

What Kudzayi is saying is that it is okay to seek help for poor mental health if the intervention is going to be talking therapies or other low-level psychosocial activities. Prescribed drugs are a no-no as they trigger other illnesses that may require more medication, leading to a cycle of illnesses and drugs.

Participants also spoke about how mental health services favour the medical over social model. Punha expresses her feelings below on being prescribed drugs instead of other therapies:

> *[…] and they're quite the whole medical model of like giving people medication […], but it's like no, actually, my childhood was xxxx* (unprintable four-letter word), *things were crap. There are tangible reasons why I was feeling the way that I was and giving me anti-depressants as opposed to therapy wasn't actually useful […].*
>
> Punha, Female, 23

What Punha was saying is that mental health practitioners are not interested in investigating the determinants of an individual's mental illness, such as their social environment and are quick to prescribe drugs as a first intervention. Agbo, who witnessed friends getting detained for mild mental illness and coming back with serious mental illness, explains what he thinks happened to them while they were in the hospital:

> *Why I'm saying that, because our culture we Black, we are not too much on tablet, on drugs. […] our Black culture drugs kill us because this drug they have here its making for them, their culture for their people. It's not made for our people because our way we need strong because the level they will give to a white man, they will give him small*

> *it will help him, you understand […]. Our body is too strong, you give that small they just swallow it […] and the white man will be surprised saying how come I give you that small thing it's not working. So, now he will double […] I'm surprised why a white man come out clean, and they take a Black man clean put him inside come out dirty […]. The way we were, we are born in the dirty, in the sun, in the dust […]. To be honest, we have a lot of bacteria in our body. But those bacteria are there to protect us.*
>
> Agbo, Male, 31

Agbo is saying that medical research is done on white populations, whose social backgrounds are different from Black populations and thus, the drugs and dosages are designed for them. When administered to Black populations, it will not work in the same way as it does on white populations, causing mental health practitioners to double the dosage, whose side effects, in turn, damage them, giving them severe mental illness. His claim about Black people receiving a high dosage of medication is supported by Samora, who says he was once given a dosage so high he was in a slumber for days and believes if it were not for his experienced mental health practitioner aunt, who intervened, the medication would have harmed him:

> *I was given some medication, […] I was in a slumber for two or three days. I didn't know which was which until I had an aunt who came and […] saw me, and she said they had to stop. […] She's a mental health nurse. […] I believe it was one of the things that actually managed to take me out of this situation; otherwise >pause< I would have just gone into the system and probably never have managed to recover to be able to talk to you today […].*
>
> Samora, Male, 45

What Samora is saying is that if the medication had not been stopped, he would have developed severe mental illness and never recovered, becoming a revolving door patient to mental health service outlets. This also has support from Setorwu, who says her friend was never the same after taking medication for post-natal depression. An extract from her narrative is given below:

> *She ended up in a mental institution. And that was the, from there, it's never been […] she's never come back. Yeah, life has never been the same. And she has never engaged with the child. It's like, you know, like, she lost the child […]. And then you, you hear stories of people that once they have taken those medication that's the, the end […], and then you think, is it medication that is making her look like this.*
>
> Setorwu, Female, 43

By saying that her friend has never come back, Setorwu means that her friend never fully recovered. The drug treatment she was given in hospital gave her serious mental illness, and she failed to look after her child, who was eventually taken into care. Samora, who has experience using mental health services, gives his opinion on the care delivered in mental health institutions below and explains why he thinks people end up on a high dose of medication:

> *The things that I experienced when in the institutions. There is a >pause< there's a lack of care if I can call it that. A lack of care and a lot of strain on the part of the, the workers. Most times, they'll be understaffed, having to deal with the number of people who are quite vocal, sometimes aggressive, and in some cases, violent, yeah. Now, when you are, you have an understaffed unit, they are already under a lot of strain. So, in the end, they will either lock you in a room or give you more medication, so you calm down. So, in the end, you are perpetually in a state of slumber, where you are just getting medication, so they don't have to be dealing with that. So, that is problematic for me […]. The care needs the person gets within a care setting, whether in a mental health unit is, is more about medication and managing the behaviour in there without actually taking time because there is not enough staff.*
>
> Samora, Male, 45

What Samora is saying is that what patients receive within mental health care settings is medication to manage their behaviour. This is because there is a shortage of staff, and to help them manage, patients are given more medication than necessary, which maintains them in a perpetual state of slumber to calm them down, or they are locked away in a room.

The above narratives shows how mental health practitioners are stuck on using the medical model and do not care to investigate and understand the social determinants of their patient’s mental health problems but are keen to prescribe drug treatments, not for recovery but to manage the symptoms. Sadly, in managing the symptoms, the patient’s mental illness deteriorates, and instead of recovering, they end up dependent on medication. This is the participant’s perception of mental health care in the UK.

This theme highlights participants' concerns regarding how mental health treatment is prescribed, particularly the overreliance on medication rather than alternative therapeutic interventions. The narratives reveal a deep scepticism toward prescribed medication, with participants fearing that it worsens their condition rather than aiding recovery.

Kudzayi’s perspective reflects a common sentiment among participants who prefer talking therapies over medication. She expresses concern that prescribed drugs often lead to a cycle of dependency, where initial side effects necessitate additional medications, ultimately resulting in a continuous reliance on pharmaceuticals. Her experience suggests that some individuals perceive mental health medication as a short-term fix that fails to address the root causes of their struggles.

Punha’s account further critiques the medical model, arguing that it prioritises drug treatments while ignoring the social determinants of mental illness. Her experience underscores the frustration that many participants feel when their lived experiences, such as childhood trauma, are overlooked in favour of prescribing antidepressants. This aligns with the view that mental health services often operate on a one-size-fits-all approach, failing to consider the social context of each individual’s condition.

Agbo’s concerns about medication highlight another layer of distrust, he believes that drugs are developed for white populations and may not be suitable for Black individuals. He argues that Black people metabolise medication differently, leading to increased dosages that may have severe consequences. His observations align with broader discussions on racial disparities in medical treatment, where standardised drug dosages may not take genetic and physiological differences into account. Samora’s experience provides a concrete example of this concern. He was given such a high dosage of medication that he remained in a state of slumber for days. He attributes his survival to his aunt, a mental health nurse, who intervened. His testimony suggests that without proper oversight, excessive medication can push individuals deeper into the mental health system rather than aiding their recovery.

Setorwu’s account further reinforces these fears, describing how her friend, after receiving medication for postnatal depression, never fully recovered and was unable to engage with her child. Her narrative highlights the lasting impact that medication can have on individuals, raising the question of whether the treatment itself contributed to the deterioration of her friend’s condition.

Samora, drawing from his experience within mental health institutions, provides insight into why overmedication is so prevalent. He attributes it to staff shortages and the need to manage patient behaviour rather than treating the underlying condition. His testimony reveals a system where medication is used as a means of control rather than a pathway to healing, leading to a perpetual cycle where individuals are sedated rather than rehabilitated.

These narratives collectively critique the medical model's dominance in mental health care, arguing that it fails to address the root causes of mental illness. Participants perceive medication as a tool for symptom management rather than recovery, with some believing that it exacerbates their condition rather than improving it. The accounts also highlight systemic issues such as racial disparities in drug prescriptions, staff shortages, and the institutional tendency to overmedicate rather than provide holistic care.

4.3.5 Talking Therapies

While in section 4.3.4, participants complained about mental health practitioners being quick to prescribe drugs and not offering alternative interventions, they also spoke openly about not favouring talking therapies either. Kwame says he was left feeling worse than he did before starting counselling therapy and described it as nothing but a data collection exercise. The extract below describes his feelings about accessing talking therapies:

> *When it comes to, uh, therapy. Um, I, I, I wouldn't want to, you know […]. It might have its help, its use if it is done, uh, professionally and if they also have all the resources. Let's say we talked about something and then what is my therapist going to do about what I said? For example, if I have, uh, an opportunity, uh, to study. Let's say yes, uh, is my therapist going to facilitate that for me, […] rather than, uh, leaving me in my dark room for entire week and giving me once a week appointment to have this kind of, uh, the one I mentioned type of conversation that, uh, forces me, uh, to relive my terrible past experience. How do you rate your feeling now? Uh, on the scale one to 10 or nine, I think that is not helpful.*
>
> Kwame, Male, 54

What Kwame is saying is that it is pointless to go through talking therapies if nothing is being done to improve the environment that broke him in the first place. The same sentiments were echoed by Chiyedza, who has been trying to regularise her immigration status for over twenty years and has been through dozens of counselling therapy sessions. She said:

> *I have been through counselling for long […] but now no […]. The best way to treat me is to give me freedom because this situation is the one causing this mental problem.*
>
> Chiyedza, Female, 54

Chiyedza is saying that her mental health problems are being caused by the challenges that come with not having a regularised immigration status, and no amount of talking or drug therapy can treat that.

Participants also mentioned how the conversation with the therapist was more like a Home Office interview to regularise their immigration status where in the end the therapist agreed that she did not have experience of working with people like this client. Ashura’s narrative is given below:

> *[…] to be interviewed as if I'm in the home office. So, from that time, I, I didn't, I didn't even want to talk about it until I started, um, coming for your session (Inini peer support group) then I felt better. They were interviewing me about why did I come here? Uh, what is my status here? Why like, will it be better if I go home and all sort of those, that I took it to be an interview for home office. So, I even asked the lady. Why are you asking me questions about immigration? I am talking about my mental health. […] at the end of it, she just said, um, um, she's sorry that she, um, it's like the, the, the, the kind of people I'm not the kind of people they, they, they look after.*
>
> Ashura, female, 46

The Home Office's stance to individuals seeking asylum is that you are guilty until proven innocent, and their questioning is aligned more to finding fault with your application so they can refuse you protection. By likening the therapist's questions to those asked by the Home Office, what Ashura is saying is that she felt like the therapist was placing fault on her, for what she was experiencing and wanted her to go back to her home country which made her disengage from the service and seeking mental health support altogether.

Participants also spoke about being offered alternative interventions that were not culturally sensitive or within their means. Punha felt that the compassion-focused group therapy she was prescribed was too idealistic. When she struggled to engage with it, the blame was placed on her, not the intervention's inappropriateness for her specific needs. She expressed her feelings in the narrative below:

> *[…] They use compassion-focused group therapy, and it is very idealistic […]. They were like to think about what makes you feel good and peaceful, and I was like do I have the money to go to a spa day, do I have the time to meditate? Do I have the luxury to sit and do nothing? And it's something they didn't get because most of the people they treated are middle-class White women, so of course they could […].*
>
> Punha, Female, 23

By likening doing things that make her feel good and peaceful as a luxury, Punha is expressing how difficult and time-consuming trying to earn a living is for her. Also, by saying most people in the group were middle-class White women, she is highlighting how interventions are designed for people outside her social category and sadly, mental health practitioners seem not to understand that not everyone can afford some of the interventions offered.

The above narratives show that participants did not favour talking therapies either. This is their perception. Because no measures were taken to address the challenges that caused them mental discomfort. This may render it pointless for them to access services. The narratives also highlighted how other psychosocial interventions offered are not adequate for Black sub-Saharan African communities because of the costs involved and time constraints. This shows a lack of understanding by mental health practitioners of the social challenges faced by these groups.

This theme highlights participants' dissatisfaction with talking therapies, revealing that while they criticised the overprescription of medication, they also found counselling interventions ineffective. The narratives suggest that for therapy to be meaningful, it must go beyond conversation and address the root causes of their distress.

Kwame expresses frustration with the lack of practical solutions offered through therapy. He views counselling as a data collection exercise rather than a transformative process, questioning its usefulness if it does not result in tangible support. His concern is that therapy forces individuals to relive painful experiences without providing any real assistance to change the circumstances causing their distress. This aligns with the broader concern among participants that talking therapies do not address the systemic issues affecting their mental well-being.

Chiyedza’s perspective reinforces this notion, as she has spent over twenty years trying to regularise her immigration status while undergoing numerous counselling sessions. For her, therapy cannot resolve the anxiety and instability caused by her precarious legal situation. She believes that what she needs is not therapy but legal recognition and freedom, suggesting that mental health services fail to acknowledge the structural factors contributing to distress.

Ashura’s experience highlights another key issue, the cultural disconnect between therapists and their clients. She describes feeling as though her therapy session mirrored a Home Office interview, with questions that seemed more focused on her immigration status than her mental health. The therapist’s eventual admission that she lacked experience working with people like Ashura further underscores the gap between mental health services and the lived realities of Black sub-Saharan African individuals. Ashura’s account suggests that therapy, instead of providing support, made her feel scrutinised and alienated, ultimately leading her to disengage from services.

Participants also critiqued the suitability of alternative interventions, particularly when they were not culturally sensitive or financially accessible. Punha, for instance, describes compassion-focused group therapy as unrealistic for someone in her socioeconomic position. She notes that the intervention seemed tailored for middle-class white women who had the time and financial resources to engage in activities like spa days and meditation. By highlighting these disparities, Punha emphasises the failure of mental health services to consider the economic and social realities of marginalised communities.

These narratives collectively challenge the effectiveness of talking therapies for Black sub-Saharan African individuals, not because therapy itself is inherently flawed, but because it often fails to address the real-life struggles that contribute to mental distress. Participants felt that therapy was inadequate when no measures were taken to resolve the root causes of their difficulties, such as immigration challenges or financial hardship. Additionally, the interventions offered were often ill-suited to their cultural and economic realities, making them inaccessible or ineffective.

4.3.6 Lack of Empathy and Human Touch

This section highlights how mental healthcare services are perceived as not seeing the human side of their patients. Participants spoke about services being programmed in a robotic manner which lacks warmth, empathy, and human connection. As such, this mechanical delivery type of service overlooks other areas of the patient’s life that may need attention. In the extract below, Akosua describes her disappointment in the English health system when clinicians who were treating her daughter for cancer ignored her mental health needs even though they were aware she was having marital problems, which may have triggered mental health issues:

> *[…] when I came, when my daughter was sick, she was sick because of, uh, the cancer, but she was also mentally sick in terms of, she had gone through a very, uh, stressful relationship. […] she was living in a sheltered accommodation, where they were protecting her from the husband […]. She was emotionally affected, and they kept treating the cancer, but she was not getting better because I think they were not looking at her psychological problems, but they kept looking at the medical problem and she was like, almost losing it […].*
>
> Akosua, Female, 59

Akosua says that it is essential to take a holistic approach when working with human beings. Treating them solely as patients with isolated medical conditions overlooks the complexity of their lives and may lead to incomplete or ineffective care. She describes England as preoccupied with the “mechanical type” of service delivery.

> *People in this country believe in a system. They are so programmed […] if you are sick, we take you home, get you carers […] they come, prepare food for you, leave, and go. […]. We are humans, we need that human support, that love that, that kind of thing is therapeutic on its own […].*
>
> Akosua, Female, 59

Here, she reiterates the importance of warmth, empathy, and human connection in aiding recovery. Her statement is supported by Samora, who has been using mental health services for more than ten years. He described mental health services as:

> *It's just now, a well-managed system that doesn't actually focus on the human being but just on supplying them with whatever they require. There has to be somebody who's dedicated […], just an extension of love […]. That hand on the shoulder or just*

> *being there for somebody can reassure that person and give them the confidence to want to get better.*
>
> Samora, Male, 45

The above interview extracts highlight the participants' perceptions of a cold, rigid, and impersonal English mental health system which focuses only on prescribing medication and treatments. These opposing elements may stop Black sub-Saharan African communities, who already struggle with isolation and exclusion, from utilising mental health services. Besides, participants felt that treating individuals in this way is not conducive for mental health recovery.

This section highlights participants' perception that mental healthcare services in England lack warmth, empathy, and a human connection. They describe the system as overly mechanical, treating patients in a rigid and impersonal manner while failing to consider the complexities of their lives. This approach, they argue, leads to inadequate care that does not fully support mental health recovery.

Akosua shares her disappointment with the healthcare system, particularly in how clinicians treated her daughter's cancer but overlooked the mental health issues arising from her abusive marriage. She argues that this narrow focus on physical illness prevents holistic healing, reinforcing the idea that healthcare services in England operate in a robotic, programmed manner. This suggests that participants see mental well-being as intertwined with social and emotional support, which is currently missing in the English system. Samora, who has been engaging with mental health services for over a decade, echoes the same sentiments. He describes the system as efficient in providing basic necessities but failing to acknowledge the emotional and psychological needs of individuals.

The narratives suggest that the impersonal nature of mental health services may deter Black sub-Saharan African communities, who already experience isolation and exclusion, from seeking help. Participants believe that treating individuals purely as medical cases rather than as human beings with complex emotional and social needs is counterproductive to recovery.

4.3.7 Lack of Cultural Competence

Another theme identified from the analysis of the data, which seemed to overlap across most of the sub-themes of this study, was the lack of cultural understanding and challenges faced by Black sub-Saharan African communities on the part of mental health practitioners. Participants spoke openly and candidly about their experiences of using mental health services. Punha, who experienced challenges using the eating disorder clinic, vented her frustration about the poor service with emotional intensity. An extract from her interview is given below:

> *They are awfully rubbish […] they are not effective. They don't know how to engage with, especially people from different cultures. Like for example, I found that a lot of my therapists were White, especially the eating disorders service; they didn't know how to engage with eating disorders with Black women […]. They don't know actually what happens and what support to offer and how to navigate that […] they have never had to engage with someone who struggles like me […]. There is literally no research into black women with bulimia, which means they like don't actually know.*
>
> Punha, Female, 23

What Punha is saying is that, as mentioned by Agbo in Section 5.3.2., because they perceive that Black populations do not participate in health research, mental health interventions are developed on the back of research conducted on White populations. This becomes problematic in doing mental health assessments where behaviours outside the 'white population behaviour' are perceived as outliers and judgements given by mental health practitioners are influenced by personal biases, which was frustrating to her. She further explains this below:

> *[..] and I feel like part of the problem that I have found as well is that they are quick to label stuff which I find is a bit of a problem, like for example, like my therapist was like to me, what happened to you was abusive and it was very, it was very judgemental, it*

> *was very in a you should be angry about everything. And I don't want to be angry […] I feel like they look at, like African culture and think that's abusive […]. It's almost like therapists and counsellors, they lose their sense to be objective and when I notice that they are losing their sense to be objective, I am like oh no, this feels worse than it actually felt, I don't want, yeah, it kind of feels like, oh no, have I said something wrong, and that, it creates a bit of a barrier.*
>
> Punha, Female, 23

What Punha is saying is that her African culture does not fit perfectly well into the Eurocentric assessment category and is viewed as being problematic. And to her displeasure, at this point, mental health practitioners become judgemental, leading her to disengage from services as she further narrates below:

> *What happened is that they were like you are not engaging with therapy, but what happened is that they didn't know how to support me therapeutically which meant that I couldn't really engage.*
>
> Punha, Female, 23

Punha feels that a lack of understanding of her needs by mental health practitioners meant the service offered was not adequate to meet them, making it difficult for her to engage with the services. Unfortunately, when this happens, it is pinned down to her as the problem, not the service.

Akua and Samora also confirmed the lack of understanding of the challenges faced by participants. Akua stopped using mental health services when a counselling therapist approached her after her asylum application was refused and she was made homeless. She asked her why she didn't just go home. This gave her an assumption that all mental health services expected her to go back home because her asylum application had been refused. She narrates her story below:

> *[…] and then she asked me to say, oh, but if you, if you, if you are being made homeless, because your asylum has been refused, why don't you just go home? So being asked that question, it also just put me off, like it means even if I go to meet someone else, they'll still be asking me about why you don’t just go home. So, I thought maybe it's not also still right for me.*
>
> Akua, Female, 49

Akua is saying that the therapist did not understand the rules of asylum. She was seeking asylum because she was facing persecution in her home country. So, asking her to go back home suggested that, like the Home Office, the counselling therapist did not believe her either, or they supported the anti-migration narrative being pushed by the English government. Moreover, it shows that the counselling therapist did not understand that one can use the feedback given for the refusal to gather more evidence and resubmit their asylum application, which can be successful. However, the counselling therapist’s response acts as a barrier to seeking help for poor mental health because participants may not feel safe being around mental health practitioners with this kind of mindset.

Kwame had a similar experience with his therapist as shown in an extract of his interview below:

> *After, after I spoke about my past experience, uh, I, I remember, uh, once my therapist was telling me, you know, that was in the past. Now you need to remind yourself, you are here in a safe country, that's not going to happen to you. How can I tell myself, still while, um, worrying about being sent back, uh, to my country?*
>
> Kwame, Male, 54

Kwame is saying, there is no way he can forget about the past when he still does not have legal status in England and can be deported at any time. What the therapist did not understand is the immigration rule that says anyone seeking asylum in England is liable for detention and removal until they get refugee status. Hence, to Black sub-Saharan Africans experiencing the lack of understanding of their problems by therapists may lead to them disengaging from services.

The lack of understanding of the challenges faced by Black sub-Saharan African communities, will also make mental health practitioners make decisions not conducive for patients' recovery from mental illness. Samora described below how he was prescribed medication and asked to go and recover at home when he was homeless, and the mental health practitioners knew this information:

> *And they did an assessment, and they said oh, they didn't believe I was unwell enough to be admitted. I could be cared for in the community and they gave me, they gave me some meds […]. I had nowhere to stay, and it was wintertime.*
>
> Samora, Male, 45

What Samora is saying is that the mental health practitioners did not care that he was homeless in winter and expected him to recover in such an environment.

The above narratives of experiences of mental health services by some participants have left others with the perception that mainstream mental health services were not fit for Black sub-Saharan Africans. Mupezeni shared his feelings on using mainstream mental health services below:

> *I wouldn't access a Western mental health service for various reasons […]. The GP or therapist I will be speaking to will not comprehend the problems or issues that I would be talking about that I am facing. So, I don't believe that they would be qualified to, to be able to help me. If I was to explain cultural concepts to them, they wouldn't really know what I am talking about […]. Perhaps they will be able to help me in a sense of understanding that I have certain conditions or, certain traits, but in terms of, uh, dealing with them, I don't think so because they don't really understand my perspective as a young Black African man […]. I don't believe they'll know practical*

> *solutions. They'll probably say something that may be relevant to someone that's English or British.*
>
> Mupezeni, Male, 27

What Mupezeni is saying is that mainstream mental health services are built on Eurocentric perceptions and hence, are not culturally equipped to support him as an African and hence, it is pointless to access them.

However, while the lack of cultural understanding and the challenges faced by Black sub-Saharan African communities are highlighted as barriers to utilising mental health services, having a mental health practitioner of sub-Saharan African origin was also said to be problematic. Punha, who worked with mental health practitioners from diverse backgrounds, including sub-Saharan Africa, said they all left her with a negative perception of mental health services:

> *Most of my counsellors and therapists have been White and Asian but then I have always kind of been reluctant to get a Black therapist because at the same time, it's like, obviously people don't understand the culture, but then I also feel like there is judgement on the other side […]. When I was a kid and when I talked about things about my family, she was kind of looking at me like yeah, well you know, you are being a bit ungrateful […].*
>
> Punha, Female, 23

What Punha is saying is that while the mental health support delivered by mental health practitioners from diverse backgrounds, she perceives is not adequate for Black sub-Saharan Africans due to their lack of cultural understanding and inability to understand the challenges faced by this group support from practitioners of Black origin is sometimes equally bad. This is because they fail to be objective and are sometimes not able to remove themselves from the unspoken Black African code, which says children must not talk bad about their parents and have to be grateful to them for enduring the harsh English environment so they can give them a better life and brighter future.

The above narratives highlight how the lack of cultural understanding and not understanding of the challenges faced by Black sub-Saharan African communities act as a barrier to utilising mental health services. It also emphasises the need for mental health practitioners to be objective and non-judgemental.

This section highlights the significant barrier that a lack of cultural understanding poses for Black sub-Saharan African communities in accessing and engaging with mental health services. Participants expressed frustration over mental health practitioners' inability to comprehend their cultural backgrounds and the specific challenges they face. This disconnect, they argue, results in ineffective care, misdiagnoses, and feelings of alienation and reflects a common sentiment among participants.

Punha, who sought help for an eating disorder, voiced her frustration over the absence of culturally competent care in eating disorder clinics. She found that her therapists, who were predominantly white, had little knowledge or experience of how eating disorders manifest in Black women. She points out that the lack of research into Black women with bulimia means that mental health practitioners are unequipped to support them effectively. This highlights a broader issue where mental health interventions are primarily developed based on studies conducted on white populations, leading to assessments that pathologise behaviours outside of this norm.

Akua and Kwame also shared their experiences of feeling misunderstood and dismissed by mental health professionals. Akua recalls a therapist asking why she did not simply return to her home country after her asylum application was refused while Kwame was told by his therapist to focus on the present and remind himself that he was now in a safe country, despite the fact that he was still at risk of deportation. Both experiences illustrate how therapists’ lack of awareness about immigration policies and the realities faced by asylum seekers can create further distress and discourage engagement with services. Samora’s experience of being assessed as not being unwell enough for admission despite being homeless in winter further highlights a lack of deeper understanding of the cultural and social challenges faced by Black sub-Saharan African communities.

These narratives highlight how a lack of cultural competence by mental health practitioners act as a barrier to accessing and engaging with mental health services.

4.3.8 Conclusion

The superordinate theme highlights the complex and interconnected barriers that Black sub-Saharan African communities face when seeking mental health support. Even when participants overcome the initial obstacles to seeking help, they encounter further challenges within the mental health system that make it difficult for them to engage with services effectively. Their experiences reveal a cycle of disbelief, long waiting times, inadequate treatment, and a lack of culturally competent care, all of which contribute to their disengagement and hinder their recovery.

These challenges are deeply interconnected, beginning with Not Being Believed by Mental Health Practitioners. Participants expressed frustration that their symptoms were dismissed unless they were in crisis, reinforcing feelings of invisibility and invalidation. This scepticism from mental health professionals leads to delays in receiving care, which is further compounded by Long Waiting Times. Those who are believed and referred for treatment often face prolonged periods without support, causing their mental health to deteriorate even further.

When participants finally access services, they often experience Not Getting a Diagnosis, which creates additional anxiety. Being prescribed medication without a clear explanation of their condition leaves them uncertain about their treatment plan and raises fears about the potential side effects of the drugs they are given. This links closely to the next sub-theme, Drug Treatment, where participants described how medication was prioritised over understanding their broader social circumstances. Many felt they were being treated in isolation from the factors that contributed to their distress, such as housing insecurity, immigration struggles, or social exclusion. Without addressing these underlying issues, medication alone felt like an inadequate solution.

This dissatisfaction extended to Talking Therapies, which participants felt were ineffective in providing meaningful support. They described sessions as spaces where they could share their problems, but little was done to address the root causes of their distress. Without tangible solutions or action, talking therapies felt like a passive form of care that did not empower them to heal.

The impersonal nature of mental health services was further reflected in the sub-theme Lack of Empathy and Human Touch. Participants felt that services were delivered in a mechanical, standardised manner that failed to acknowledge their individual circumstances. Rather than receiving holistic, compassionate care, they felt as though they were being processed through a rigid system that focused solely on symptom management rather than treating them as whole human beings.

These challenges are further exacerbated by Lack of Cultural Competence, which underpins many of the other sub-themes. Participants expressed frustration that mental health practitioners failed to understand their cultural background and the unique struggles they faced. This disconnect led to misinterpretations of their experiences, judgmental attitudes, and an inability to offer appropriate support. Without cultural awareness, mental health services often failed to meet their needs, leading to disengagement and a lack of trust in the system.

Together, these sub-themes illustrate how the mental health system creates a series of obstacles that reinforce one another. From the initial disbelief they encounter to the long waiting times, lack of diagnosis, over-reliance on medication, ineffective talking therapies, impersonal service delivery, and lack of cultural awareness, each stage of their mental health journey presents additional challenges. These interconnected barriers ultimately prevent Black sub-Saharan African communities from accessing the care they need and contribute to their continued struggle with mental health issues.

The next chapter will engage with Critical Race Theory to critically analyse these findings, examining how race and systemic racism shape the experiences of Black sub-Saharan African communities within the mental health system. As discussed in Chapter 1, Section 1.5.3., Critical Race Theory provides a framework for understanding how structural inequalities and racial biases contribute to disparities in mental health care. By applying this perspective, the study will explore how the racialised nature of mental health services impacts help-seeking behaviours and what steps can be taken to create a more equitable and inclusive system.

Chapter 5: Discussion

"Social justice is not just about raising awareness. It's about changing the system"

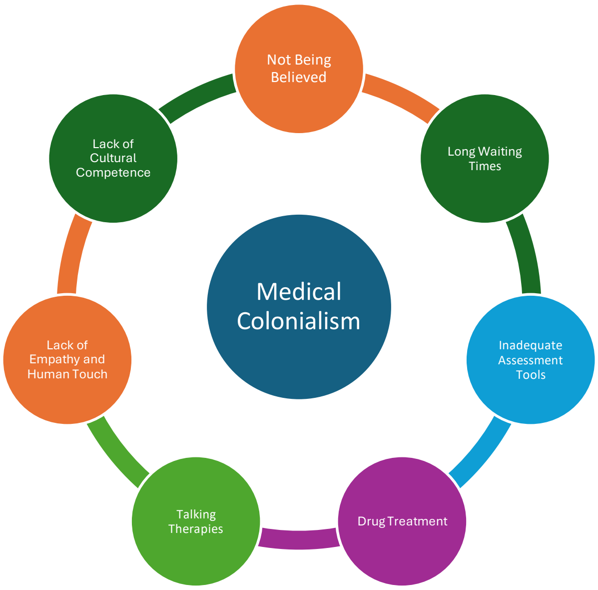
— Mona Eltahawy

5.1 Introduction

This chapter is guided by Stage 4 of The Silences Framework which positions the discussion section next after the presentation of the findings (Serrant-Green 2011). In Chapter 4, I presented my interpretations of the meanings a sample of 21 Black sub-Saharan Africans constructed based on their lived experiences of the social environment they reside in the West Midlands of England, UK. The data revealed a nuanced landscape of barriers to seeking mental health services deeply rooted in social, cultural, historical, and political contexts in two superordinate themes. Superordinate theme 1, Struggle and Oppression, outlined the participants' experiences of the challenges they faced while trying to navigate their social terrain and highlighted how these negatively influenced their decisions to seek help for poor mental health. Superordinate theme 2, Medical Colonialism, outlined the experiences of participants who managed to break barriers and proceeded to seek help for poor mental health. Figures 5 and 6 below give visual representations of the superordinate themes and their sub-themes.

Figure 5 – Superordinate Theme 1 – Struggle and Oppression

Figure 6 - Superordinate Theme 2 – Medical Colonialism



The historical relationship between England and sub-Saharan Africa highlighted a relationship in which the former dominated over the latter by exerting power that produced knowledge, identities, and social realities which shaped the way its indigenous people understood themselves and the world today (Rodney 1972; Peosche 2019; Kyriakides and Virdee 2003). Hence, besides disempowering the region by stripping it of autonomy, the legacy of colonialism instilled its inhabitants with a sense of inferiority which continues today no matter where they live in the world. Findings from this study revealed barriers to seeking mental health support deeply rooted in social, cultural, historical, and political contexts. For this reason, I found it appropriate to use the Critical Race Theory to critically analyse the findings as it offers a framework that interrogates how historical injustices may have created and sustained the barriers. The goal was to understand the role of race, racism, and power dynamics in making the decision to seek help for poor mental health among participants. However, before doing this, the chapter revisits the study's initial aim and research questions and after the critical analysis, proceeds to offer summaries on the implications of the study findings to mental health service delivery, suggested recommendations, study limitations, study contributions to the body of knowledge on barriers to mental health service utilisation among Black sub-Saharan African communities, researcher benefits from the study, opportunities for future research, and conclude by sharing the theoretical benefits of the study.

5.2 Initial Research Aim and Questions

The study aimed to gain an in-depth understanding of the low uptake of mental health services among Black sub-Saharan African communities in England. My central research questions were: What socio-economic and socio-cultural factors influence the uptake of mental health services, and what beliefs and perceptions do Black sub-Saharan African communities hold towards the uptake of mental health services?

The following section draws upon the Critical Race Theory to analyse the findings and deduce if race, racism, and power dynamics play any part in influencing the mental health help-seeking behaviours of Black sub-Saharan African communities.

5.3 Black sub-Saharan African Communities' Lived Experiences of the Social Environment in England Applied to the Critical Race Theory – (Critiquing Silences Heard)

As explained in Chapter 1.6.3, the Critical Race Theory works to understand and challenge how racism functions in society. One of its understandings is that racism is common in today's society (Lynn and Parker 2006) and that racial subordination, and the normalising of white privilege are reinforced in everyday life through systemic racism ingrained in policies and legal frameworks (Delgado and Stefancic 2017). This understanding provides a valuable starting point to examining how power, race, and racism influence Black sub-Saharan African communities' decisions to seek help for poor mental health. I categorised the findings' themes into four broader concepts: many intersect with multiple categories. The categorisation helps frame the discussion by emphasising how these issues operate within different layers of systemic racism and oppression.

5.3.1 Institutional Power and Racialised Structures

A key insight from the findings is the role of institutional power in maintaining racial hierarchies. The Critical Race Theory highlights that racism is not merely an individual bias but embedded in societal structures. The data reveals how policies and institutional norms subtly reinforce racial disparities. For example, the challenges associated with legal immigration status and the fear of deportation emerged as key barriers to seeking mental health support among Black sub-Saharan African communities. Participants described the prolonged uncertainty, financial burden, and systemic barriers imposed by the Home Office, particularly for those seeking asylum or on temporary visas. They explained how the process of regularising immigration status is marked by high costs, stringent requirements, and long waiting periods, exacerbating stress and financial instability (UK Government 2024). For instance, the visa renewal process often demands significant fees upfront, with refusal rates disproportionately affecting Black migrants (Gammeltoft-Hansen and Vedsted-Hansen 2016). This bureaucratic complexity further compels applicants to seek costly legal assistance, adding another layer of hardship.

Through the Critical Race Theory lens, these policies are viewed as products of systemic racism, reinforcing exclusion and economic precarity (El-nanny 2020). The stark contrast in the treatment of Sudanese and Ukrainian asylum seekers exemplifies this racial bias. While Ukrainians were granted immediate protection under the Temporary Protection Directive, Sudanese asylum seekers were denied similar safe passage (Crawley 2010; Heschl 2023). This differential treatment has been widely criticised as racially discriminatory (ENAR 2022), reinforcing the perception that Black migrants are unwelcome and unworthy of state protection. These findings support previous claims in the literature that identified legal frameworks of host countries as negatively influencing access to psychological and healthcare services (Lindert Schouler-Ocak and Priebe 2008; Bissonnette 2020).

Compounding these issues, the fear of deportation emerged as a significant psychological stressor, even for those with legal immigration status. Participants in this study reported experiencing heightened surveillance, racial profiling, and a general mistrust of state institutions. The 'Windrush scandal' serves as a historical reminder that even individuals with documented status are not immune from wrongful detention and deportation (Wardle and

Obermuller 2019). Additionally, the UK government's memorandum of understanding with the NHS, which mandates data sharing with the Home Office, has heightened concerns among Black sub-Saharan African communities about seeking healthcare services, including mental health support (Hiam, Steele and McKee 2018). However, those who managed to access mental health services spoke about the challenges of long waiting times to receive support, making it a barrier to accessing mental health services, particularly in densely populated areas where access to healthcare is already strained. From a Critical Race Theory perspective, this issue reflects historical and racial inequities shaped by racial tracking, a lack of interest convergence, and institutional racism. Racial tracking has resulted in Black sub-Saharan African individuals residing in resource-deprived areas where healthcare services are overstretched.

The study also highlighted the inadequate assessment tools used by mental health practitioners when diagnosing Black sub-Saharan African individuals. The absence of cultural competency in diagnostic practices often leads to misdiagnosis and inappropriate treatments. This is compounded by the pathologisation of Black bodies within Western psychiatric models, where mental health symptoms are often interpreted through a Eurocentric lens, overlooking the cultural and social factors that may be influencing distress. As a result, Black patients may be over-medicated or misdiagnosed, exacerbating their mental health struggles. The Critical Race Theory suggests that this is a product of colonial legacies in medical practice, where non-Western cultures and symptoms are often misunderstood or dismissed, leading to an erosion of trust in healthcare services. Interest convergence theory suggests that healthcare policies prioritise the interests of those in power: predominantly white policymakers, leading to a lack of urgency in addressing racial disparities (NHS Digital 2021; Carter 2020). This may explain why mental health inequalities persist despite policy reforms (Independent Review 2019). Additionally, institutional racism plays a role, as healthcare systems fail to integrate cultural competency and responsiveness to the specific needs of Black sub-Saharan African communities. These factors highlight the necessity of amplifying Black voices in shaping mental health policies and interventions that address systemic discrimination in healthcare access.

Ultimately, these interwoven factors create a pervasive sense of vulnerability and anxiety within Black sub-Saharan African communities, reinforcing social isolation and deterring individuals from engaging with formal healthcare services. The findings of this study support existing literature that identifies fear of service utilisation as a major barrier for undocumented migrants (Held et al. 2020; Mona et al. 2021). Addressing these concerns requires a policy shift that delinks immigration enforcement from essential services such as healthcare and social support, ensuring that individuals feel safe to access mental health services without fear of deportation or discrimination.

5.3.2 Racialised Narratives and Representation

Beyond legal and immigration concerns, participants in this study highlighted systemic racism as a significant barrier to seeking mental health support. The experience of living in unwelcoming dominant communities was described as a continuous source of stress and alienation, contributing to poor mental health outcomes. From a Critical Race Theory perspective, this unwelcoming environment is not merely the result of individual prejudices but is embedded in the structural and historical legacies of racial discrimination. Racial hierarchies and Eurocentric ideologies, rooted in colonial history, continue to shape contemporary societal attitudes and policies. This aligns with the concept of interest convergence, where dominant groups only support racial progress when it aligns with their interests (Bell 1980).

Gillborn (2008) highlights how education curricula often erase or misrepresent racialised histories, reinforcing systemic biases. The ways in which racialised individuals are represented in the media, policy discussions, and everyday interactions shape public perceptions and perpetuate stereotypes. Participants in this study noted how dominant narratives frequently marginalised or distorted their lived experiences. For instance, Almaz described how media portrayals of Black sub-Saharan African communities predominantly focused on crime rather than their contributions to society, reinforcing negative stereotypes.

The Critical Race Theory also underscores the centrality of whiteness in structuring societal benefits and protections. A stark example of this is the differential treatment of Ukrainian and Sudanese refugees, which illustrates how racial hierarchies influence migration policies and public attitudes. White migrants are often perceived as more deserving of asylum and support, while Black migrants are constructed as threats or burdens (Sinclair, Granberg, and Nilsson 2023). The ‘Homes for Ukrainians’ scheme, launched by the UK government, saw an overwhelming response from the British public, with thousands of people offering accommodation and support. In contrast, right-wing pressure groups protested against hotels temporarily housing non-Ukrainian asylum seekers, demonstrating racial bias in public sentiment and policy implementation. This overt discrimination discourages Black sub-Saharan African communities from seeking mental health support due to fear of further marginalisation.

Racial stratification extends into healthcare, where Black communities face greater scrutiny, denial of care, and exclusion from culturally competent mental health services. The lack of representation and cultural understanding among mental health practitioners exacerbates this issue, as Black individuals’ experiences and traumas are often invalidated within a Eurocentric framework. Existing research supports these concerns, showing that British individuals are more willing to help, hire, and donate money to refugees from Ukraine than those from Yemen, largely due to perceived similarities and reduced perceptions of threat (Sinclair, Granberg, and Nilsson 2023). These findings can be extended to Black sub-Saharan African individuals, who are often stereotyped as dangerous, lazy, criminal, or violent (Cooke 2018).

Another significant barrier to mental health support highlighted in the study was the disbelief participants faced when presenting with mental health concerns. Many reported being turned away by practitioners who did not believe they were unwell enough to warrant care. In some cases, participants only received mental health support after being detained for physical health conditions. Others were denied immediate support due to rigid adherence to referral processes, leading to situations where individuals on the brink of crisis were refused care. For example, Samora was turned away for not following the correct referral process, only to be detained under the Mental Health Act 1983 a few days later. Such practices reflect systemic biases that perpetuate racial hierarchies and Eurocentric norms within healthcare.

A core theme of the Critical Race Theory is the idea that institutions operate on values and principles that often lack cultural diversity and representation (Graham et al. 2011). The concept of differential racialisation suggests that racial groups are constructed and treated differently based on shifting societal needs (Crenshaw et al. 1995). Within the UK's mental health system, Black individuals are frequently subjected to racial stereotypes that frame them as either dangerous or inherently resilient, leading to misdiagnosis, over-surveillance, and mistrust (Fernando 2017). The perception that Black individuals should be strong and self-sufficient contributes to mental health stigma within the community, as seeking help may be seen as a sign of weakness. Moreover, participants who engaged with mental health services reported experiences of disbelief, dismissal, or coercion into punitive interventions, such as involuntary hospitalisation (Adams et al. 2014). These systemic inequities result in Black sub-Saharan African distress being minimised or criminalised rather than treated with care and understanding.

Dominant cultural norms within mental health services are often considered universal, leading to implicit biases that cast doubt on the credibility of Black sub-Saharan African individuals seeking support. These biases are rooted in colonial histories, which perpetuate notions of cultural inferiority and mistrust. The Critical Race Theory draws attention to the cultural dissonance between racialised groups and mental health professionals who may lack adequate cross-cultural competence. The absence of cultural competency can lead to misdiagnoses, misunderstandings, and inadequate treatment. Research acknowledges that mental illness manifests differently across cultures (Kleiman 1988), and a lack of cultural understanding can result in incorrect symptom interpretation, denial of support, or misdiagnosis leading to inappropriate treatment.

Participants in this study reported being assessed as either too ill for certain services or not ill enough to qualify for care. Misdiagnosis can have severe consequences, as a correct diagnosis is the foundation for determining symptom causes and planning treatment (Kring 2013). An incorrect diagnosis can lead to inappropriate treatment, with side effects that may exacerbate mental illness. Some participants witnessed friends being detained for minor mental health issues and discharged with more severe conditions. The literature suggests that assessments under the Mental Health Act 1983 are susceptible to bias and discrimination due to the high level of subjective discretion involved (Department of Health and Social Care 2019). While some researchers argue that there is no definitive confirmation of how discrimination impacts assessment outcomes (Bignall 2019; Department of Health and Social Care 2019), Nazroo et al. (2020) caution against focusing solely on prejudice at the evaluation stage, arguing that systemic factors play a more significant role. These findings challenge the dominant narrative that Black sub-Saharan African individuals primarily seek mental health services during crises (Bignall et al. 2019; Kane 2014; Care Quality Commission 2022; NHS Digital 2021). Instead, they reveal a broader systemic failure, where Black sub-Saharan African individuals attempting to access mental health services encounter numerous structural barriers that ultimately deter them from seeking support. Addressing these issues require a fundamental shift towards culturally competent care and a critical examination of the racialised dynamics within mental health systems.

5.3.3 Resistance and Agency (Reshaping Power Dynamics)

Despite systemic barriers, individuals and communities develop strategies of resistance. The findings highlight how Black sub-Saharan African communities challenge dominant structures through activism, storytelling, and community-building. This section explores how these acts of resistance reshape power dynamics and create spaces for equity.

Participants in this study illustrated the role of activism in resisting oppressive mental health structures and advocating for systemic change. Despite facing institutional barriers, Black sub-Saharan African communities actively challenge discriminatory practices, advocate for better service accessibility, and promote culturally inclusive mental health care. Many participants emphasised the importance of community-driven initiatives, such as peer support groups, religious meetings, and cultural advocacy networks, in addressing mental health stigma and providing alternative spaces for healing. These activist efforts counteract mainstream mental health approaches that often overlook the lived realities of Black sub-Saharan African communities. Through activism, these communities assert their agency, resist marginalisation, and ensure that their voices are included in discussions on mental health care reform. Recognising and supporting these efforts is essential in fostering a mental health system that is accessible, culturally affirming, and just.

A key tenet of the Critical Race Theory is the importance of counter-narratives in challenging dominant discourses and exposing systemic injustices (Matsuda 1991). Counter-narratives serve as powerful tools to reclaim histories and resist marginalisation (Delgado 1989). In this study, the testimonies of Black sub-Saharan African individuals regarding racial profiling, discrimination, and mental health stigma act as counter-narratives that disrupt mainstream assumptions of equality and neutrality in healthcare and immigration. By amplifying these voices, the need for policy changes, increased cultural competency in mental health services, and community-led support initiatives that centre lived experiences is underscored.

Participants' experiences also highlight the critical role of familial support in navigating mental health systems. Black sub-Saharan African communities often encounter systemic barriers, cultural misunderstandings, and medical neglect when accessing mental health services. However, rather than being passive recipients of care, participants demonstrated agency by mobilising familial and community resources. Setorwu's decision to travel from Africa to support her daughter's recovery from cancer is an act of agency that challenges the limitations of healthcare systems that often overlook the emotional and cultural needs of migrant patients. Her intervention illustrates how Black sub-Saharan African communities resist fragmented care by providing holistic and culturally responsive support. Similarly, Samora's aunt leveraged her expertise as a mental health practitioner to challenge medical decisions that could have exacerbated his condition. By preventing the unnecessary sedation of Samora, she demonstrated how knowledge and advocacy within families can protect against medical mistreatment.

While some participants exhibited resilience through community and family support, the study also revealed the vulnerabilities of those lacking advocacy networks. Without informed support systems, individuals are at greater risk of misdiagnosis, coercion, and neglect. However, this does not imply a lack of agency: rather, it highlights the structural inequalities constraining Black sub-Saharan African communities' ability to access adequate mental health care. Even in these circumstances, some participants resisted marginalisation by seeking support from cultural organisations, religious groups, and peer networks that provided emotional and practical assistance.

Another form of resistance emerged in participants' efforts to educate their families and communities about mental health. Stigma and misinformation often hinder familial support, but some participants engaged in knowledge-sharing, discussing their experiences and advocating for mental health awareness. This challenges dominant narratives that position Black sub-Saharan African communities as merely vulnerable, instead highlighting their active role in reshaping perceptions and creating inclusive support systems.

A significant area of resistance among Black sub-Saharan African communities is the challenge to dominant medical approaches to mental health treatment, particularly concerning medication and talking therapies. Some participants expressed scepticism about psychiatric drugs due to past experiences of overmedication, coercion, or misdiagnosis. This scepticism reflects broader concerns about how mental health institutions often fail to consider the social and cultural contexts of Black sub-Saharan African communities' distress. Resistance in this area manifests through the pursuit of alternative therapies, including faith-based healing, herbal medicine, and culturally grounded therapeutic practices. While some participants reported positive experiences with talking therapies, others found traditional Western models inadequate for addressing their specific traumas and lived experiences. Some engaged in activism by advocating for culturally responsive therapeutic approaches that incorporate storytelling, collective healing, and community-based interventions. By challenging the limitations of dominant mental health practices, Black sub-Saharan African communities assert their agency in defining meaningful and effective care.

Challenging stigma remains central to mental health activism among Black sub-Saharan African communities. Many participants actively worked to dismantle misconceptions about mental health, recognising that stigma often discourages individuals from seeking help. Through education, peer mentorship, and public advocacy, grassroots organisations such as Inini Initiative and faith groups resist narratives that equate mental illness with weakness or failure. Instead, they promote conversations that validate mental health struggles and encourage help-seeking behaviours.

Ultimately, the experiences of Black sub-Saharan African communities underscore the intersection of resistance and agency in their engagement with mental health services. While structural barriers persist, Black sub-Saharan African communities continuously adapt, advocate, and challenge-imposed limitations. By centring their voices, this study contributes to a broader understanding of how these communities navigate and transform mental health systems, highlighting the necessity of policies that recognise and support their agency in accessing care.

5.3.4 Intersectionality and Compounded Inequalities

Racial injustice does not operate in isolation. It intersects with other axes of oppression such as gender, class, and immigration status. The Critical Race Theory emphasises the importance of intersectionality in analysing how multiple forms of discrimination converge. The findings illustrate how Black sub-Saharan African communities navigate complex and compounding challenges. Punha, for instance, described how being both a woman and an immigrant compounded her experiences of workplace discrimination. Crenshaw (1991) posits that intersectionality is crucial in understanding the compounded disadvantages that marginalised groups face. Other scholars, such as Collins (2000), further argue that these overlapping oppressions create unique barriers that require intersectional policy solutions.

The experiences of Black sub-Saharan African participants in this study also highlight the intersectionality of race, gender, socioeconomic status, and immigration status in shaping access to mental health services. This group often face compounded inequalities, as their marginalised identities interact to create unique forms of disadvantage within healthcare systems. Structural barriers such as language differences, lack of culturally competent care, and restrictive immigration policies disproportionately affect those who already experience socioeconomic hardships and racial discrimination.

For sub-Saharan African women, for example, gendered expectations around caregiving can place additional burdens on their mental health while simultaneously limiting their access to services. Many women in this study reported prioritising the well-being of their families over their own mental health needs, reinforcing systemic neglect of their psychological well-being. Furthermore, experiences of racialised medical discrimination, such as being dismissed or misdiagnosed, further alienate Black sub-Saharan African communities from seeking professional care. Economic instability exacerbates these challenges, as financial insecurity restricts access to private mental health services, forcing many to rely on overburdened public health systems with long waiting times and inadequate resources. Undocumented sub-

Saharan African individuals, in particular, experience heightened vulnerability due to fears of deportation, which often prevent them from seeking essential mental health support.

Despite these systemic inequities, Black sub-Saharan African communities continue to navigate and resist these challenges through collective action, advocacy, and alternative healing practices. By acknowledging intersectionality in mental health research and policymaking, it becomes possible to design more inclusive and responsive mental health services that address the compounded inequalities faced by Black sub-Saharan African communities.

5.3.5 Conclusion

This study has examined the systemic barriers and racial inequalities that Black sub-Saharan African communities face in accessing mental health services. Drawing on the Critical Race Theory, the discussion has demonstrated how institutional power, racialised narratives, and intersectional inequalities contribute to the marginalisation of individuals of Black sub-Saharan African heritage within healthcare and immigration systems. The findings highlight how structural racism is embedded in policies and practices, from discriminatory immigration laws to inadequate mental health assessments that fail to account for cultural differences.

Despite these barriers, the study also emphasises the resilience and agency of Black sub-Saharan African communities. Through activism, community-driven initiatives, and counter-narratives, individuals resist oppressive structures and advocate for more culturally competent mental health care. The role of peer support, family networks, and grassroots organisations in fostering mental well-being further illustrates the importance of collective resistance. However, these efforts cannot replace the need for systemic change.

To address these persistent inequalities, policymakers and healthcare institutions must prioritise culturally responsive mental health services, de-link immigration enforcement from essential healthcare, and actively work to dismantle racial biases in mental health assessments. A more inclusive and equitable mental health system requires not only acknowledging historical injustices but also implementing tangible reforms that amplify Black voices and centre their lived experiences. By addressing these issues at a structural level, society can move toward a future where mental health care is accessible, just, and free from racial discrimination.

5.4 Implications of the Research Findings on Mental Health Service Delivery

The findings from this study highlight the importance of engaging in open dialogue with individuals of Black sub-Saharan African origin. Such open communication provides deeper insights into their lived experiences and the unique challenges they face, particularly around mental health. It fosters trust and allows for a better understanding of how cultural, social, and systemic factors influence their perceptions of mental health and their decisions to seek help. This dialogue is essential for addressing their needs in a respectful and culturally sensitive manner, ultimately improving their engagement with mental health services. Combining parts of The Silences Framework (Serrant-Green 2011) to guide the study and IPA (Smith, Flowers and Larkin 2022) to collect and analyse the data, effectively assessed the influence of socio-cultural and socio-economic factors on their decisions to seek help for poor mental health. In addition, engaging the Critical Race Theory (Freeman 2011; Delgado 2009) to analyse the findings critically proved a powerful tool to highlight how race and racism influence these decisions. It also illuminated how this was reinforced in everyday life through policies and legal frameworks and how Eurocentric perceptions continue to shape the development of mental health services today (Delgado and Stefancic 2012). The study found white supremacy to be the overarching social, political, and legal authority that, besides giving life to European hegemony, also perpetuates inequalities in mental healthcare. As such, it is clear that to reduce/eradicate mental health inequalities, strategies which tackle white supremacy must be implemented.

Important to note is that explanations for mental health inequalities are a controversial topic. While some scholars believe that how institutions respond to factors that act as barriers to accessing mental health services are shaped by processes related to racism (Nazroo et al. 2018), others are of a different opinion, arguing this not to be accurate as there is no evidence to it (Singh and Burns 2006). Nonetheless, the two groups agree that mental health inequalities are caused by multiple social disadvantages such as poverty, unemployment, exclusion, living in areas with resource-poor services, and experiences of racism and discrimination at both interpersonal and societal levels. Interestingly, the findings of this study also highlight similar factors but go on further to show how the white supremacy mindset drives these. As such, it can be argued that both barriers to accessing mental health services and factors used to mitigate them are shaped by processes related to racism. This evidences how racism permeates every aspect of mental healthcare, leading to inequalities in the delivery of mental health services. This underscores the importance of employing concerted efforts to dismantle it at its root if we are to realise equity in the delivery of mental health care and the need to involve a wide variety of players. Continuing to turn a blind eye to the white supremacy mindset while employing other means to reduce inequalities in mental healthcare can be likened to treating the symptoms of the illness and not the cause. Acting in this way will only perpetuate the inequalities, which may be the reason why mental health inequalities have persisted even in periods of increased funding and when new policies were implemented. In the next section, I give my recommendations on how the white supremacy mindset can be dismantled and mental health inequalities reduced.

5.5 Recommendations

The findings of this study highlight the systemic barriers and legal frameworks that hinder Black sub-Saharan African communities from accessing mental health support in the West Midlands of England, UK. The impact is compounded by an intersection of various challenges that reinforce the barriers to accessing mental health services. As such, a concerted effort by multiple players to address this is paramount. This will create a more inclusive and responsive mental healthcare system that prioritises accessibility, cultural sensitivity, and holistic well-being. In this section I provide recommendations for various stakeholders whose collective action is essential for fostering sustainable change in the delivery of a more equitable and inclusive mental healthcare system.

5.5.1 Service Users and their Communities

Findings indicate that stigma and low mental health awareness are significant barriers to seeking help for poor mental health among Black sub-Saharan African communities. This underscores the need to raise awareness of mental health at both individual and community levels while educating people about the harmful effects of mental health stigma. To address this, it is important that Black sub-Saharan African communities, both users and non-users of mental health services, conduct open discussions about mental health and stigma, and advocate for culturally appropriate interventions such as, faith-based counselling and community-led initiatives. They should seek knowledge about their healthcare rights and available legal support to empower themselves in navigating systemic barriers. Communities should lead in the development of mental health education programmes that offer practical coping strategies and facilitate access to relevant resources. Strategies such as peer support groups, where individuals share personal experiences of mental illness can be a powerful tool in reducing stigma and disseminating mental health information. In addition, leveraging radio and social media campaigns can also help disseminate mental health information in an accessible and culturally relevant manner, fostering a more supportive environment.

5.5.2 Social Services and Community Support Networks

Social services and community support networks should work collaboratively with mental health providers and immigration advisors to ensure a holistic support. Accessible housing, employment opportunities, and financial assistance programmes should be strengthened to address the socio-economic barriers that contribute to poor mental health outcomes. Community-based crisis intervention services should be developed to provide culturally responsive care without relying on law enforcement for mental health emergencies. Additionally, training programmes for family members and caregivers should be implemented to ensure they have the knowledge and skills to support loved ones experiencing mental illness.

Since, the findings show that decisions to seek help for poor mental health are heavily influenced by the interactions of Black sub-Saharan African and dominant communities trust building initiatives must be implemented at community level. This is essential for fostering positive interactions and addressing discrimination. The idea is to have local authorities support initiatives that create safe spaces for open dialogue regarding issues such as, colonialism, where narratives of race, racism, and cultural nuances are acknowledged and respected. This positive interaction in communities should allow the active involvement of organisations led by Black sub-Saharan Africans and, community cultural and faith leaders.

They should receive training to recognise signs of mental illness and refer individuals to appropriate mental health services. Collaborations between faith institutions and mental health providers should be encouraged to create integrated care models that respect both spiritual and psychological well-being. The process will create a stronger sense of belonging and acceptance, strengthening community resilience. Once community cohesion is achieved, trust levels will increase, and relationships created will lead to information sharing on available services, including where mental health services are located and how they can be accessed.

5.5.3 Mental Health Practitioners

To provide effective mental health support for Black sub-Saharan Africans, practitioners must approach their work with openness and a non-judgemental attitude. Participants in this study reported that non-Black providers often lacked cultural awareness, leading to misunderstandings of their experiences, while some Black sub-Saharan African practitioners were perceived as judgemental. These findings highlight the importance of cultural humility and unbiased care, regardless of a provider's background. Mental health professionals should engage in a continuous learning process involving mentorship and self-reflection to ensure responsiveness to evolving cultural needs.

It, however, is important to note that cultural competence training has been implemented in the UK for some time now and yet barriers to accessing mental health services have persisted. This might be due to gaps between how it is often practised and how it ought to be practised. Available cultural competence training is frequently surface level, delivered as one-off sessions that provide generic cultural awareness without deep engagement with specific communities. Instead, it should be ongoing, immersive, and tailored, incorporating lived experiences and real-world case studies. Moreover, many programmes focus on theoretical knowledge and stereotypes rather than practical application, whereas effective training should equip practitioners with the skills to adapt their approach dynamically. Too often, cultural competence initiatives become tokenistic, lacking meaningful engagement with the communities they aim to serve when it should be prioritised to shape service delivery. Current approaches often place the burden on individual practitioners without addressing institutional racism and systemic inequalities. True cultural competence must be embedded in structural change, influencing policies, hiring practices, and service models. For cultural competence to be effective, it must go beyond a box-ticking exercise and become an integral, evolving part of mental health service design and delivery.

However, to ensure for an ethical and non-exploitative co-production of mental health services, contributors must be fairly compensated through paid roles, stipends, or career development opportunities. Power dynamics should be equitable, with genuine decision-making authority and transparent agreements. Long-term sustainability is key, requiring ongoing funding, capacity building, and continuous partnerships rather than one-off consultations. Ethical practices, including informed consent, data ownership, and transparency, must be upheld to protect contributors' rights and ensure meaningful impact.

5.5.4 Policymakers

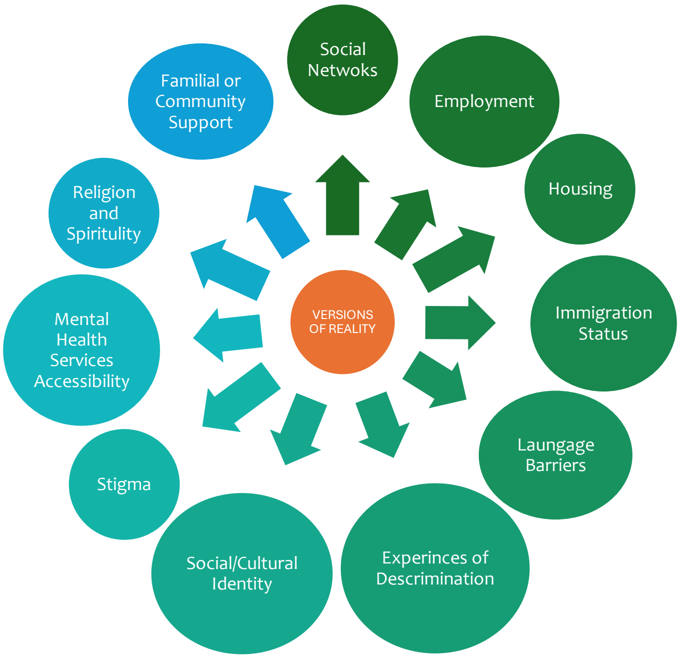
Policymakers should work towards reforming immigration policies that hinder mental health access and ensure that individuals can seek support without fear of deportation. Allocating funding for targeted mental health programmes designed to meet the needs of Black Sub-Saharan African communities is crucial. Resourcing community development initiatives that prioritise the needs and interests of Black sub-Saharan Africans can increase their mental health help-seeking behaviours. This can involve supporting grassroots organisations and community-led projects that address local challenges and promote social justice. By doing this, communities are empowered to advocate for their rights and create positive change, including accessing and utilising mental health services. Also, investing in infrastructure and public amenities in historically marginalised neighbourhoods can improve the quality of life and enhance community resilience. Providing funding and resources for cultural and recreational programmes that celebrate the diversity and heritage of Black sub-Saharan African communities can foster a sense of belonging and pride. Facilitating partnerships between community organisations, local government, and businesses can leverage collective resources and expertise to address systemic issues and promote community development. This includes changing the current narrative where such projects are, on average, only funded for short periods, making it challenging to recruit and retain quality qualified staff and sustain them. Besides, research has shown that community-led projects are crucial in addressing local challenges and promoting social justice (John Rowntree Foundation 2020).

Structural inequalities in healthcare, housing, and education must be addressed to create a fairer society. As such, political leaders must take an active role in challenging racism and ensuring diverse representation in government. By taking a multi-faceted approach, England can work towards a more inclusive and equitable society. However, both the literature and findings highlighted that legislation has already been enacted in some areas, but implementation and enforcement is a challenge. This is because individuals responsible for this are mainly from dominant cultures who may hold Eurocentric perceptions towards Black sub-Saharan Africans and therefore, not see the importance of doing this.

In addition, to promote mental health equity, policy-makers and funding agencies should also have funding streams dedicated to research investigating mental health issues within Black sub-Saharan African communities. This funding should examine the unique health challenges, social determinants, and systemic factors affecting these community groups. By prioritising research focused on this cohort, insights that contribute to more targeted interventions and policies can be uncovered. This funding approach supports the development of evidence-based solutions, promotes inclusivity in research, and helps dismantle white supremacy in interventions. Ultimately, investing in research specific to Black sub-Saharan African communities is a crucial step towards understanding and rectifying mental health disparities, promoting a more equitable and just healthcare system for all.

Similarly, policymakers should also introduce anti-racist policies within healthcare services to eliminate racial biases in diagnosis, treatment, and the use of the Mental Health Act 1983. However, anti-racist policies were implemented in England decades ago, but racism remains deeply rooted. This means that stronger enforcement of existing laws is essential, ensuring that violations are met with stricter penalties and greater accountability. A historical recommendation was put forward by McColl et al. (2008) regarding concerns around the validity of diagnostic instruments and the concepts on which they are based. As such, I recommend a social model as an effective assessment tool in addressing the unique mental health challenges faced by Black sub-Saharan African communities. Unlike conventional individual-focused approaches, a social model considers the mental well-being's collective and communal aspects. Black sub-Saharan African societies often emphasise community interconnectedness, familial bonds, and cultural identity. By utilising a social model, mental health assessments can be tailored to consider these cultural dynamics, providing a more holistic understanding of an individual's mental health within the context of their community. This approach encourages a collaborative and supportive network, fostering resilience and promoting mental wellness at the individual and community levels. Additionally, a social model aligns with the communal values inherent in Black sub-Saharan African cultures, offering a culturally sensitive framework for mental health assessment that is more likely to resonate with individuals and encourage engagement in mental health initiatives. Below is a visual representation of ‘The Inini Fan’, a social model under construction, which is based on my concept of how Black sub-Saharan African communities should be assessed, following the findings of this study. The model's emphasis is on ‘talking and not ticking’. Work is continuing to test its validity before publishing it.

Figure 7 – The Inini Fan Model



5.5.5 Corporate Leaders

Corporate leaders should implement workplace mental health policies that recognise the stressors faced by Black sub-Saharan African employees due to racial discrimination and socio-economic hardships. Providing access to culturally competent Employee Assistance Programmes (EAPs) and establishing anti-racism policies will help create inclusive and supportive workplace environments. On top of that, economic inclusion should be prioritised by promoting fair hiring practices and addressing pay disparities. Companies should also offer paid mental health days and greater workplace flexibility for those struggling with mental health challenges. To help reduce mental health inequalities among Black sub-Saharan African communities, more individuals from these communities must be recruited into decision-making positions. However, not to be brown outside and white inside, where they push the same Eurocentric ideologies but to bring in and model diverse perspectives from silenced communities. Together with policy-makers, corporate leaders should prioritise targeted initiatives, including mentorship programmes, leadership training, and recruitment efforts specifically focused on this cohort. By doing this, they benefit from a richer range of perspectives and experiences, thereby diluting Eurocentric perspectives and realising more informed and equitable decision-making processes. Creating an inclusive environment that values and supports career progression for individuals of Black sub-Saharan African heritage is crucial, as it not only enhances representation but also serves as an inspirational model for future generations. Emphasising diversity at the decision-making level is not only a matter of equity but also essential for fostering innovation and ensuring a comprehensive understanding of the diverse needs and aspirations of the broader community. There may be need for treatment decisions involving detention under the Mental Health Act 1983 which is known to disproportionately affect individuals of Black heritage, and hence, supporting this group in advancing to senior positions across all mental health professions, including psychiatry, psychiatric research, psychiatric nursing, and management is vital (NHS Digital 2021; Department of Health and Social Care 2018; Barnett et al. 2019).

5.5.6 Education and Training Institutions

Education must play a key role in combating racism through comprehensive anti-racism programmes in schools and mandatory diversity training in workplaces and public services.

Institutions should integrate cultural competency and anti-racism education into the curricula of psychology, psychiatry, and social work. Extending similar training to law enforcement officers and judicial personnel can help reduce racial bias, improve fairness in the criminal justice system, and lead to more equitable outcomes for Black individuals. Similarly, training programmes on cultural beliefs, practices, and preferences of Black sub-Saharan African communities, including factors such as immigration, housing, and employment issues should be introduced in schools to build confidence and cultural awareness from an early age. Incorporating culturally relevant content into educational curricula will promote inclusivity and diversity, creating a more supportive learning environment for Black students. Initiatives that enhance the inclusivity and representation of Black sub-Saharan African communities in health studies and clinical trials should be prioritised. This will make research findings more applicable to them, addressing the mistrust in medical research and ensuring that mental health interventions are not solely designed for dominant cultures. Gaining insights into the specific mental health needs, risk factors, and treatment preferences of Black sub-Saharan African communities fosters a collaborative approach that empowers individuals, promotes transparency, and encourages help-seeking behaviour for mental health issues.

Additionally, health researchers should adopt a transformative citizen social science approach by actively involving Black sub-Saharan African communities in designing, implementing, and interpreting research. This ensures that their unique perspectives shape the research agenda, leading to more vibrant, inclusive, and resilient communities where individuals can thrive. The history of colonialism should also be taught in schools to help dominant communities understand Black sub-Saharan African communities and challenge Eurocentric perspectives. This education will foster recognition of Black communities' positive contributions to society. Likewise, Black sub-Saharan African communities will benefit from learning about the cultures of dominant communities, promoting mutual respect and understanding.

5.5.7 Legal and Immigration Services

Legal and immigration services should advocate for policy reforms that allow asylum seekers and undocumented individuals to access mental health services without legal repercussions. Free or low-cost legal support should be made available to individuals facing immigration-related barriers to mental health care. Additionally, mental health practitioners should receive guidance on navigating legal restrictions when treating individuals with precarious immigration statuses. Public awareness campaigns should also be developed to educate migrants on their healthcare rights and available mental health services.

5.5.8 Law Enforcement and Criminal Justice System

To reduce racial profiling in mental health crises, the law enforcement and criminal justice system must implement anti-racism training for police officers and other criminal justice professionals. Additionally, alternative crisis response teams should be developed, prioritising mental health professionals over police intervention in non-violent cases. This approach ensures that individuals experiencing mental distress receive healthcare support rather than face criminalisation. Furthermore, accountability measures must be established to address racial discrimination within law enforcement and its impact on mental health outcomes. Broader police and criminal justice reforms are also essential, focusing on reducing racial profiling and increasing diversity within both law enforcement agencies and the judiciary.

5.5.9 Healthcare Regulatory Bodies and Professional Associations

Healthcare regulatory bodies and professional associations must mandate cultural competency training as a core requirement for all mental health professionals. Licencing and accreditation processes should assess practitioners’ ability to work with diverse populations. Oversight mechanisms should be introduced to track racial disparities in mental health diagnoses and treatments. Lastly, funding should be allocated to support community-led mental health initiatives tailored to the specific needs of Black sub-Saharan African populations.

5.6 Limitations of the Study

All scholarly investigations have limitations, and different strategies can be applied to improve them. In this study I have noted four limitations which I have summarised below.

5.6.1 Participants Known to the Researcher

I am a community leader working in the area of mental health service delivery with global majority populations, including Black sub-Saharan African communities and hence, am well known in the community. As such, all of my participants, except one, were well known to me. While this was an advantage in that it gave me more access to participants who trusted me and found it easier to share their experiences openly with me, there is a risk they may have given responses they knew aligned with my philosophical perspectives since similar discussions have been held at the peer support groups I run. Also, because of my former refugee status and Black sub-Saharan African heritage, I found the interpretation process difficult. This is because of the similarities between our lived experiences, and I was worried I would project my own experiences more than that of the participants. However, to mitigate against this, I maintained transparency regarding my role right from the beginning and encouraged participants to be truthful in their responses. I also, actively engaged in reflexivity to acknowledge and address my own biases throughout the research. Besides, my reasons for conducting the research motivated me to make sure I get it right; I was triggered to conduct the research by the realisation that conversations around mental health inequalities in the UK had been going on for more than 60 years and rather than getting better, the situation was deteriorating. Because of this, I wanted to understand the social determinants influencing the uptake of mental health services so I could develop adequate interventions for individuals accessing Inini services. Moreover, because I was self-funding the PhD, I also wanted to get real value for money.

5.6.2 Homogenising Black sub-Saharan Africans

Another limitation encountered in carrying out the research was the amalgamation of Black sub-Saharan Africans across the region as a sample. Sub-Saharan Africa comprises several ethnicities, languages, cultures, religions, and migration histories. Treating them as a homogeneous group risks oversimplifying complex realities and overlooking unique challenges and experiences specific to particular subgroups. Besides, one of the motivations for conducting the study was that I did not use the Karanga culture philosophy, which is specific to southern Zimbabwe, as a blanket framework for developing mental health interventions delivered at Inini Initiative Ltd. To address the issue, I implemented several strategies to acknowledge and respect the diversity within the group. My sample was made up of participants from 10 sub-Saharan African countries that represented all its sub-regions; south, central, west, and east. This ensured a recognition of its vast cultural, linguistic, and socioeconomic diversity. Furthermore, I considered factors such as gender, age, and religious background to reflect the diverse experiences of migration and mental health. However, the study used more male than female participants reflecting historical patterns of migration of Black individuals from sub-Saharan Africa (UK Government 2022).

5.6.3 Using Participants on Different Immigration Statuses

The same principle identified in 5.6.2 applied to my using participants on different immigration statuses. The study used participants from undocumented, naturalised British, asylum seekers, refugee backgrounds and another who was born in England to Black sub-Saharan African migrant parents. While this was good for offering diverse perspectives, it may also have skewed the findings as individuals on various immigration statuses may have different needs, affecting the way they use mental health services. However, to mitigate against this I acknowledged the differences in immigration status and explicitly discussed how immigration status influenced participants' access to services, social integration, and mental health outcomes. I distinguished between the experiences of asylum seekers, refugees with legal status, and undocumented migrants, rather than assuming a uniform experience across all participants. While recognising the increased vulnerabilities faced by undocumented individuals, I ensured that their narratives were not seen as representative of the entire Black sub-Saharan population in the west midlands of England, UK. I provided context regarding the legal and systemic barriers they encountered, while contrasting these experiences with those of individuals possessing more stable legal statuses.

5.6.4 Using Qualitative Research

The research used qualitative research which has several limitations such as generalisability, reliability, researcher bias, subjectivity, time and resource constraints, and ethical concerns (Creswell and Poth 2018; Maxwell 2013). Qualitative studies rely on small, non-random samples and hence, their findings may not apply to larger populations (Bryman 2016). On top of that, they prioritise depth over breadth making it challenging to draw conclusions that can be generalised beyond the specific context studied (Tracy 2019). Nevertheless, findings may be transferrable to similar contexts. Another issue is that of subjectivity and researcher bias as the researcher's perspective may influence data collection, analysis and reporting (Denzin and Lincoln 2018). However, as mentioned in Chapter 3, in this research reflexivity was used to mitigate against bias. Besides being time consuming and resource intensive, the lack of standardisation of qualitative studies makes them difficult to replicate (Yin 2018). Ethical issues are also significant as researchers often engage with sensitive topics, leading to concerns about participant privacy, informed consent, and emotional distress (Orb, Eisenhauer and Wynaden 2001). The power dynamics between researchers and participants can also affect the data collection process, as participants may alter their responses due to perceived expectations or social desirability bias (Tracy 2019).

5.6.5 Theoretical Framework Used

This section acknowledges the limitations of the theoretical frameworks underpinning this research. While IPA provides a rich, in-depth exploration of lived experiences, it is limited in that it is subjective in nature. Its focus on individuals' lived experiences and perceptions mean that the findings are based on various individual contexts and the researcher's interpretation. For example, an undocumented individual may view certain phenomenon in a different way from someone who has legal status and therefore, generalising the findings can be misleading. Similarly, though the Critical Race Theory is invaluable in uncovering structural inequalities and the role of race in shaping experiences, it has been critiqued for sometimes prioritising macro-level analyses over the deeply personal and phenomenological aspects of lived experiences (Delgado and Stefancic 2017). The same goes for the Silences Framework which was used partly to guide this thesis. It has been critiqued for its emphasis on absences and omissions, which may lead to interpretative gaps where meaning is inferred rather than directly expressed (Mazzei 2007). Nonetheless, integrating multiple frameworks ensured a nuanced, multidimensional understanding of participants' narratives and helped contextually ground the understanding of the complex interplay of social factors that influence decisions to seek help for poor mental health among Black sub-Saharan African communities.

5.6.6 Sample Size too Small for National Policy and Practice Recommendations

One of the key limitations of this study is the use of a small sample from a single region of England. While the findings offer valuable insights into the experiences of sub-Saharan Africans in this specific context, they may not be fully representative of the broader sub-Saharan African population across the UK. Given the diversity of migration histories, socio-economic backgrounds, and settlement patterns within this community, it is important to consider how these factors might vary in different parts of the country. For instance, sub-Saharan Africans living in a small town or village in Northeast England may experience different challenges compared to those in London, Newport, or Glasgow. In rural or less diverse areas, issues of social isolation, access to culturally competent services, and community support networks may be more pronounced (Phillimore 2011; Netto 2011). In contrast, in cities with larger African populations, individuals may have better access to community-led support systems but still face structural inequalities in employment, housing, and healthcare (Aspinall and Chinouya 2008; Kone et al. 2020).

Existing research suggests that regional variations in ethnic minority experiences in the UK are significant. Phillimore et al. (2019) found that newly arrived migrants in smaller towns often struggled with limited-service provision and greater social exclusion than those in urban areas. Similarly, Netto (2011) highlighted African migrants in Scotland faced unique barriers to employment and housing that differed from those in England. Meanwhile, research on global majority communities in London has documented the impact of urban deprivation, racial discrimination, and systemic barriers to healthcare access (Chouhan et al. 2021). These variations indicate that findings from one region cannot be straightforwardly applied to another without careful contextualisation.

Without comparative data from multiple regions, it is difficult to ascertain whether the themes identified in this study are universally applicable or whether they are shaped by the unique characteristics of the study location. To strengthen the relevance of these findings for national policy, it would be necessary to draw on existing research from other parts of the UK, even where it does not focus exclusively on sub-Saharan Africans. For example, studies on migrant integration in different UK regions have shown that factors such as local authority support, community cohesion, and labour market access significantly shape the experiences of global majority communities (Jones et al. 2017).

5.7 Opportunities For Future Research

The above limitations of the study necessitated several opportunities for further research, as listed below:

- The study combined participants with origins from a total of 10 sub-Saharan African countries. This may give distorted findings as cultures may differ across countries. Further research can be conducted with a more homogeneous cohort from a single country. By doing this, researchers can account for unique cultural, political, and historical factors that may shape how they respond to the social environment in the West Midlands of England, UK. This would facilitate the development of targeted interventions for a particular group's needs and challenges.
- The study used participants with different immigration statuses, which can give distorted findings considering that challenges differ according to immigration status. For example, asylum seekers receive social support from the Home Office, while undocumented migrants have no recourse to public funds, and refugees have a right to work, giving them a vantage point when it comes to economic earnings. Hence, their economic needs may differ, affecting the way they access and utilise mental health services. Also, while the findings showed that the one, second-generation participant faced challenges similar to those experienced by first-generation participants, further research can be conducted with just second-generation participants to ascertain whether cultural aspects also influence their decisions to seek help.

- It would also be interesting to investigate the role of religion and community-based worship since the church could be used to disseminate information about local mental health services. The data in this study evidence that word of mouth is a powerful way to obtain trusted information. Therefore, using health promotions in this community could mean that congregations and social meetings will be influencers.
- Given the known weaknesses of qualitative study design mixed methods research designs should be explored in future research. This can help to quantify the magnitude of the problem in the target population and enable comparative analysis to examine if any subgroups of Black sub-Saharan Africans are differentially affected.
- Additionally, conducting comparative studies across multiple UK regions, that employ larger and more representative samples should be conducted to effectively inform national policy and practice. Engaging with Black sub-Saharan African communities across different geographical contexts, as well as drawing on national datasets and qualitative studies from varied locations, would help ensure that policy recommendations are both inclusive and effective.
- Furthermore, it could be helpful for future research to explore opinions, experiences and/or challenges faced by mental health professionals delivering services to Black sub-Saharan Africans. This would help to uncover areas of needs from their own end and identify how they can be supported to improve the services that they render.

5.8 Contribution to the body of knowledge

In the UK, the mental health disparity debate has been going on for more than half a century and yet still, limited research has been carried out using the lived experience of Black sub-Saharan African communities. By conducting this research, I have contributed to the existing body of knowledge on the uptake of mental health services within Black sub-Saharan African communities and enriched the mental health field by understanding the factors influencing their decisions to seek help for poor mental health. The study uncovered the drivers of the barriers to seeking help for poor mental health, particularly illuminating how they are not believed by mental health practitioners when they present to primary care with symptoms of mental illness and are not in crisis. This is important for informing targeted interventions that meet the needs of Black sub-Saharan African communities. By addressing mental health disparities among this group, I contribute to broader social justice goals while advocating for more equitable and inclusive mental healthcare practices. While the study was conducted in England, it provides a comprehensive understanding of global mental health. It recognises the importance of bringing in voices of diverse populations in mental health research and policy development. The findings of this study can be used to inform evidence-based policies and interventions, thereby reducing disparities, and improving the mental health outcomes of Black sub-Saharan African communities and the overall mental well-being of this group. Also, this is the first time the Critical Race Theory was combined with The Silences Framework to conduct research on the uptake of mental health services among Black sub-Saharan African communities in the UK. This point is explained further in the next section.

5.9 Theoretical Contribution of the Study – (The Silences Framework and the Critical Race Theory)

Understanding power dynamics and the impact of silences within marginalised communities is crucial for addressing issues of inequality and oppression (Serrant-Green 2011). This thesis clearly shows that marginalised communities often face systemic barriers that prevent their voices from being heard or their experiences from being acknowledged. These barriers include historical, social, economic, and political factors that perpetuate inequalities and marginalisation in making decisions to seek help for poor mental health.

‘Silences’ in this context refer to the absence or suppression of specific narratives, perspectives, or voices within society. These silences can be deliberate or unintentional and can maintain existing power structures and privilege certain groups over others. The data in this thesis showed that people were aware that the services were pre-programmed to fit the lifestyles of indigenous populations. The paradox in these voices was that they did not see a solution in being prescribed medication or given counselling sessions. Still, their problems could only be resolved through policies and legislation in the UK. This is evidenced in one of the participants, Chiyedza, who has been trying to regularise her immigration status for more than two decades and been through dozens of counselling sessions for her mental health who in her interview said.

> *[…] the best way to treat me is to give me freedom because this situation is the one causing this mental problem.*

Hence, to address these issues effectively, it is essential to listen to and amplify the voices of marginalised communities, acknowledge the power dynamics at play, and work towards creating inclusive spaces where all voices are heard and respected. The NHS's anti-racist policy recognises this to some extent. However, this involves actively challenging and disrupting silences, advocating for equity and justice, and centring the experiences and needs of marginalised groups in decision-making processes.

While the Critical Race Theory acknowledges the intersectionality of race with other forms of oppression, such as gender and class, some critics argue that it may not fully incorporate all dimensions of intersectionality. For example, inter-sectional experiences related to disability, sexuality, religion, and nationality may not always be adequately addressed within traditional Critical Race Theory frameworks. This thesis adds to empirical research with sections of society that are refugees, asylum seekers, undocumented individuals, migrants, and individuals of Black sub-Saharan African origin. This thesis addresses a broader range of marginalised experiences as described by Gillborn (2015).

The Critical Race Theory primarily emerged within the context of the United States and focuses mainly on race relations within that context. Critics argue that it may not adequately account for the global dimensions of racism and oppression or incorporate perspectives from non-western contexts. By combining global perspectives and experiences of racism and oppression from diverse cultural and geographical contexts, the Critical Race Theory could become more inclusive and applicable to a broader range of social and political contexts. This study took place in the United Kingdom, where health services are free at the point of need and the 'no health without mental health' strategy was used by the Department of Health and Social Care and the NHS to promote the prioritisation of mental health and integrate mental health services into the broader healthcare system (UK Government 2011). Therefore, the theory that mental health services are booming in certain developed countries will always be criticised or challenged by the real-life context of those oppressed in that society. The data in this thesis shows the accurate picture of access or seeking help for poor mental health by Black sub-Saharan African communities in the West Midlands of England, UK.

The Critical Race Theory has historically been rooted in legal scholarship and primarily focused on analysing laws, policies, and institutions to uncover how they perpetuate racial inequality. While this legal analysis is essential, critics argue that the theory may sometimes overlook other forms of power and resistance outside legal frameworks. In this thesis, the legal frameworks have only formed part of the theory whilst it incorporates historical power such as colonialism, specifically about the experiences of individuals of Black sub-Saharan African communities. Furthermore, some critics also argue that while the Critical Race Theory provides a critical analysis of racism and oppression, it may not always offer clear solutions or action-oriented approaches for addressing these issues. There is a need for the Critical Race Theory to not only critique existing power structures but also to provide practical strategies for dismantling them and promoting social justice. The participants in this study explained how their communities, religion, and connections kept them afloat. In his interview Almaz narrated how he was homeless and struggling for two years and was saved by the church which became his source of strength. As such, this thesis gives a significant emphasis on community organising, coalition-building, and grassroots activism to enact social change.

Finally, there is a critique which says that the Critical Race Theory may not always be inclusive or representative of diverse voices within marginalised communities. Some critics argue that there is a need for greater diversity within the Critical Race Theory scholarship, including more voices from women, LGBTQ+, disabled, and non-western scholars. This unique work was conducted by a woman of sub-Saharan African heritage, a former refugee in the UK. By centring the perspectives of a broader range of marginalised individuals and communities, the Critical Race Theory could become more reflective of the diverse experiences of oppression and resistance.

Overall, while the Critical Race Theory provides a robust framework for understanding systemic racism and oppression, this thesis has provided an opportunity for further development and expansion to address the critiques and ensure that it remains relevant and inclusive in an evolving social and political landscape.

5.10 Researcher Benefits In Carrying Out The Study

Conducting research in this area contributed to my development as a researcher and community organiser. The uniqueness of researching asylum seekers, refugees, migrants, and undocumented individuals in England as a former refugee, can have several benefits both for myself and for the broader community. My personal growth includes self-awareness. Engaging in refugee research has helped me better understand my own experiences and the challenges I faced as a refugee in England. It allowed me to reflect on my journey, struggles, and successes, increasing self-awareness and personal development. A surprise for me was how much this work made me reflect on my past, including my childhood which was spent under colonialism, seeing how it affected all of these experiences. Another area in which I noticed growth was in personal empowerment; by conducting this research, I was empowered by gaining a clear voice and a platform to share my story, and to advocate for change. My previous working life allowed me to contribute to the discourse around refugee/migrant issues, but this study has highlighted the realities and needs of refugee/migrant communities in England including Black sub-Saharan Africans.

This work assisted my position in the social enterprise, Inini Initiative by having a robust community impact. My research findings impacted the refugee/migrant community in England by informing policymakers, mental health service providers, and advocacy groups about the specific challenges faced by this cohort. This led to the development of more effective policies and programs to support refugee/migrant communities and improve their integration outcomes. This work has taught me how to think critically and supported my position as independent chairperson of the Coventry and Warwickshire Mental Health Alliance, consultant for Coventry and Warwickshire NHS Partnership Trust Mental Health Act Detentions (Black populations) Steering Group, founding member of the Coventry and Warwickshire Cultural Inclusion Network, Coventry and Warwickshire Multi-Agency Migration Network, West Midlands Police Key Individual Network, Health-watch Steering Group Committee, and the NHS National Health Inequalities Group.

By working on this research, I have raised awareness among the broader public about the experiences and contributions of refugee/migrant communities in England. I have challenged stereotypes and misconceptions by sharing my insights and findings, fostering greater understanding and empathy within society, and creating heated debates. Engaging in research provides opportunities to connect with other researchers, activists, and organisations working on refugee/migrant issues, and by disseminating my research in different groups and support networks for people, I feel that the impact is much more substantial in this group of people. This can lead to valuable collaborations, knowledge sharing, and support networks that can further amplify my impact and advocacy efforts.

Applying the Johari window theory (Luft and Ingham 1955) to better understand myself, I would say, researching Black sub-Saharan African communities has helped expand both my open and hidden selves. Conducting research in which I share my experiences as an asylum seeker first, a refugee, and now a British citizen, has increased my open self by disclosing information about my thoughts and feelings to others. This has fostered mutual understanding and empathy, strengthening my connections with the broader community. In terms of my hidden self, engaging in this research has helped uncover aspects of me that I was not aware of, particularly around my childhood which was spent under colonialism. Through reflection and data analysis, I gained new insights into my experiences, motivations, and aspirations as a former refugee of Black sub-Saharan African heritage living in England. Overall, conducting research about Black sub-Saharan African communities in England has been a powerful tool for personal empowerment, community engagement, and social change.

Chapter 6: Conclusion

"As long as poverty, injustice, and gross inequality persist in our world, none of us can truly rest." — Nelson Mandela

6.1 Introduction

This final chapter of the PhD study, concludes the body of work which aimed to develop an in-depth understanding into how the social experiences of Black sub-Saharan African communities in the West Midlands of England, UK, influences their decisions to seek help for poor mental health. The stories shared by the participants provided fresh insights into the barriers to accessing mental health services, along with valuable contributions to the understanding of how these barriers can be more effectively addressed and how services can be improved and delivered more efficiently. I start the chapter by giving a summary of the thesis and conclude by articulating my reflections on the process taken to conduct the research.

6.2 A Summary of the Thesis

In Chapter 1, I gave the background of the study. I highlighted the global inequalities inherent in mental health service delivery in which global majority populations are overrepresented in both experiencing mental health problems and not accessing and utilising mental health services. I presented the UK statistics which showed that individuals of Black heritage were the most affected; from the access pathways they use, which include detentions under the Mental health Act 1983, the negative service outcomes, to being released on Community Treatment Orders. The chapter briefly touched on what is known about the causes of the disparities which highlighted socio-economic challenges and inadequate assessment tools that are likely to produce misdiagnoses. It went on to explain how the debate on mental health inequalities in England has been going on for over five decades and mentioned how structural racism was identified in mental health service delivery in the early nineties. However, researchers were said to be conflicted on the racism identification issue, with one group accusing structural racism of maintaining the disparities (Bhui et al. 2018; Kapadia et al. 2022; Mental Health Alliance 2021; Commission on Race and Ethnic Disparities 2021), while another argues there is no such evidence and hence, it is improper to lay such a claim (Singh and Burns 2006). In this section, I also highlighted how over the years, the government had designed and implemented policies and legislation to try and shift the disparities in mental health service delivery without much success. I provided a table bearing the various policies and legislation enacted by government since 1965 showing how most of the legislation and reviews highlighted the same issues of racial discrimination, lack of cultural competence, and workforce representation. However, it shows the willingness by the government to investigate and understand the factors that fed the inequalities and worked to mitigate against them. Most legislation promoted diversity, equality, and inclusion; areas today's legislation is still working on. This shows how stubborn these factors have been and can be blamed on the lack of funding to support initiatives working to reduce inequalities which was found to be a permanent theme for all services. Despite that, success in mental health service delivery to global majority populations has been found in voluntary and grassroots organisations who provide 'for and by' services to these groups which are difficult to sustain due to poor funding. In addition, progress has also been made in improving access to mental health services by designing leaflets and websites in different languages. This thesis has added to the discussion on mental health services focusing on Black sub-Saharan African communities in the UK. It can now be argued that further attention is needed to gain a more comprehensive picture of the mental health status of this cohort. The views in this thesis can be used to create a more aware mental health system, since in spite of implementing various legislation, services have remained ineffective due to a lack of awareness of the situation regarding the social factors that deter communities from seeking help for their mental health.

In the second section of the chapter, I went on to give a summary of what motivated me to conduct the study and what my interests were for conducting it. Reasons included listening to members' narratives at the Inini Initiative peer support group and my own experiences of the challenges I faced while navigating the asylum process and trying to integrate into my new communities when I first arrived in the West Midlands of England, UK. The members' narratives made me wonder whether the social environment was conducive for supporting diverse cultures, particularly those of Black sub-Saharan African heritage who mostly come from cultures that value the interconnectedness of the individual with their community, especially because most did not have family or other networks in England and also because the British exercise an individualistic culture.

This section was followed by another short summary on how the research significance supported the synergy of NHS leaders who after the well-publicised global Black Lives Matter demonstrations, signed the National Statement of Intent pledging to reduce ethnic inequalities in mental health care delivery. The summary also highlighted how the research also supports the United Nations General Assembly's SDG-3, which calls for, health for all by 2030 and suggests that interventions that meet the needs of diverse populations be developed. It concluded by mentioning that the study was also building upon recommendations of other researchers in this area who have called for interpretative research which uses experiential knowledge.

Before I summarised the structure of the thesis to conclude the first chapter, I presented the theoretical framework that was used to guide the study. Thus, I introduced The Silences Framework and highlighted how it was designed to define areas that are under researched, little understood, and unspoken in the community. I also mentioned how it emphasises the importance of examining what is silenced or omitted in the discourse, shedding light on power dynamics inherent in these omissions. I found The Silences Framework suitable for use in this study because of its reliance on personal experiences and its understanding of how different individuals and groups experience different 'silences' and derive meanings from them, thereby acknowledging that different groups experience different realities based on their lived experiences, identities, and unique contexts. However, some of its stages were reorganised to suit the flow of my thesis. For example, to support the reader understand the key features of the study as well as, underpin its research design, data collection and analysis, The Silences Framework proposes highlighting the 'silences' at the centre of the research which involves presenting the researcher, research participants, and research topic in Stage 2. In this thesis, the researcher and research participants were briefly touched on in Chapter 1, the introduction chapter and expanded on in Chapter 3 which according to The Silences Framework falls under Stage 3, and the 'silences' were presented in Chapter 2 which falls under Stage 1. Nonetheless, it was a good fit for the study, and thus, the thesis has contributed to its theoretical stance. In addition, the Critical Race Theory was applied to the findings to explore how power dynamics influenced the process of seeking help for poor mental health among Black sub-Saharan African communities in the West Midlands of England, UK and therefore, I introduced its origins and how it explains the long-standing continuity of racial inequality in society today. Important to note, is the similarity between The Silences Framework and the Critical Race Theory in that both value the experiential knowledge of under-served communities and scrutinised how race and racism directly or indirectly affects them, highlighting how the two frameworks complement one another.

Now that I have completed the data collection and analysis, I can add more reflections about how the power dynamics work. The Critical Race Theory is clear that racism is imbedded into our daily lives; it's a normal sociological pattern that supports white privilege. I can also say that, based on the findings of this study, systemic racism is engraved in policies and legislations. Furthermore, it is transferred to some mental health workers of Black heritage who consciously and unconsciously also support the white supremacy mindset thereby becoming barriers to access and utilisation of mental health services. This reinforces the idea of in-groups/outgroups being continuously made due to people's desire to acquire position and power. In his publication, 'Asylums', Goffman (1961), identified how people experiencing mental illness and living in mental asylums were made to 'behave or comply' to enable their release from the institution. The data in this thesis evidence similar requirements of compliance and a lack of power in terms of mental health in the UK.

In Chapter 2, I gave a brief summary on how I searched for literature on what other researchers were saying about the topic, which took a narrative concept. To provide context to the study, I gave an overview of the historical relationship between England and sub-Saharan Africa. Here, I explained how the white supremacy mindset was used to colonise the region, discriminate against indigenous populations and to continue extracting wealth from colonies after they were granted independence. The overview also gave a narrative on the burden of disease that fell upon the region, which in part, was caused by the way colonialists rearranged the settlement setup of cattle and indigenous people instigating an outbreak of sleeping sickness transferred through tsetse fly bites. This section also highlighted how they struggled to control the disease due to their lack of knowledge of the region and how they turned indigenous populations into experiment material with no regard for ethics while trying to find cures for different ailments. It also touched on the Economic Structural Adjustment Programmes purportedly designed to overturn the effects of high inflation that were offered to the region by the International Monetary Fund and the World Bank with negative results due to their high interest rates. They ended up leaving those countries who adopted them deeper in poverty. On reflection, now that I have collected and analysed data, I can see how this has motivated migration to different parts of the world including England. The section highlighted the beginning of powerlessness for Black sub-Saharan African communities and showed how legal and political structures favoured the powerful who in this instance were white colonialists who held Foucauldian power over them for centuries.

From revealing the powerlessness of Black sub-Saharan African communities in their own homelands, the chapter moved on to show how they were further disempowered in the West Midlands of England, UK, in an overview summarising the environment they occupy. The section began by showing how difficult it was for them to move from the region to Europe including England, where a visa is required 100% of the time. This means a lack of safe and legal routes to travel and seek asylum in Europe. As such, the cohort has resorted to using unsafe means of travel, where they are targeted for modern day slavery by unscrupulous business individuals. I also highlighted how the UK immigration system (the hostile environment) has created an unwelcoming environment for them; a claim that was supported by the findings of this study. I summarised how this legislation has made the lives of Black sub-Saharan African communities unbearable, making it difficult for them to access education, employment, housing, and healthcare, and how this situation affects even those with the legal right to access these services.

The section also revealed how individuals of Black heritage experience over policing and racial profiling and are overrepresented in the prison population. It showed how they occupied all positions of disadvantage and have maintained the spot of being more than twice as poor as their white counterparts for more than 25 years; they have the highest rate of unemployment and the lowest rate for claiming benefits. When employed they are offered zero contract hours in lowly paying jobs and because the hostile environment imposes working restrictions on individuals under immigration control, some of them end up taking employment illegally where they are taken advantage of and abused by dodgy employers. The section also highlighted how the hostile environment was responsible for difficulties in accessing housing as landlords have been instructed by this legislation to not rent out to undocumented migrants leaving them sceptical of renting properties out to individuals who look like migrants. Black individuals are mostly affected by this as they stand out due to the colour of their skin.

In this section, I also highlighted how Black sub-Saharan African communities struggle to get into higher education because, unless they are refugees, they usually receive a ten-year route visa which requires renewal every two and half years, until they reach indefinite leave to remain at ten years; the renewal gap is not long enough to complete a degree programme which on average is three years in the UK. Separation from family is another issue that Black sub-Saharan African communities in the West Midlands of England, UK struggle with. This is because it is usually the person fleeing persecution in their country who travels first and then apply for family reunion. This is not always possible due to various reasons, such as families members struggling to get legal documents such as birth certificates in their countries due to broken infrastructure caused by war. Furthermore, they battle to build networks and to navigate their social terrain as they are faced with unwelcoming host communities and hence, also lack community support. Evidence from the findings show that the cohort's experiences in England reflect a longstanding struggle against structural racism which on reflection is seen to be rooted in historical injustices such as colonialism.

Chapter 2 also gave a summary of the NHS, the statutory healthcare system provider in England. It explained how this was initiated by the Beveridge committee as part of a welfare reform to eliminate socio-economic problems. However, on inception migrant communities were excluded from benefitting from this welfare reform and based on the findings of this study, it can be said that similar challenges still exist for migrants. The section also showed how the NHS staff was not representative of the population makeup and how decision makers within the organisation were mainly of white heritage; of the global majority population doctors, most of them were said to be of Asian descent. Furthermore, when it came to salaries, statistics showed that individuals of Asian heritage earned more than their white and Black counterparts for workers on the same pay grade, with workers of Black heritage earning the least.

Before identifying the research gap, the chapter highlighted how the literature has evidenced the persistent inequalities in pathways to and the delivery of mental health services for generations. Barriers identified included stigma, cultural and religious barriers, mistrust of services, and ethnic disadvantage. The chapter concluded by highlighting the research gap. It explained how the literature evidenced a lack of effective mental health interventions for Black sub-Saharan African communities and revealed how the medical model used to deliver mental health services does not work for this cohort. It also, explained how the exclusion of their cultural and religious beliefs meant that mental health services did not meet their needs adequately. The literature also highlighted how the homogony of treating Black individuals as one and using administration data, and surveys vis a vis lived experience in research mean that their voices are not captured and therefore silenced. Similarly, amalgamating all global majority or Black African and Black Caribbean individuals as participants gives a distorted image of the phenomena leading to the design and development of inadequate interventions.

In Chapter 3, I presented the methodology used for the study. I started by introducing IPA and mentioning how it has its history rooted in psychology but has evolved over the years to cover other areas such as, sociology and public health. I also showed how its phenomenological lens went well with both The Silences Framework partly guiding the thesis and the Critical Race Theory which critically analysed the findings, as well as, how it is suited for examining the lived experiences of Black sub-Saharan African communities. The chapter gave a summary of my positionality reference to the insider/outsider perspective before highlighting the research design, sampling, inclusion criteria, and the instruments used, and how they were developed. It also gave a narrative summary of the pilot study. Following this, a summary of how the data was collected and analysed including the steps taken and ethical considerations made were given. The chapter concluded by explaining how the well-being of both the participants and me as the researcher were ensured.

In Chapter 4, I presented my interpretation of the findings. The first section presented findings on how participants' experiences of challenges created barriers for them to seek help for poor mental health under Superordinate theme 1 – Struggle and Oppression. This had 9 sub-themes under it as listed and summarised below.

a. **Sub-theme 1 – Regularising Immigration Status,** under this sub-theme, participants described how they struggled to regularise their immigration statuses, as they struggled to pay visa application and immigration solicitor fees. They spoke about the long periods spent waiting for a response from the Home Office and how their lives were dominated by fear during this process and how it becomes a barrier to seeking help for poor mental health.
b. **Sub-theme 2 – Fear of Deportation,** participants mentioned how deportation was their biggest fear which increased their vulnerability as they were afraid to report any violence or undesirables meted against them as they did not want to do anything that made them visible including seeking help for poor mental health.
c. **Sub-theme 3 – Dealing with Unwelcoming Host Communities,** participants gave narratives regarding how they were made to feel unwelcome by host communities and hence struggled to integrate into their new communities.
d. **Sub-theme 4 – Experiences of Racial Discrimination,** participants described their experiences of discrimination and racism from different areas of their life including, friendships, employment, and communities. They also highlighted how subtle racism was in England.
e. **Sub-theme 5 – Loss of Social and Cultural Identity,** participants spoke about how they experienced social descent in many areas of their lives including employment as qualifications, skills, and work experiences gained in their home countries were not recognised in England which meant they had to start at the bottom doing menial jobs and earning little. Moreover, the immigration policies were restrictive and did not allow them to learn new skills which they found disempowering.
f. **Sub-theme 6 – Social Exclusion and Isolation,** participants spoke about how they were excluded from activities happening in the community which left them feeling isolated and struggling to comprehend the individualistic English culture.
g. **Sub-theme 7 – Decreased Mental Health Awareness,** under this sub-theme, participants' narratives showed how they were not aware that the psychological distress they were experiencing had reached levels that required professional support and a lack of information on who to approach and knowledge about their eligibility to use mental health services.

h. **Sub-theme 8 – Lack of Familial and Community Support,** under this theme participants highlighted how the social challenges faced by Black sub-Saharan African communities required their full attention and hence, they struggled to afford time to entertain or support their loved ones or even build new community networks.
i. **Sub-theme 9 – Mental Health Stigma,** participants spoke about how they were expected to keep going under stressful conditions otherwise they were perceived as being weak or lacking in faith and were ridiculed for it.

The second section presented Superordinate theme 2 – Medical Colonialism. Participants spoke about how after breaking the barriers to seeking help for poor mental health, their experiences of utilising mental health services created barriers for them to continue engaging. The theme had 6 sub-themes under it as listed and summarised below.

a. **Sub-theme 1 – Not being believed by Mental Health Practitioners,** participants spoke about how they were treated with suspicion by mental health practitioners who did not believe them when they first present to mental health services and refused to support them. This taught them to not seek support until their mental health had deteriorated.
b. **Sub-theme 2 – Long Waiting Times,** participants spoke about how those who are lucky to be believed had to wait on average, a year, to get support and how by the time they received support their mental health had deteriorated.
c. **Sub-theme 3 – Inadequate Assessment Tools,** here participants spoke about receiving drug treatment without getting a diagnosis which left them wondering if they were being treated for recovery. The doubt made them lose trust in mental health practitioners and brought the fear that their mental health may be damaged from taking the wrong medication.
d. **Sub-theme 4 – Drug Treatment,** participants shared how mental health professionals were quick to prescribe drug treatment without investigating other issues such as, social factors that may be causing them distress. They likened this to being asked to recover in an environment that broke them in the first place and said they feared getting addicted to the medicine which was not treating them but merely managing symptoms.

e. **Sub-theme 5 – Talking Therapies,** participants’ narratives showed that they did not favour talking therapies because they do nothing to rectify the issues that caused them the mental distress in the first place. They also said that some of the activities suggested as therapy were not accessible to them due to high costs showing a lack of understanding of the challenges faced by Black sub-Saharan African communities.
f. **Sub-theme 4 – Lack of Empathy and Human Touch,** participants highlighted how mental healthcare services lacked empathy and cultural sensitivity in their delivery of services which they described as being programmed in a mechanical way.
g. **Sub-theme 5 – Cultural Incompetence**, Participants also mentioned how mental health practitioners lacked the understanding of diverse cultures, and the challenges faced by Black sub-Saharan African communities and prescribing interventions that meet their needs leading this cohort to believe that services were not adequately equipped to meet their needs and therefore, not worth accessing.

Chapter 5 comprised the discussion chapter of the study and applied the Critical Race Theory lens to the participants’ lived experiences. Applying various tenets of the Critical Race Theory, the chapter evaluated whether race, racism and power dynamics played a part in influencing participants’ decisions to seek help for poor mental health. The chapter highlighted how structural racism rooted in colonial legacies contributed to a system less responsive to the mental health needs of Black sub-Saharan African communities. Their limited voices in shaping policy, as well as insufficient community involvement was revealed as contributing to this. The chapter also illuminated how racism was ingrained in policies and legal frameworks, and how Eurocentric perspectives continued to shape the development of mental health services. White supremacy was revealed to be the overarching social, political, and legal authority perpetuating inequalities in mental health care delivery and breathing life to European hegemony. The chapter offered recommendations on how the white supremacy mindset, which seems to be the one holding mental health disparities can be dismantled leading to the development of interventions that meet the mental health needs of Black sub-Saharan African communities and empowering them to seek help for poor mental health thereby reducing inequalities in mental healthcare. It also highlighted the limitations of the study and gave a summary of future research opportunities offered by the conducting the study, its contribution to the body of knowledge, and the theoretical framework. It concluded by summarising the researcher’s benefits in carrying out the study.

The above is a summary of my thesis which reports on the processes taken to conduct the study. However, there is a claim that qualitative researchers often influence research processes and therefore should inform the reader of their identity, position, and ways in which they may have influenced their research findings. There are several ways in which this may have happened and in Chapter 1, I briefly introduced myself and expanded the introduction in Chapter 3 where I described my insider/outsider position. Nonetheless, in the next section I offer a critical reflection on the research process and me conducting the research as an individual of Black sub-Saharan African heritage, a community organiser to Black sub-Saharan African communities, who is also a former refugee.

6.3 A reflection on Researching Black sub-Saharan African Communities and Their Uptake of Mental Health Services

The idea to embark on this PhD study became apparent to me after listening to narratives of challenges being faced by clients while trying to integrate into their communities at the Inini Initiative peer support group. The peer support group which happens to be Inini Initiative’s best service in terms of impact and outcomes provides a safe space for refugee/migrant communities to connect, share experiences and support each other. However, the narratives served as reinforcement to an inkling I had developed while volunteering for Coventry Refugee and Migrant Centre, where I had witnessed asylum seekers, refugees, and migrants facing similar challenges. They struggled with their mental health and found it difficult to engage with mental health professionals provided by the centre. I had done the same when I first arrived in the UK and was facing challenges navigating my social environment. As such, the driving force fuelling my determination to fully understand how social challenges influence Black sub-Saharan African communities’ decisions to seek help for poor mental health is also motivated by personal encounters.

As mentioned in Chapter 1, Section 3, the reason Inini Initiative Ltd was established was because I wanted to recreate the kwaMafuva community environment and use it as prevention against developing mental health problems caused by experiencing the challenges of integration faced by asylum seekers, refugees and migrants in Coventry and the West Midlands of England, UK. KwaMafuva is a community which, while experiencing social injustices under colonialism and at independence, managed to organise, build resilience in its members, and heal itself, and has continued to do so today. However, because members of the Inini Initiative peer support group came from diverse cultural backgrounds, I decided to conduct a PhD study to understand what social factors influenced their decisions to uptake mental health services and not impose the kwaMafuva ethics and values to the whole group. Nonetheless, I chose to work with Black sub-Saharan African communities because besides being overrepresented in both experiencing mental health problems and not accessing mental health services, they were also the biggest ethnic group at the Inini Initiative peer support group. In addition, I hoped the findings would be able to influence policy and the development of interventions that meet the mental health needs of this cohort and are conducive for their recovery. Hence, this work was important to me, and I employed my best efforts to produce findings that were as close to perfection as possible. Hence, I engaged in continuous reflexivity throughout the study.

The experiences I made embarking on this study hold personal significance and the journey has been both enlightening and emotionally charged. Engaging with academic literature and existing research provided valuable insights into the broader context of global majority populations' mental health. It highlighted disparities in access to services, cultural stigmas surrounding mental illness, and structural barriers within healthcare systems. This knowledge, combined with information gathered from conversations conducted at the Inini Initiative peer support group, laid the foundation for framing research questions that would delve deeper into the complexities of mental health service uptake among Black sub-Saharan African communities. Also, knowing that mental health disparities have been ongoing for over half a century reinforced in me, the idea of creating a community that was able to heal itself as different measures implemented over the years appeared to have failed to do this.

However, the research was brought to life by the first-hand accounts and narratives shared by the participants during the interviews. Participants were recruited from the Inini Initiative peer support group and other community groups, such as African places of worship. As a community leader and organiser working with global majority, mostly Black sub-Saharan African communities, I did not struggle to recruit participants. As such, most participants I interviewed were known to me. Listening to their stories of resilience, vulnerability, and the many social challenges they encounter that negatively influence their decisions to seek help for poor mental health, highlighted how crucial it was to address these social challenges. Navigating ethical considerations was paramount throughout the research process. I did not experience much trust issue problems because, like I mentioned, most participants were known to me. However, trust was tried in some of them when in the interviews I asked them to provide private and intimate details that we both knew I already had, such as immigration status and whether they were working or not, and this was because I was recording the interviews. Nonetheless, because of the long-standing trust that existed between me and the participants this was easy to rectify. The downside was that some participants viewed the interviews as a counselling session, and I had to engage my basic counselling skills and working experience as a mental health advocate and support worker to contain the interviews. The obstacles provided opportunities for growth, pushing me to adopt more innovative approaches to bridge gaps in understanding.

The main challenge that arose from conducting this research was that of me experiencing mental upset and distress. Listening to the participants laying bare their struggles and resilience left me distressed and occasionally touched on my own struggles which meant that I went through the reflexivity process often. At one point my supervisory team suggested I engaged clinical supervision, but I decided against it because I sensed that embarking on it would trigger the excess trauma that I have been carrying around since childhood. I was also afraid that this would interfere with the progress of my study. On reflection, in conducting this research I surprised myself because I realised that even though I work to create awareness and promote talking therapies to global majority populations including Black sub-Saharan African communities for Inini Initiative, I personally still pushed them aside to pursue other commitments. This is similar to what was said by participants in their interviews that they focused on finding solutions to their challenges than seeking help for poor mental health. It felt like I was agreeing with Kwame, who in his interview when arguing against engaging in talking therapies said, if his therapist did not have a way of providing him with opportunities that changed the environment that was giving him mental health problems then engaging in them were a waste of time.

Deep down I think I still prefer the kwaMafuva community kind of healing; probably because it was instilled in me from a young age and therefore, I am comfortable with it. During the research and thesis writing process, when I experienced some distress, I found relief in supporting my Inini Initiative clients and this would motivate me to continue. This especially happened when I received positive responses for them on whatever challenges they may have been experiencing that I would have been working on with them. As such, during periods of distress, I would remove myself from the research completely and spend more time at the Inini Initiative peer support group. I also engaged in an exercise routine that I had created for myself and have lost a considerable amount of weight since embarking on this research journey.

As the research unfolded, it became apparent to me that addressing mental health inequalities among Black sub-Saharan African communities required more than just improving access to services and employing a culturally diverse workforce to deliver mental health services. A multifaceted approach where culturally informed mental health services, policy reforms, and the addressing of the social challenges faced by this cohort is paramount. Reflecting on the research process, I am reminded of the profound impact marginalised perspectives have in driving meaningful change to their circumstances. Moving forward, I am committed to advocating for Black sub-Saharan African voices to be heard in developing mental health services and delivering mental health services. I am also committed to supporting them overcome the challenges of integration that, besides inducing mental illness also act as barriers to accessing mental health services. The goal is to create a community where this cohort is empowered to seek help for poor mental health, where mental health services meet their mental health needs, and support their recovery thereby building happy, healthier, cohesive communities.

6.4 Conclusion

In conclusion, the research journey for this study has deepened my understanding of mental health inequalities and how the challenges faced by Black sub-Saharan African communities act as barriers to accessing and utilising mental health services. It has also reinforced my belief in the power of communities as healing agents, as well as the transformative power of highlighting silenced voices as weapons for social justice and equity. The findings have empowered me to continue advocating for health equity in marginalised communities.

References

Aas, K.F. and Bosworth, M., eds., 2013. *The Borders of Punishment: Migration, Citizenship, and Social Exclusion*. Oxford: OUP Oxford.

Abernethy, D. B., 2000. *The Dynamics of Global Dominance: European Overseas Empires,* pp.1415-1980. Yale University Press.

Acheson, K., 1998. *Globalization, Liberalization, and Policy Change: A Political Economy of Policy Reform in Developing Countries*. Cambridge: Cambridge University Press.

Achtyes, E., Simmons, A., Skabeev, A., Levy, N., Jiang, Y., Marcy, P. and Weiden, P.J., 2018. Patient preferences concerning the efficacy and side-effect profile of schizophrenia medications: a survey of patients living with schizophrenia. *BMC psychiatry*, 18, pp.1-7.

Adams, A., Vail, L., Buckingham, C.D., Kidd, J., Weich, S. and Roter, D., 2014. Investigating the influence of African American and African Caribbean race on primary care doctors' decision making about depression. *Social Science & Medicine*, 116, pp.161-168.

Addison, T., Pikkarainen, V., Ronkko, R. and Tarp, F., 2020. Genocide in sub-Saharan Africa: Colonial Borders and Ethnic Conflicts. *Journal of African Economies,* 29(3), pp.345-367.

African Union, 2022. African Union slams ‘racism’ in the wake of Ukraine war. *East African Herald*, 1 March. Available at: https://www.eastafricanherald.com/politics/2022/3/1/african-union-slams-racism-in-the-wake-of-ukraine-war [Accessed 7 August 2024].

Aggarwal, N.K., Pieh, M.C., Dixon, L., Guarnaccia, P., Alegria, M. and Lewis-Fernandez, R., 2016. Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: a systematic review. *Patient Education and Counselling*, 99(2), pp.198-209.

Agiomirgianakis, G. and Zervoyianni, A., 2001. Macroeconomic Equilibrium with Illegal immigration. *Economic Modelling*, 18(2), pp.181-202.

Akther, S.F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A. and Oram, S., 2019. Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open*, 5(3), p.e37.

Alase, A., 2017. The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, 5(2), pp.9-19.

Alencar, A., 2020. Mobile communication and refugees: An analytical review of academic literature. *Sociology Compass*, 14(8), p.e12802.

Allison, J., 2018. Sub-Saharan Africa and the IMF: The impact of structural adjustment programs. *Journal of Economic Policy,* 32(2), pp. 123-145.

American Psychiatric Association., 2013. *Diagnostic and Statistical Manual of mental Disorder* (5th edition). APA

Anyanwu, J. C. and Anyanwu, A. 2017. Poverty in Africa and the Sustainable Development Goals: Lessons and Policy Options. *African Development Review*, 29(1), pp.1-18.

Arber, S., 2006. *Reflexivity: A Challenge for the Researcher as Practitioner*. In: L. Finlay and C. Ballinger, eds. *Qualitative Research for Allied Health Professionals: Challenging Choices*. Chichester: John Wiley & Sons, pp. 72-83.

Arboleda-Flórez, J., 2003. Considerations on the stigma of mental illness. *The Canadian Journal of Psychiatry*, 48(10), pp.645-650.

Asongu, S.A. and Le Roux, S., 2019. Understanding sub-Saharan Africa’s extreme poverty tragedy. *International Journal of Public Administration*, 42(6), pp.457-467.

Aspinall, P. J., & Chinouya, M., 2008. Is the standardised term ‘Black African’ useful in demographic and health research in the United Kingdom? *Ethnicity & Health,* 13(3), pp.183-202.

Asselin, M.E., 2003. Insider research: Issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Professional Development*, 19(2), pp.99-103.

Athias, L. and Macina, M., 2022. Demand for vaccination in Sub-Saharan Africa: The vertical legacy of the slave trade. *Social Science & Medicine*, 293, p.114640.

Au, S. and Cornet, A., 2021. Medicine and colonialism. *Medical histories of Belgium*, pp.99-133.

Audini, B. and Lelliot, P., 2002. Age, gender and ethnicity of those detained under Part II of the Mental Health act 1983. *British Journal of Psychiatry,* 180, 222-226.

Austin, G., 2016. Sub-Saharan Africa. In J. Baten, ed. *A History of the Global Economy: 1500 to the Present*. Cambridge: Cambridge University Press, p. 316.

Ayinde, H. and Gillum, R.F., 2014. Cardiovascular disease mortality in Sub-Saharan Africa and the Caribbean. *Ethnicity & Disease*, 24(4), pp.495-501.

Barnett, P., Matthews, H., Lloyd-Evans, B., Mackay, E., Pilling, S. and Johnson, S., 2018. Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis. *The Lancet Psychiatry*, 5(12), pp.1013-1022.

Bashford, A. and Levine, P. eds., 2010. *The Oxford Handbook of the History of Eugenics*. Oxford: Oxford University Press.

Baxter, L. and Fancourt, D., 2020. What are the barriers to, and enablers of, working with people with lived experience of mental illness amongst community and voluntary sector organisations? A qualitative study. *PLoS one*, 15(7), p.e0235334.

BBC 2020. https://www.bbc.co.uk/news/world-europe-52151722 Accessed 22 May 2024

Beauchemin, C., Flahaux, M.L. and Schoumaker, B., 2020. Three sub-Saharan migration systems in times of policy restriction. *Comparative Migration Studies*, 8(1), p.19.

Bergman, J., 2014. *The Darwin Effect: It's influence on Nazism, Eugenics, Racism, Communism, Capitalism & Sexism*. New Leaf Publishing Group.

Bertocchi, G. and Canova, F., 2002. Did colonisation matter for growth? An empirical exploration into the historical causes of Africa’s underdevelopment. *European Economic Review,* 46(10), pp.1851-1871.

Bhugra, D., Leff, J., Mallet, R., Der, G., Corridan, B. and Rudge, S., 1997. Incidence and outcome of schizophrenia in Whites, African-Caribbeans and Asians in London. *Psychological Medicine,* 27, 791-798.

Bhabha, H.K., 1994. *The Location of Culture.* Routledge.

Bhui, K., 2002. Developing mental health services for a diverse society. We need to marry plan and policy. *British Medical Journal,* 4, 329-363.

Bhui, K. and McKenzie, K., 2008. Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales. *Psychiatic Services,* 59, 4, 414-420.

Bhui, K. and Olajide, D., 1999. Unanswered Questions: A user's perspective on mental health service provision. *London: Saunders*.

Bhui, K., Halvorsrud, K. and Nazroo, J., 2018. Making a difference: ethnic inequality and severe mental illness. *The British Journal of Psychiatry*, 213(4), pp.574-578.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F. and Feder, G., 2003. Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic Review. *The British Journal of Psychiatry*, 182(2), pp.105-116.

Biggerstaff, D. and Thompson, A.R., 2008. Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative research in psychology*, 5(3), pp.214-224.

Bignall, T., Jeraj, S., Helsby, E. and Butt, J., 2019. Racial disparities in mental health. Race Equality Foundation.

Bilger, V. and Kraler, A., 2005. Introduction: African Migrations. *Historical Perspectives and contemporary dynamics,* 8(21), Sp5.

Binagwaho, A., Ngarambe, B. and Mathewos, K., 2022. Eliminating the white supremacy mindset from global health education. *Annals of Global Health*, *88*(1).

Bisin, A. and Verdier, T., 2001. The economics of cultural transmission and the dynamics of preferences. *Journal of Economic theory*, 97(2), pp.298-319.

Bissonette, A., 2020. Legal Barriers and Their Impact on Migrants' Access to Psychosocial Support in Host Countries. *Journal of Migration and Health*, 7, pp. 45-58.

Bloch, A., Kumarappan, L. and Mckay, S., 2015. Employer sanctions: The impact of workplace raids and fines on undocumented migrants and ethnic enclave employers. *Critical Social Policy*, 35(1), pp.132-151.

Bochel, H. and Daly, G., 2020. Research, evidence and social policy. In *Social Policy* (pp. 111-129). Routledge.

Bolton, P., 1984. Management of compulsorily admitted patients in a high security unit. *International Journal of Social Psychiatry,* 30, 77-84.

Bonds, A. and Inwood, J., 2016. Beyond white privilege: Geographies of white supremacy and settler colonialism. *Progress in human geography*, 40(6), pp.715-733.

Bonilla-Silva, E., 1997. Rethinking Racism: Toward a Structural Interpretation. *American Sociological Review,* 62(3), pp.465-480.

Boone, C., 1992. The State and Capitalism in Contemporary Africa: The Political Economy of Rent-Seeking. Yale University Press.

Boonstra, N., Klaassen, R., Sytema, S., Marshall, M., De Haan, L., Wunderink, L. and Wiersma, D., 2012. Duration of untreated psychosis and negative symptoms—a systematic review and meta-analysis of individual patient data. *Schizophrenia Research*, 142(1-3), pp.12-19.

Bosworth, M., Parmar, A. and Vázquez, Y. eds., 2018. *Race, criminal justice, and migration control: Enforcing the boundaries of belonging*. Oxford University Press.

Bowling, B. and Westenra, S., 2020. ‘A really hostile environment’: Adiaphorization, global policing and the crimmigration control system. *Theoretical Criminology*, 24(2), pp.163-183.

Bradford, B. and Tiratelli, M., 2019. Does stop and search reduce crime. *UK Justice Policy Review*, 4, pp.1-11.

BRAP, 2012. *Improving mental health for BME communities: an event report.* Birmingham.

Bromley, E., Mikesell, L., Jones, F. and Khodyakov, D., 2015. From subject to participant: Ethics and the evolving role of community in health research. *American Journal of Public Health*, 105(5), pp.900-908.

Brown, R., 2000. Social identity theory: Past achievements, current problems and future challenges. *European Journal of Social Psychology*, 30(6), pp.745-778.

Brown, Y., 2021. *Black Men, Mental Health and Oppression: What Do We Learn when We Listen to Black Men's Voices?* (Doctoral dissertation, Coventry University).

Bryman, A., 2016. *Social Research Methods.* (5th Ed.). Oxford University Press.

Busby, M., 2020. 'Black people in the UK 'seven times more likely' to be tasered', *The Guardian*, 26 June. Available at: https://www.theguardian.com/uk-news/2020/jun/26/black-people-in-uk-seven-times-more-likely-to-be-tasered [Accessed: 7 August 2024].

Buswell, G., 2022. The Immigration Health Surcharge: Access to NHS Services, *Journal of Immigration and Health Policy*, 14(3), pp. 45-50.

Burgess R. A. and Choudary, N., (2021). Time is on our side: operationalising ‘phase zero’ in co-production of mental health services for marginalised and under-served populations in London. *International Journal of Public Administration,* 44(9), 753-766.

Care Quality Commission., 2022. *Monitoring the Mental Health Act in 2020/21*. Available at: https://www.cqc.org.uk/sites/default/files/20220525_mhareport2020-21_report.pdf [Accessed: 16 August 2024].

Carter, C., 2020. 'Mental Health Social Work "must do better" as study finds less staff diversity than in rest of profession', *Community Care*. Available at: https://www.communitycare.co.uk/2020/mental-health-social-work-diversity/ [Accessed: 16 August 2024].

Carter, R.T., 2007. 'Racism and psychological and emotional injury', *The Counselling Psychologist*, 35(1), pp. 13-105.

Casey, D., Brown, L., Gajwani, R., Isma, Z., Jasani, R., Parsons, H., Tah, P., Birchwood, M.J. and Singh, S. P., 2016. Predictors of engagement in first episode psychosis. *Schizophrenia Research,* 175 (1-3), 204-208.

Castles, S., 2007. Twenty-first-century migration as a challenge to sociology. *Journal of Ethnic and Migration Studies*, 33(3), pp.351-371.

Centre for Social Justice., 2020. *Unsafe Journeys: The exploitation and abuse of migrants traveling to Europe,* [online]. Available at: https://www.centreforsocialjustice.org.uk/publications/unsafe-journeys [Accessed: 7 August 2024].

Chakraborty, A. and McKenzie, K., 2002. Does racial discrimination cause mental illness? *British Journal of Psychiatry,* 180, 475 – 477.

Chakraborty, A., McKenzie, K. and King, M., 2002. Discrimination, ethnicity and psychosis – a qualitative study. In: *Ethnicity and Inequalities in Health and Social Care,* 2 (1), 18-29.

Charmaz, K., 2004. *Grounded Theory*. In: S. N. Hesse-Biber and P. Leavy, eds. *Approaches to Qualitative Research: A Reader on Theory and Practice*. New York: Oxford University Press, pp. 496-521.

Chen, L. and Garcia, M., 2019. Challenges to the validity of Eurocentric assessment tools in diverse cultural contexts: A critical review. *Cultural Diversity and Ethnic Minority Psychology*, 25(3), pp.356-368. American Psychological Association.

Chikowero, M., 2015. *African music, power, and being in colonial Zimbabwe*. Indiana University Press.

Chouhan, K., Nazroo, J. and Becares L., 2021. Have Ethnic Inequalities in the Prevalence of Medical Conditions in England over the last 20 years? *Journal of Epidemiology and Community Health,* 75(5), pp.446-453.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rusch, N., Brown, J.S. and Thornicroft, G., 2015. What is the impact of mental health-related stigma on help seeking? A Systemic Review of Quantitative and Qualitative Studies. *Psychological Medicine,* 45(1), pp.11-27.

Clibbens, N., Baker, J., Booth, A., Berzins, K., Ashman, M., Sharda, L., Thompson, J., Kendal, S. and Weich, S., 2022. Explanation of context, mechanisms and outcomes in adult community mental health crisis care: the MH-CREST realist evidence synthesis. *Health Services and Delivery Research*. 10(9), pp. 1-268.

Clift, E., Jones, L. and Corrigan, P., 2013. 'Respecting Strengths: The Need for Anti-Stigma Interventions to Consider Muslim Attitudes Towards Mental Illness', *Mental Health Review Journal*, 18(4), pp. 221-230.

CNN., 2022. *Foreign students fleeing Ukraine say they face segregation, racism at border.* [Online] Available at: https://edition.cnn.com/2022/02/28/europe/students-allege-racism-ukraine-cmd-intl/index.html [Accessed 9 Aug. 2024].

Cochrane, R. and Bal, S. S., 1989. Mental hospital admission rates of immigrants to England: a comparison of 1971 and 1981, *Social Psychiatry and Psychiatric Epidemiology,* 24, 2-11.

Codjoe, L., Barber, S. and Thornicroft, G., 2019. Tackling inequalities: a partnership between mental health services and black faith communities. *Journal of Mental Health*, 28(3), pp.225-228.

Codjoe, L., Barber, S., Ahuja, S., Thornicroft, G., Henderson, C., Lempp, H. and N'Danga-Koroma, J., 2021. Evidence for interventions to promote mental health and reduce stigma in Black faith communities: systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 56, pp.895-911.

Coid, J., Kahtan, N., Gault, S. and Jarman, B., 2000. Ethnic differences in admissions to secure forensic psychiatry services. *The British Journal of Psychiatry*, 177(3), pp.241-247.

Coid, J., Rodriguez, R.G., Kallis, C., Zhang, Y., Bhui, K., De Stavola, B., Bebbington, P. and Ullrich, S., 2020. Ethnic disparities in psychotic experiences explained by area-level syndemic effects. *The British Journal of Psychiatry*, *217*(4), pp.555-561.

Comaroff, J. and Comaroff, J.L., 2008. *Of revelation and revolution, volume 1: Christianity, colonialism, and consciousness in South Africa* (Vol. 1). University of Chicago Press.

Commission of Integration and Cohesion., 2007. *Our Shared Values*. CIC. London.

Commission of Race and Ethnic Disparities., 2021. The Report of the Commission on Race and Ethnic Disparities (2021). Available at: https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities

Committee on the Elimination of Racial Discrimination., 2022. Statement on Racial Discrimination against persons fleeing from the armed conflict in Ukraine, Statement 1 (2022). Relief web. [online] Available at: https://reliefweb.int/report/world/statement-racial-discrimination-against-persons-fleeing-armed-conflict-ukraine [Accessed 9 Aug. 2024].

Compton, M.T. and Shim, R.S., 2015. The social determinants of mental health. *Focus*, 13(4), pp.419-425.

Cook, B.L., Zuvekas, S.H., Carson, N., Wayne, G.F., Vesper, A. and McGuire, T.G., 2014. Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Services Research*, 49(1), pp.206-229.

Cooke, B.G., 2018. Creating a stereotype of a race as dangerous, unintelligent, and lazy: examining consequences of cultural and psychological conditioning in America. In *Socio-economic and education factors impacting American political systems: Emerging research and opportunities* (pp. 1-28). IGI Global.

Corrigan, P., Markowitz, F.E., Watson, A., Rowan, D. and Kubiak, M.A., 2003. An attribution model of public discrimination towards persons with mental illness. *Journal of health and Social Behaviour*, pp.162-179.

Crawford, T.A. and Lipsedge, M., 2004. Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine. *Mental Health, Religion & Culture*, 7(2), pp.131-148.

Crawley, H., 2010. *No Safe Place: Sudanese Refugees and the Denial of Protection in Europe. Journal of Refugee Studies*, 23(4), pp. 465-485.

Crenshaw, L., 1991. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review,* 43(6), pp. 1241-1299.

Creswell, J.W., 2021. *A concise introduction to mixed methods research*. SAGE publications.

Crown Prosecution Service., 2023. *'Statistical Evidence on the Over-representation of Black People in the Criminal Justice System'*, [online]. Available at: https://www.cps.gov.uk/publications/statistical-evidence-black-overrepresentation (Accessed: 7 August 2024).

Cummins, I., 2015. Discussing race, racism and mental health: Two mental health inquiries reconsidered. *International Journal of Human Rights in Healthcare*, 8(3), pp.160-172.

Cummins, I., 2018. The impact of austerity on mental health service provision: a UK perspective. *International Journal of Environmental Research and Public Health*, 15(6), p.1145.

Czyzewski, K., 2011. Colonialism as a broader social determinant of health. *The International Indigenous Policy Journal*, *2*(1).

Davies, S., Thornicroft, G., Leese, M., et al (1996). Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. *British Medical Journal, 312,* 533-537.

Dauncey, E., Desai, V. and Potter, R.B. eds., 2024. *The Companion to Development Studies*. Taylor & Francis.

De Bruijn, M., van Dijk, R. and Foeken, D., 2001. Mobile Africa. *Changing patterns of movement in Africa and beyond*. Leiden: Brill.

de Freitas, D.F., Fernandes-Jesus, M., Ferreira, P.D., Coimbra, S., Teixeira, P.M., de Moura, A., Gato, J., Marques, S.C. and Fontaine, A.M., 2018. Psychological correlates of perceived ethnic discrimination in Europe: A meta-analysis. *Psychology of Violence*, 8(6), p.712.

de Haan, A. and Rogaly, B., eds., 2002. *Labour mobility and rural society*. London: Frank Cass.

Delamothe, T., 2008. Founding principles. *BMJ*, *336*(7655), pp.1216-1218.

Delgado, R. and Stefancic, J., 2017. Critical Race Theory: An Introduction. 2nd ed. New York. New York University Press.

Delgado, R., 2008. Liberal McCarthyism and the origins of critical race theory. *Iowa Law Review*, *94*, p.1505.

Dell'Osso, B., Glick, I.D., Baldwin, D.S. and Altamura, A.C., 2012. Can long-term outcomes be improved by shortening the duration of untreated illness in psychiatric disorders? A conceptual framework. *Psychopathology*, *46*(1), pp.14-21.

Denzin, N. K. and Lincoln, Y. S., 2018. *The SAGE Handbook of Qualitative Research* (5th Ed.) SAGE Publications.

Department of Health and Social Care., 2018. *Modernising the Mental Health Act: Increasing choice, reducing compulsion. Final Report of the Independent Review of the Mental Health Act 1983*. London: Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review [Accessed: 16 August 2024].

Department of Health and Social Care., 2019. *Independent Review of the Mental Health Act 1983: supporting documents*. London: Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/mental-health-act-1983-review-supporting-documents [Accessed: 16 August 2024].

Department of Health and Social Care., 2021. *Reforming the Mental Health Act*. London: Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/reforming-the-mental-health-act (Accessed: 16 August 2024).

Department of Health., 1999. The National Service Framework for mental Health. London. Department of Health.

Department of Health., 2005. *Delivering Race Equality in Mental Health Care. An action plan for reform inside and outside services and the government's response to the independent inquiry into the death of David Bennett.* TSO (The Stationery Office).

Department of Health., 2005. *Research Governance Framework for Health and Social Care*. 2nd ed. London: Department of Health.

Department of Health., 2015. Visitor and Migrant Cost Recovery – Extending Charging: Impact Assessment, London: Department of Health.

Department of Health and Social Care., 2022. Mental health inequalities: Black individuals and community treatment orders, *gov.uk*, [online]. Available at: https://www.gov.uk/government/publications/mental-health-inequalities-black-individuals-and-community-treatment-orders (Accessed: 7 August 2024).

DiAngelo, R., 2018. *White Fragility: Why It's so Hard for White People to Talk About Racism*. Beacon Press.

Doucet, A. and Mauthner, N.S., 2008. What can be known and how? Narrated subjects and the Listening Guide. *Qualitative Research*, 8(3), pp.399-409.

Dunn, J. and Fahy, T. A., 1990. Police admissions to a psychiatric hospital. Demographic and clinical differences between ethnic groups. *British Journal of Psychiatry, 156,* 373-378.

Dwyer, S.C. and Buckle, J.L., 2009. The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), pp.54-63.

Earl, T.R., Fortuna, L.R., Gao, S., Williams, D.R., Neighbours, H., Takeuchi, D. and Alegría, M., 2015. An exploration of how psychotic-like symptoms are experienced, endorsed, and understood from the National Latino and Asian American Study and National Survey of American Life. *Ethnicity & health*, *20*(3), pp.273-292.

Eatough, V. and Smith, J.A., 2017. Interpretative phenomenological analysis. *The Sage Handbook of Qualitative Research in Psychology*, pp.193-209.

El Sharkawy, G., Newton, C. and Hartley, S., 2006. Attitudes and practices of families and health care personnel toward children with epilepsy in Kilifi, Kenya. *Epilepsy & Behaviour*, *8*(1), pp.201-212.

El-Enany, N., 2020. (B)ordering Britain: Law, Race and Empire. In *(B)ordering Britain*. Manchester University Press.

ENAR (European Network Against Racism)., 2022. Racist Double-Standards Persist at EU Ukraine Borders and Beyond. [online] Available at: https://www.enar-eu.org/racism-borders-eu-ukraine/ [Accessed 9 Aug. 2024].

Eseonu, T., 2024. Racialised institutions in the UK welfare state. In *Diversity and Welfare Provision* (pp. 78-96). Policy Press.

Eshareturi, C., 2016. Mapping the offender health pathway: challenges and opportunities for support through community nursing. (Doctoral Dissertation. Wolverhampton University).

European Policy Dialogue Forum., 2021. Improving the Engagement of Migrant and Refugee-led Organisation in Public Policy making Processes in Europe. *Input paper at the 3rd European Dialogue Forum on Refugees and Migrants on 19-21 October 2021.* Lisbon. Portugal.

European Policy Dialogue Forum., 2021. Using Education to Counter Anti-Refugee and Migrant Hate Speech in Europe. *Input paper to the 3rd European Policy Dialogue Forum on Refugees and Migrants on 19-21 October 2021.* Lisbon. Portugal.

Fanon, F., 1961. *The Wretched of the Earth.* Translated by C. Farrington. London: Penguin Books.

Farrington, A., 2018. Navigating Mental Health Services: Challenges Faced by Migrants, *Journal of Mental Health and Migration Studies*, 16(4), pp. 233-245.

Fernández-Reino, M. and Rienzo, C., 2021. Migrants in the UK Labour Market: An overview. *Migration Observatory briefing. Retrieved on*, *4*.

Fernando, S., 2002. *Mental Health Race and Culture.* (2nd Ed). Basingstoke.

Fernando, S., 2003. *Cultural diversity, mental health and psychiatry. The struggle against racism.* Hove, UK: Brunner-Routledge.

Fernando, S., 2005. Multicultural Mental Health Services: Projects for Minority Ethnic Communities in England. *Transcultural Psychiatry, 42, (3),* 420-436.

Fernando, S., 2010. *Mental Health, Race, and Culture* (3rd Ed.). London: Palgrave. MacMillan.

Fernando, S., 2017. *Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health.* Palgrave Macmillan.

Ferro, M., 1994. Histoire des colonisations [History of colonialisms]. Paris: Seuil.

Finlay, L., 2002. "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), pp.531-545.

Finotelli, C. and Sciortino, G., 2013. Through the gates of the fortress: European visa policies and the limits of immigration control. *Perspectives on European Politics and Society*, *14*(1), pp.80-101.

Foucalt, M., 1973. *The Birth of the Clinic: An Archaeology of Medical Perception*. Translated by A. M. Sheridan. London: Tavistock Publications.

Francois, J., Thompson, R. and Patel, V., 2017. 'Side Effects of Psychotropic Medicines: A Comprehensive Review', *Journal of Clinical Psychiatry*, 78(4), pp. 345-359.

Fredrickson, G. M., 1981. *White Supremacy: A Comparative Study in American and South African History*. Oxford University Press.

Freeman, D., 2011. Teaching Obama: History, Critical Race Theory and Social Work Education. *Social Work Education*, 45, pp.177-197. Routledge.

Fripp, C., 2017. Stigma and Help-Seeking: The Interplay of Cultural and Social Factors among African Americans Seeking Mental Health Counselling. *Journal of Counselling Psychology*, 64(2), 192-204.

Fussey, P., and Leese, M., 2021. Surveillance, technology, and Migration Governance. *Surveillance & Society*, 19(3), pp.288-304.

Gajwani, R., Parsons, H., Birchwood, M. and Singh, S. P., 2016. Ethnicity and detention: Are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007? *Social Psychiatry and Psychiatric Epidemiology, 51, (5),* 703-711.

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J. and Sartorius, N., 2015. Toward a new definition of mental health. *World Psychiatry*, *14*(2), p.231.

Galván, J., Saavedra, N., Bartolo, F. and Berenzon, S., 2017. Perceptions of Mexican women regarding barriers in Mental Health Services in primary care. *BMC Women's Health*, *17*, pp.1-6.

Gammeltoft-Hansen, T. and Vested-Hansen, J., 2016. *European migration policy and the externalization of border control*. *DIIS Working Paper*, 2016:10. Copenhagen: Danish Institute for International Studies.

Gaston, G.B., Earl, T.R., Nisanci, A. and Glomb, B., 2016. Perception of mental health services among Black Americans. *Social Work in Mental Health*, *14*(6), pp.676-695.

Gaventa, J., 1980. *Power and powerlessness: Quiescence and rebellion in an Applalachian Valley.* Urbana: University of Illinois Press.

GDP 2019 Mental Disorders Collaborators., 2022. Global, Regional, and National Burden of 12 Mental Disorders in 204 Countries and Territories, 1990-2019: A Systemic Analysis for the Global Burden of Disease Study 2019, *Lancet Psychiatry,* 9(2), pp.137-150.

General Medical Council. 2019. What our data tells us about general practitioners working for the NHS in England and Scotland. Available at: https://www.gmc-uk.org/-/media/documents/what-our-data-tells-us-about-gps_pdf-74830685.pdf Accessed – 21 May 2022.

Ghali, S., Fisher, H.L., Joyce, J., Major, B., Hobbs, L., Soni, S., Chisholm, B., Rahaman, N., Papada, P., Lawrence, J. and Bloy, S., 2013. Ethnic variations in pathways into early intervention services for psychosis. *The British Journal of Psychiatry*, *202*(4), pp.277-283.

Gill, M., (2008). 'Increased Visibility of Black Sub-Saharan African Communities in the UK: A New Millennium Perspective', *Journal of Ethnic and Migration Studies*, 34(5), pp. 789-805.

Gillborn, D., 2015. Intersectionality, critical race theory, and the primacy of racism: Race, class, gender, and disability in education. *Qualitative Inquiry*, *21*(3), pp.277-287.

Gillespie, M., Osseiran, S., and Cheesman, M., 2018. Refugee Connectivity: Mobile Phones as a Lifeline. *Information, Communication & Society,* 21(6), pp.748-765.

Giscombe, S., Williams, L. and Johnson, R., 2016. The Role of Prayer in Daily Functioning: Helping Individuals Get Out of Bed and Manage Daily Life, *Journal of Health Psychology*, 21(6), pp. 1040-1051.

Gopalkrishnan, N., 2018. Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, *6*, p.308538.

Graham, A.B., 2023. *Negotiating spaces in academia: what mediating factors impact on the participation and progression of British African Caribbean males in academia* (Doctoral dissertation, London South Bank University).

Graham, L., Brown-Jeffy, S., Aronson, R. and Stephens, C., 2011. Critical race theory as theoretical framework and analysis tool for population health research. *Critical Public Health*, *21*(1), pp.81-93.

Gramsci, A., 1971. *Selections from the Prison Notebooks*. Edited and Translated by Q. Hoare and G. Nowell Smith. London: Lawrence and Wishart.

Green, J. and Thorogood, N., 2018. *Qualitative Methods for Health Research*. London. Sage publications.

Greenwood, H., Matthews, H. and Barnett, P., 2020. Reasons behind the rising rate of involuntary admissions under the Mental Health Act (1983): Service use and cost impact. *International Journal of Law and Psychiatry*, *68*, p.101506.

Griffiths, M. and Yeo, C., 2021. The UK's hostile environment: Deputising immigration control. *Critical Social Policy*, *41*(4), pp.521-544.

Grosios, K., Gahan, P.B. and Burbidge, J., 2010. Overview of healthcare in the UK. *The European Association for Predictive, Preventive and Personalised Medicine Journal*, *1*, pp.529-534.

Gupta, S., Dinakaran, D. and Athanas, E., 2021. Mental Health of Black and Minority Ethnic Communities in the UK and the Utilization of the Mental Health Legislation. In *Mental Health, Mental Illness and Migration* (pp. 513-522). Singapore: Springer Singapore.

Hadsel, F.L., 1997. Divide and Rule: the partition of Africa, 1880–1914 by HL Wesseling, translated by Arnold J. Pomerans. New York, Praeger; London, Eurospan Group; 1996. Pp. xvi+ 446. 29.75 paperback. *The Journal of Modern African Studies*, *35*(2), pp.335-366.

Hall, W., 2018. Racialisation in Mental Health services: Understanding Implicit Bias and Power Dynamics. *Psychiatric Quarterly*, 89(1), pp.123-138.

Halvorsrud, K., Nazroo, J., Otis, M., Brown Hajdukova, E. and Bhui, K., 2018. Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis. *BMC medicine*, *16*, pp.1-17.

Halvorsrud, K., Nazroo, J., Otis, M., Brown Hajdukova, E. and Bhui, K., 2019. Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses. *Social Psychiatry and Psychiatric Epidemiology*, *54*, pp.1311-1323.

Hammersley, M. and Atkinson, P., 2007. *Ethnography: Principles in Practice* (3rd ed.). Routledge.

Hansard., 2000. Parliamentary Business. *Written Answers.* Education Action Zones. Available at: https://publications.parliament.uk/pa/1d199900/1dhansrd/vo001023/text/01023w01.htm?utm_source (Accessed – 10 April 2025).

Harris, J., 2020. 'Prayer as a Coping Mechanism for Mental Health Problems: An Exploration', *Journal of Mental Health and Spirituality*, 22(3), pp. 210-225.

Harrison, G., Owens, D., Holton, A., Neilson, D. and Boot, D., 1988. A prospective study of severe mental disorder in Afro-Caribbean patients. *Psychological Medicine*, *18*(3), pp.643-657.

Haslam, S. A., Jetten, J., Postmes, T. and Haslam, C., 2009. Social Identity, Health and Well-being: An Emerging Agenda for Applied Psychology. *Applied Psychology*, 58(1), 1-23.

Hawkins, M.,1997. *Social Darwinism in European and American Thought, 1860-1945: Nature as Model and Nature as Threat*. Cambridge: Cambridge University Press.

Held, R., Phillips, J., Clarke, S. and Johnson, M., 2020. *Fear as a Barrier to Service Utilisation: Understanding the Impact on Access to Health Services. Journal of Health Services Research*, 15(2), pp. 123-136.

Helland, L.F. E. and Lindgren, T., 2016. What goes around comes around: From the coloniality of power to the crisis of civilization. *Journal of World-Systems Research*, *22*(2), pp.430-462.

Henry, B.F., 2020. Typologies of adversity in childhood & adulthood as determinants of mental health & substance use disorders of adults incarcerated in US prisons. *Child Abuse & Neglect*, *99*, p.104251.

Hercelinskyj, G., 2020. Theoretical frameworks underpinning practice in mental health nursing: applying theory to practice, in Hercelinskyj, G.J. and Alexander, L. (eds) *Applying Theory to Practice*. Australia: Cengage AU.

Heschl, L., 2022. A Refugee is a Refugee is… a Refugee? Differential Treatment of Persons in Need of Protection and Non-discrimination Law. *Peace Human Rights Governance*, *7*(Peace Human Rights Governance 7/1), pp.107-141.

Hiam, L., Steele, S. and McKee, M., 2018. *The NHS and Home Office Memorandum of Understanding: Data Sharing and its Implications. The Lancet Public Health*, 3(7), pp. 341-342.

Home, J., 2010. 'Corresponding Law for Every Immigration Offense', *Journal of Immigration and National Security Law,* 28(4), pp. 567-580.

Hooks, B., 1984. *Feminist Theory: Frome Margin to Center*. Boston, MA: South End Press.

Hooks, B., 1992. *Black looks: Race and Representation*. Boston, MA: South End Press.

Houlden, V., Weich, S., Porto de Albuquerque, J., Jarvis, S. and Rees, K., 2018. The relationship between green space and the mental well-being of adults: A systematic review. *PloS one*, *13*(9), p.e0203000.

House of Commons Library., 2024. Changes to legal migration rules for family and work visas. [online] Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-9920/ Accessed: 06 August 2024.

Huberman, A.M. and Miles, M.B., 2002. *The Qualitative Researcher's Companion*. Thousand Oaks, CA: Sage Publications.

Hughes, S., Noblit, G. and Cleveland, D., 2013. 'Derrick Bell's post-Brown moves toward critical race theory', *Race Ethnicity and Education*, 16(4), pp. 442-469.

Hui, A., Stickley, T., Stubley, M. and Baker, F., 2019. Project eARTh: participatory arts and mental health recovery, a qualitative study. *Perspectives in Public Health*, *139*(6), pp.296-302.

Huxley, P., Evans, S., Webber, M. and Gately, C., 2005. Staff shortages in the mental health workforce: the case of the disappearing approved social worker. *Health & Social Care in the Community*, *13*(6), pp.504-513.

Iancu, S.C., Zweekhorst, M.B., Veltman, D.J., van Balkom, A.J. and Bunders, J.F., 2014. Mental health recovery on care farms and day centres: a qualitative comparative study of users' perspectives. *Disability and Rehabilitation*, *36*(7), pp.573-583.

Idemudia, E. and Boehnke, K., 2020. *Psychosocial experiences of African migrants in six European countries: A mixed method study* (p. 237). Springer Nature.

Institute of Health Metrics and Evaluation. Global Health Data Exchange (GHDx), (https://vizhub.healthdata.org/gbd-results/, accessed 14 May 2022).

International Monetary Fund (2024). *Regional Economic Outlook: Sub-Saharan Africa*. April 2024. Available at: https://www.imf.org/-/media/Files/Publications/REO/AFR/2024/April/English/text.ashx (Accessed: 7 August 2024).

Iwanaga, M., Iwanaga, H., Kawakami, N. and World Mental Health Japan Survey Group., 2017. Twelve-month use of herbal medicines as a remedy for mental health problems in Japan: A cross-national analysis of World Mental Health Survey data. *Asia-Pacific Psychiatry*, *9*(3), p.e12285.

Jankovic, J., Parsons, J., Jovanović, N., Berrisford, G., Copello, A., Fazil, Q. and Priebe, S., 2020. Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities—a population-based study. *BMC Medicine*, *18*, pp.1-12.

John Rowntree Foundation., 2002. *Mental Health Advocacy for Black and minority ethnic users and carers.* London. JRF Analysis Unit. Available at: https://www.jrf.org.uk/race-and-ethnicity/mental-health-advocacy-for-black-and-minority-ethnic-users-and-carers (Accessed: 20 June 2020).

John Rowntree Foundation., 2017. *First report on UK poverty 2017.* London. JRF Analysis Unit. Available at: https://www.jrf.org.uk/uk-poverty-2017 (Accessed: 20 June 2020).

John Rowntree Foundation., 2020. UK Poverty 2019/20. London. JRF Analysis Unit. Available at: https://www.jrf.org.uk/uk-poverty-2019-20 (Accessed: 26 May 2022).

John Rowntree Foundation., 2022. *The essential guide to understanding poverty in the UK.* London. JRF Analysis Unit. Available at: https://www.jrf.org.uk/uk-poverty-2022-the-essential-guide-to-understanding-poverty-in-the-uk (Accessed: 30 January 2024).

Jones, H., Gunaratnam, Y., Bhattacharyya, G., Davies, W., Dhaliwal, S., Forkert, K., and Jackson, E., 2017. *Go Home? The Politics of Immigration Controversies.* Manchester University Press.

Jones, R. and Patel, S., 2021. 'Social deprivation and mental health service uptake: a global perspective', *International Journal of Social Psychiatry*, 67(5), pp. 437-448. Sage Publications.

Juju, D., Baffoe, G., Dam Lam, R., Karanja, A., Naidoo, M., Ahmed, A., Jarzebski, M.P., Saito, O., Fukushi, K., Takeuchi, K. and Gasparatos, A., 2020. Sustainability challenges in sub-Saharan Africa in the context of the sustainable development goals (SDGs). *Sustainability Challenges in Sub-Saharan Africa I: Continental Perspectives and Insights from Western and Central Africa*, pp.3-50.

Jung, M.K., 2009. 'The racial unconscious of assimilation theory', *Du Bois Review: Social Science Research on Race*, 6(2), pp. 375-395.

Kaltmeier, O., 2016. *Konjunkturen der (De-) Kolonialisierung* [Booms of de-coloniality]. Bielefeld: Transcript.

Kamwangamalu, N. M., 1999. The Social and Political Context of African Philosophy. *African Studies Quarterly,* 3(1), pp.1-15.

Kane, E., 2014. *Prevalence, patterns and possibilities: The experience of people from black and minority ethnic minorities with mental health problems in the criminal justice system.* London: Nacro. A background reader.

Kanuha, V.K., 2000. “Being” native versus “going native”: Conducting social work research as an insider. *Social Work*, *45*(5), pp.439-447.

Kang, S., Tom, A., and Farrington, A., 2019. 'Challenges and Barriers for Migrants in Accessing Mental Health Services: A Comparative Study', *International Journal of Migration and Health*, 21(2), pp. 105-120.

Kapadia, D., Smith, R. and Jones, A., 2016. 'Barriers to Accessing Mental Health Services in England: An Examination of Various Hypotheses', *Journal of Mental Health Research*, 24(3), pp. 175-189.

Kapadia, D., Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarroel-Williams, N., Becares, L. and Esmail, A., 2022. Ethnic Inequalities in Healthcare: *A Rapid Evidence Review.* NHS Race and Health Observatory.

Kapoor, N., 2018. *The State of Race*. Palgrave Macmillan.

Karlsen, S., Nazroo, J. Y., McKenzie, K., Bhui, K. and Weich, S., 2005. Racism, psychosis and common mental disorders among ethnic minority groups in England. *Psychological Medicine, 35,* 1795-1803.

Keating, F., Robertson, D., McCulloch, A. and Francis, E., 2002. *Breaking the circles of fear.* London: Sainsbury Centre for Mental Health.

Kerstetter, K., 2012. Insider, outsider, or somewhere in between: The impact of researchers’ identities on the community-based research process. *Journal of Rural Social Sciences*, 27(2), pp.99-117.

Khalifa, M., Dunbar, C. and Douglas, T.R., 2013. 'Derrick Bell, CRT, and educational leadership 1995–present', *Race, Ethnicity & Education*, 16(4), pp. 489-513.

Kiev, A., 1965. Psychiatric morbidity of West Indian immigrants in an urban group practice. *The British Journal of Psychiatry, 111,* 51-6.

Kilne, R., Naqvi, H., Razaq, S.A., Wilhelm, R. and WRES Implementation Team 2017. *NHS Workforce Race Equality Standard: 2016 Data Analysis Report for NHS Trusts*. NHS Equality and Diversity Council.

King, M., Coker, E., Leavey, G., Hoare, A. and Johnson-Sabine, E., 1994. Incidence of psychotic illness in London: comparison of ethnic minority groups. *British Medical Journal, 309,* 1115-1119.

Kirk, S. A., and Kutchins, H., 1992. *The Selling of DSM: The Psychiatric Bible and the Politics of Diagnosis.* New York: Praeger Publishers.

Kirkup, J. and Winnett, R., 2012. Theresa May interview: "We're going to give illegal migrants a really hostile reception", *The Telegraph*, 25 May.

Kleinman, A., 1988. *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: Free Press.

Kpanake, L., 2018. Cultural concepts of the person and mental health in Africa. *Transcultural Psychiatry*, *55*(2), pp.198-218.

Kring, A.M., Johnson, S. L., Davison, G.C., Neale, J.M., John, M. E., Edelstyn, N. and Brown, D. 2013. *Abnormal Psychology. 12th ed.* New York: Wiley.

Kyriakides, C. and Virdee, S., 2003. Migrant labour, racism and the British national health service. *Ethnicity & Health*, *8*(4), pp.283-305.

Langridge, D., 2007. *Phenomenological Psychology: Theory, Research and Method*. Harlow: Pearson Education Limited.

Lankelly Chase Foundation., 2013. *Review of a short consultation exercise on ethnic inequalities in mental health by Lankelly Chase foundation, Mind, The Afiya Trust and The Centre for Mental Health.* London: Lankelly Chase Foundation.

Larkin, M., Eatough, V. and Osborn, M., 2011. Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory & Psychology*, *21*(3), pp.318-337.

Larkin, M., Flowers, P. and Smith, J.A., 2022. *Interpretative phenomenological analysis: Theory, method and research*. 2nd ed. London: SAGE.

Lawrence, E., Fearon, P., Morgan, C. and Dazzan, P., 2021. 'Follow-up of the AESOP (Aetiology and Ethnicity in Schizophrenia and Other Psychoses) Study: Ten-Year Outcomes and Ethnic Disparities', *British Journal of Psychiatry*, 219(6), pp. 487-495.

Lawrence, V., McCombie, C., Nikolakopoulos, G. and Morgan, C., 2021. Ethnicity and power in the mental health system: experiences of white British and black Caribbean people with psychosis. *Epidemiology and Psychiatric Sciences*, *30*, p.e12.

Le Cook, B., Manning, W. and Alegria, M., 2013. Measuring disparities across the distribution of mental health care expenditures. *The Journal of Mental Health Policy and Economics*, *16*(1), p.3.

Lee-Tauler, S.Y., Eun, J., Corbett, D. and Collins, P.Y., 2018. 'A systematic review of interventions to improve initiation of mental health care among racial-ethnic minority groups', *Psychiatric Services*, 69(6), pp. 628-647.

Leichsenring, F., 2011. The Efficacy of Psychodynamic Therapy in the Treatment of Mental Disorders. *American Journal of Psychotherapy,* 65(1), pp.1-14

Leong, F.T.L., Wagner, N.S. and Tata, S.P., 1995. Racial/ethnic variations in help-seeking attitudes, in Ponterotto, J.G., Casas, J.M., Suzuki, L.A. and Alexander, C.M. (eds.) *Handbook of Multicultural Counselling*. Thousand Oaks: Sage Publications, pp. 415-438.

Lewis, H., Dwyer, P., Hodkinson, S. and Waite, L., 2017. 'Precarious Lives: Forced Labour, Exploitation and Asylum', *Bristol: Policy Press*.

Liberty., 2018. *A guide to the hostile environment: The border controls dividing our communities and how we can bring them down*. Available at: https://www.libertyhumanrights.org.uk/sites/default/files/HE%20web.pdf (Accessed: 28 July 2024).

Liberty., 2018. *'Care Don't Share': Hostile Environment Data Sharing*. Available at: https://www.libertyhumanrights.org.uk/issue/care-dont-share/

Liberty., 2020. 'Stop and search without suspicion: A briefing on the expansion of police powers in England', *Liberty*, 15 March. Available at: https://www.libertyhumanrights.org.uk/issue/stop-and-search-without-suspicion/ (Accessed: 7 August 2024).

Lindert, J., Schouler-Ocak, M. and Priebe, S., 2008. Legal frameworks and their impact on access to psychosocial interventions for migrants in host countries*. International Journal of Migration, Health and Social Care*, 4(2), pp. 10-19.

Long, J., Ohlsen, S., Senek, M., Booth, A., Weich, S. and Wood, E., 2023. Realist synthesis of factors affecting retention of staff in UK adult mental health services. *BMJ Open*, *13*(5), p.e070953.

Loomba, A., 2015. *Colonialism/Postcolonialism* (3rd Ed.). Routledge.

Lubian, K., Weich, S., Stansfield, S., Bebbington, P., Brugha, T., Spiers, N., McManus, S. and Cooper, C., 2016. Mental health treatment and services in S McManus, P bebbington, R Jenkins, and T. Brugha, eds. *Mental health and well-being in England Adult Psychiatric Morbidity Survey 2014.* Leeds. NHS Digital.

Lucas, R., 2014. 'The introduction of the Blue Card: Facilitating work opportunities for non-EU nationals in Europe', *European Journal of Migration and Law*, 16(3), pp. 321-339.

Luft, J., and Ingham, H., 1955. *The Johari Window: A Graphic Model of Awareness in Interpersonal Relations. Proceedings of the Western Training Laboratory in Group Development.* Los Angeles: University of California, Los Angeles.

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., ... & Patel, V., 2010. Poverty and common mental disorders in low- and middle-income countries: A systematic Review. *Social Science & Medicine*, 71(3), 517-528.

Lynn, M. and Parker, L., 2006. Critical race studies in education: Examining a decade of research on U.S. schools*. The Urban Review*, 38(4), pp. 257-290.

Macpherson, W., 1999. The Stephen Lawrence Inquiry: Report of an Inquiry.' Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf

Mamdani, M., 1996. *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism.* Princeton University Press.

Mantovani, N., Pizzolati, M. and Edge, D., 2017. Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. *Health Expectations*, *20*(3), pp.373-384.

Martinez, A., Garcia, M. and Rivera, L., 2020. 'Barriers to Mental Health Help-Seeking Behaviour in the Filipino Community: A Comprehensive Study', *International Journal of Mental Health and Cultural Diversity*, 15(2), pp. 112-126.

Maxwell, J. A., 2013. *Qualitative Research Design: An Interactive Approach* (3rd ed.). SAGE Publications.

Mayston, R., Frissa, S., Tekola, B., Hanlon, C., Prince, M. and Fekadu, A., 2020. Explanatory models of depression in sub-Saharan Africa: Synthesis of qualitative evidence. *Social Science & Medicine*, *246*, p.112760.

Mazzei, L.A., 2007. *Inhabited Silence in Qualitative Research: Putting Post-Structural Theory to Work.* Peter Lang.

Mbembe, A., 2001. *On the Post colony.* University of California Press.

McColl, H., McKenzie, K. and Bhui, K., 2008. Mental healthcare of asylum-seekers and refugees. *Advances in Psychiatric Treatment*, *14*(6), pp.452-459.

McCulloch, J., 1995. *Colonial psychiatry and 'the African mind'*. Cambridge: Cambridge University Press.

McGibbon, E. A. and Etowa, J.B., 2009. Anti-racist Health Policy for a Diverse Population. *Journal of Black Studies,* 39(1), pp.11-25.

McGovern, D. and Cope, R., 1987. First psychiatric admission rates of first- and second-generation Afro-Caribbeans, *Social Psychiatry, 22,* 139-149.

McKay, S. and Rowlingson, K., 2022. Want: Still the easiest giant to attack. *Social Policy & Administration*, *56*(2), pp.230-244.

McKinsey & Company., 2020. *Problems amid progress: improving lives and livelihood for ethnic minorities in the United Kingdom*. McKinsey. Available at: https://www.mckinsey.com/industries/public-sector/our-insights/problems-amid-progress-improving-lives-and-livelihoods-for-ethnic-minorities-in-the-united-kingdom (Accessed: 8 August 2023).

Mclean, K., Foster, R. and Hopkins, N., 2003. Accessing Mental Health Services: A Review of Barriers and Facilitators for Ethnic Minority Groups. *Ethnicities,* 3(1), pp.49-69.

Memon, A., Taylor, K., Mohebati, L.M., Sundin, J., Cooper, M., Scanlon, T. and De Visser, R., 2016. Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ Open*, *6*(11), p.e012337.

Mental Health Alliance., 2021. *Open letter to Sajid Javid on institutional racism within mental health act reforms*. NSUM website. Available at: https://www.nsun.org.uk/news/open-letter-to-sajid-javid-institutional-racism-mha-reform/ (Accessed 15 August 2023).

Mental Health Foundation., 2016. Race, ethnicity and mental health: Summary of findings. Retrieved from https://www.mentalhealth.org.uk/sites/default/files/race-ethnicity-mental-health-summary.pdf

Mental Health Task Force., 1994. *Black mental health – A Dialogue for Change.* London: Department of Health.

Metzl, J. M., 2010. *The Protest Psychosis: How Schizophrenia Became a Black Disease.* Beacon Press.

Meyer, P., Saw, D., Cho, Y. and Fancher, E., 2015. 'Racial Disparities in Mental Health Care: Little Change Since the 2014 Secretary General's Report', *American Journal of Psychiatry*, 172(6), pp. 562-570.

Millen, D., 1997. Some methodological and epistemological issues raised by doing feminist research on non-feminist women. *Sociological Research Online*, *2*(3), pp.114-128.

Mills, C. and Fernando, S., 2014. Globalising mental health or pathologising the Global South? Mapping the ethics, theory and practice of global mental health. *Disability and the Global South*, *1*(2), pp.188-202.

Mind., 2017. Advocacy in Mental Health. Available at: https://www.mind.org.uk/information-support/guides-to-support-and-services/advocacy/imhas-england/ (Accessed: 10 August 2024).

Mitchell, R., 2005. The Long Shadow of J. Marion Sims: A History of Medical Experimentation on African American Women. *Journal of the History of Medicine and Allied Sciences*, 60(4), pp. 469-496.

Moffat, J., Sass, B., Mckenzie, K. and Bhui, K., 2009. Improving pathways into mental health care for black and ethnic minority groups: a systematic review of the grey literature. *International Review of Psychiatry*, *21*(5), pp.439-449.

Mohan, R., McCrone, P., Szmukler, G., Micali, N., Afuwape, S. and Thornicroft, G., 2006. Ethnic differences in mental health service use among patients with psychotic disorders. *Social Psychiatry and Psychiatric Epidemiology*, *41*, pp.771-776.

Mona, J., Patel, R., Sanchez, L., and Williams, A., 2021. *Fear of Police Detainment as a Barrier to Accessing Mental Health Services: An Analysis*. *Journal of Mental Health and Wellbeing*, 22(4), pp. 405-418.

Monga, C. and Lin, J. Y., 2015. *The Oxford Handbook of Africa and Economics: Context and Concepts.* Oxford University Press.

Moon, K. & Blackman, D., 2014. A guide to understanding social science research for natural scientists. *Conservation Biology*, 28(5), pp.1167-1177.

Morgan C, Dazzan P, Morgan K, Jones P, Harrison G, Leff J, AESOP study group., 2006. First episode psychosis and ethnicity: Initial findings from the AESOP study. *World Psychiatry 5*(1):40–46

Morgan, C., Fearon, P., Lappin, J., Heslin, M., Donoghue, K., Lomas, B., Reininghaus, U., Onyejiaka, A., Croudace, T., Jones, P.B. and Murray, R.M., 2017. Ethnicity and long-term course and outcome of psychotic disorders in a UK sample: the ÆSOP-10 study. *The British Journal of Psychiatry*, *211*(2), pp.88-94.

Morgan, C., Mallett, R., Hutchinson, G. and Leff, J., 2004. Negative pathways to psychiatric care and ethnicity: The bridge between social science and psychiatry. *Social Science and Medicine 58, 4,* 739-752.

Mosotho, L., Louw, D.A., Jacobus, F. and Calitz, W., 2011. The manifestation of anxiety among Sesotho speakers. *South African Journal of Psychology*, *41*(4), pp.437-450.

Muhammad, M., Wallerstein, N., Sussman, A.L., Avila, M., Belone, L. and Duran, B., 2015. Reflections on researcher identity and power: The impact of positionality on community based participatory research (CBPR) processes and outcomes. *Critical Sociology*, *41*(7-8), pp.1045-1063.

Naidu, T., 2021. Modern medicine is a colonial artefact: Introducing decoloniality to medical education research. *Academic Medicine*, *96*(11S), pp. S9-S12.

National Institute for Mental Health in England, 2003. *Inside outside: Improving mental health services for black and minority ethnic communities in England*. Department of Health. London. Available at: https://www.nimhe.org.uk/downloads/inside_outside.pdf (Accessed: 18 November 2020).

Nazroo, J. Y., 2003. The Structuring of Ethnic Inequalities in Health: Economic Position, Racial Discrimination, and Racism. *American Journal of Public Health,* 93(2), pp.277-284.

Nazroo, J.Y., Bhui, K.S. and Rhodes, J., 2018. 'Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism', *Sociology of Health & Illness,* 40(4), pp. 735-750.

Nazroo, J.Y., Bhui, K.S. and Rhodes, J., 2020. Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. *Sociology of Health & Illness*, *42*(2), pp.262-276.

Ndlovu-Gatsheni, S.J., 2012. Beyond the equator there are no sins: Coloniality and violence in Africa. *Journal of Developing Societies*, *28*(4), pp.419-440.

Nesterko, Y., Jäckle, D., Friedrich, M., Holzapfel, L. and Cwik, J.C., 2020. Cultural competency and mental health care of refugees: the need for an inter-sectional approach, *Frontiers in Psychiatry*, 11, p. 672. Frontiers Media.

Netto, G., 2011. Identity negotiation, pathways to housing and "place": The experience of African Immigrants in Glasgow. *Housing Studies,* 26(5), pp.651-673.

Newbigging, K., Mohan, J., Rees, J., Harlock, J. and Davis, A., 2017. Contribution of the voluntary sector to mental health crisis care in England: protocol for a multi method study. *BMJ Open*, *7*(11), p.e019238.

NHS Confederation., 2021. *'Reducing Mental Health Inequalities: A Priority for NHS England'*, NHS Confederation*,* 15 July. Available at: https://www.nhsconfed.org/articles/reducing-mental-health-inequalities-priority-nhs-england (Accessed: 7 August 2024).

NHS Digital. 2017. Mental health Act Statistics, Annual Figures: 2016-17, Experimental Statistics. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/mental-health-act-statistics-annual-figures-2016-17-experimental-statistics (Accessed: 18 May 2024).

NHS Digital., 2019. Mental Health Statistics, Annual Figures 2018-2019. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures (Accessed: 20 May 2024).

NHS Digital 2021., How you can access mental health services. Available at: https://www.nhs.uk/mental-health/social-care-and-your-rights/how-to-access-mental-health-services/

NHS Digital 2021., Mental health Act Statistics, Annual Figures – 2020-21. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures (Accessed: 17 August 2024).

NHS Digital. 2021. National Healthcare Inequalities Improvement Programme. Retrieved from: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/ Accessed: 2 December 2022.

NHS Digital., 2019. Online version of the Long-Term Plan. Available at: https://www.longtermplan.nhs.uk/online-version/overview-and-summary/ (Accessed: 15 June 2024).

NHS Digital 2021., Workforce, Race-Equality Standard: 2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf (Accessed: 18 May 2024).

NHS Digital 2022. Mental Health Act. Available at: https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/ (Accessed: 18 May 2024).

NHS Digital. 2023. Advancing mental health equalities. Available at: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/ (Accessed: 2 December 2022).

Norfolk, Suffolk & Cambridgeshire Strategic Health Authority., 2003. *Independent enquiry into the death of David Bennett* (Chairman: Sir John Blofeld). Cambridge: Norfolk, Suffolk & Cambridgeshire Strategic Health Authority.

Nyashanu, M., 2017. *Beliefs and perceptions in the construction of HIV stigma and sexual health seeking behaviour among Black sub-Saharan African (BSSA) communities in Birmingham, UK*. PhD thesis, Wolverhampton University.

Nyashanu, M., Mbalinda, S.N., Mushawa, F. and Ekpenyong, M.S., 2020. Exploring perceptions and attitudes of black Sub-Sahara African (BSSA) migrants towards residential care in England. *International Journal of Migration, Health and Social Care*, *16*(3), pp.307-315.

Nyashanu, M., Mbalinda, S, N., Madziva, R. and Ekpenyong, M.S., 2024. Perceptions and attitudes of Black sub-Saharan African migrants from war torn zones towards accessing health services in the English West Midlands region, UK, *International Journal of Migration*, *Health and Social Care,* 20(1), pp. 19-31.

O'Brien, M., 2010. The Beveridge Report: its impact on women and migrants. *Studies in Sociology Journal*, *2*(2), pp.21-38.

Ochieng, B. M., 2013. Black African Migrants: The barriers with Accessing and Utilising Health Promotion Services in the UK. *The European Journal of Public Health,* 23(2), pp.265-269.

Odimegwu, C.O. and Adewoyin, Y. eds., 2022. *The Routledge handbook of African demography*. New York, NY: Routledge.

Office for National Statistics. (2013). Ethnicity and national identity in England and Wales 2011. Available at: https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11/pdf

Ogundare, T., 2020. Culture and mental health: Towards cultural competence in mental health delivery. *Journal of Health and Social Sciences*, *5*(1), pp.023-034.

Okeke-Ihejirika, P., Salami, B., Karimi, A., and Vallianatos, H., 2020. The Use of Semi-Structured Interviews in Researching Immigrant Experiences: The Case of African Immigrants in Canada. *Qualitative Sociology Review*, 16(2), pp. 60-77.

Okello, E. and Musisi, S., 2006. Depression as a clan illness (eByekika): an indigenous model of psychotic depression among the Baganda of Uganda. *World Cultural Psychiatry Research Review*, *1*(2), pp.60-73.

Okello, E.S. and Ekblad, S., 2006. Lay concepts of depression among the Baganda of Uganda: a pilot study. *Transcultural Osychiatry*, *43*(2), pp.287-313.

Olajide, D., 1999. Government policy and ethnic minority mental health. In: K. Bhui and D. Olajide, eds. *Mental Health Service Provision for a Multi-cultural Society*. London: Saunders.

Olusoga, D., 2016. *Black and British: A Forgotten History.* London: Pan Macmillan.

Orjiako, M. and So, T., 2014. 'Ethnic Disparities in Mental Health Outcomes: A Review of the AESOP Study and Similar Research', *Journal of Ethnic and Migration Studies*, 40(12), pp. 1967-1983.

Orb, A., Eisenhauer, L., and Wynaden, D., 2001. Ethics in qualitative research. *Journal of Nursing Scholarship,* 33(1), 93-96.

Osungbade, K.O. and Siyanbade, S.L., 2011. Myths, misconceptions, and misunderstandings about epilepsy in a Nigerian rural community: implications for community health interventions. *Epilepsy & Behaviour*, *21*(4), pp.425-429.

Palmer, D., 2006. Imperfect prescription: mental health perceptions, experiences and challenges faced by the Somali Community in the London Borough of Camden and service responses to them*. Taylor & Francis, 12,* 45-56.

Parahoo, K., 2006. *Nursing Research: Principles, Process and Issues. 2nd edition*. Basingstoke: Palgrave Macmillan.

Parkman, S.E., Davies, S.N., Leese, M., Phelan, M. and Thornicroft, G., 1997. Ethnic differences in satisfaction with mental health services among representative people with psychosis in south London: PRiSM study 4. *The British Journal of Psychiatry*, *171*(3), pp.260-264.

Parliamentary Office of Science and Technology. 2007. *Ethnicity and Health.* Millbank. London.

Patel, R. and Khan, S., 2020. The Influence of Eurocentric Medical Models on Clinical Practice in the UK: A Qualitative Inquiry. *Journal of Cultural Diversity in Healthcare,* 2(1), pp.45-58. Springer.

Patel, N. & Fatimilehin, I., 1999. Racism and mental health. In: G. Newnes, G. Holmes & C. Dunn, eds. This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services. Ross on Wye: PCCS, pp. 27-42.

Payne-Gill, J., Whitfield, C. and Beck, A., 2021. The relationship between ethnic background and the use of restrictive practices to manage incidents of violence or aggression in psychiatric inpatient settings. *International Journal of Mental Health Nursing*, *30*(5), pp.1221-1233.

Pelias, R.J., 2011. *Writing into Position: Strategies for Composition and Evaluation*. In: N.K. Denzin and Y.S. Lincoln, eds. *The Sage Handbook of Qualitative Research*. 4th ed. Thousand Oaks, CA: Sage Publications, pp. 659-668.

Petryna, A., 2005. Ethical variability: drug development and globalising clinical trials. *American Ethnologist*, *32*(2), pp.183-197.

Pew research Center., 2019. *Unauthorized Immigrants in the United Kingdom*. Available at: https://www.pewresearch.org/global-migration-and-demography/fact-sheet/unauthorized-immigrants-in-the-united-kingdom/ (Accessed: 15 August 2024).

Phillimore, J.., Humphris, R. and Khan, K., 2019. Reciprocity for New Migrant Integration: Resource Conservation, Investment and Exchange. *Journal of Ethnic and Migration Studies,* 45(8), pp.1405-1423.

Phoenix, J., 2013. Sex work, sexual exploitations and consumerism. *Crime, Justice and Social Democracy: International Perspectives*, pp.147-161.

Pietkiewicz, I. and Smith, J.A., 2014. A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), pp.7-14.

Pilcher, J.K., 2001. Engaging to transform: Hearing black women's voices. *International Journal of Qualitative Studies in Education*, *14*(3), pp.283-303.

Pilgrim, D., 2017., *Key Concepts in Mental Health.* SAGE Publications.

Pinsent, R., 1963. Morbidity in an immigrant population, *Lancet,* 281, 437-9

Pinto, R., Ashworth, M. and Jones, R., 2008. Schizophrenia in black Caribbeans living in the UK: an exploration of underlying causes of the high incidence rate. *British Journal of General Practice*, *58*(551), pp.429-434.

Pisani, E., 2009. The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS: W. W. Norton & Company.

Poesche, J., 2019. Coloniality in sub-Saharan Africa and the Americas. *Journal of Developing Societies*, *35*(3), pp.367-390.

Porteus-Sedouhian, B., 2021. Mental Health Act Reforms and Institutionalised Racism. *Mental Health Today*.

Priebe, S., Katsakou, C., Amos, T., Leese, M., Morriss, R., Rose, D., Wykes, T. and Yeeles, K., 2009. Patients' views and readmissions 1 year after involuntary hospitalisation. *The British Journal of Psychiatry*, *194*(1), pp.49-54.

Prins, H., 1994. Report of the Committee of Enquiry into the death of Orville Blackwood and a Review of the Deaths of Two Other African-Caribbean Patients. London: SHSA. *Psychologist,* 35, 13–105.

Punton, G., Dodd, A.L. and McNeill, A., 2022. You're on the waiting list: An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *Plos one*, *17*(3), p.e0265542.

Qureshi, A., Morris, M. and Mort, L., 2021. *Access denied: The human impact of the hostile environment,* London: IPPR.

Radez, L., Danese, A., Wiggins, M. and Shafran, R., 2020. Parents and teachers as facilitators and barriers to accessing mental health services. *Journal of Child Psychology and Psychiatry*, 61(7), pp.764-772. https://doi.org/10.1111/jcpp.13259

Ramírez-Tagle, R., Ávalos, V., Silva, E., Martínez, F. and Valladares, M., 2018. Medicinal plants consumption by patients under psychological treatment in a municipality in Chile. *Journal of Pharmacy & Pharmacognosy Research*, *6*(2), pp.126-135.

Ray, V., 2019. A theory of racialized organizations. *American sociological review*, *84*(1), pp.26-53.

Rees, P. and Butt, F., 2004. Ethnic Change and Diversity in England, 1981-2001. *Royal Geographical Society,* 36(2), pp.174-186.

Reidy, C., Papoutsi, C., KC, S., Gudgin, B., Laverty, A. A., Greaves, F. and Powell, J., 2025. Qualitative Evaluation of the Implementation and National Roll-Out of the NHS App in England. BMC Medicine, 23(1).

Rhodes, M., 2013. *How two intuitive theories shape the development of social categorization.* Department of Psychology, University of New York.

Rich, P.B., 1986. Conservative Ideology and Race in Modern British Politics. In: Layton-Henry, Z., Rich, P.B. (eds) Race, Government and Politics in Britain. Palgrave Macmillan, London.

Robotham, D., Satkunanathan, S., Doughty, L. and Wykes, T., 2016. Do we still have a digital divide in mental health? A five-year survey follow-up. *Journal of Medical Internet Research*, *18*(11), p.e309.

Rodney, W., 1972. *How Europe Underdeveloped Africa.* Verso Books.

Rogers, A. and Faulkner, A., 1987. *A place for safety*. London: MIND.

Rollock, N., Gillborn, D., Vincent, C. and Ball, S., 2011. The public identities of the black middle classes: Managing race in public spaces. *Sociology*, *45*(6), pp.1078-1093.

Rose, N., 1999. *Powers of Freedom: Reframing Political Thought.* Cambridge University Press.

Rüdell, K., Bhui, K. and Priebe, S., 2008. Do 'alternative' help-seeking strategies affect primary care service use? A survey of help-seeking for mental distress. *BMC Public Health*, *8*, pp.1-10.

Rugkasa, J. and Canvin, K., 2011. Researching Mental Health in Minority Ethnic Communities: Reflections on Recruitment. *Qualitative Health Research,* 21(1), 132-143.

Runnymede Trust., 2017. *Ethnic Inequalities in Mental Health: Facts and Figures.* London: Runnymede Trust.

Runnymede Trust., 2020. *Beyond BAME: Rethinking the politics of race*. Runnymede Trust.

Scottish Government., 2004. Analysis of Ethnicity in the 2001 Census – Summary Report. Available at: http://www/gov/scot/publications/analysis-ethnicity-2001-census-summary-report/pages/2/ (Accessed 10 April 2025).

Smaje, C., 1995. The Politics of Ethnicity in Health Care. *British Journal of Sociology,* 46(2), pp.167-187.

Saeed, S.A. and Masters, R.M., 2021. Disparities in health care and the digital divide. *Current Psychiatry Reports*, *23*, pp.1-6.

Sainsbury Centre for Mental Health, 2002. *Breaking the circles of fear: a review of the relationship between mental health services and African and Caribbean communities*. Sainsbury Centre for Mental Health.

Salisbury, H., Quinton, P., Brunton-Smith, I. and Apolice, A., 2017. 'Ethnic Disparities in Stop and Search: The Persistence of Racial Bias', *Journal of Policing Studies*, 9(4), pp. 345-362.

Sashidharan, S. P., 2001. Institutional Racism in British Psychiatry. *Psychiatric Bulletin, 25,* 244-247.

Sashidharan, S. P., 2003. *Inside Outside—Improving mental health services for Black and minority ethnic communities in England.* London; 2003

Saunders, M. Lewis, P. and Thornhill, A., 2015. *Research Methods for Business Students.* 8th Ed. Prentice Hall. Harlow. England.

Scanlan, C.L., 2020. *A Guide to Using Semi-Structured Interviews in Research Projects*. In: J. Saul, ed. *Research Methods for Social Science Students*. London: Sage Publications, pp. 150-165.

Schoch, M. and Lakner, C., 2020. The number of poor people continues to rise in sub-Saharan Africa despite a slow decline in the poverty rate. World Bank Blogs.

Seamark, D.A. and Gabriel, R.M., 2018. Exploring the Dynamics of Semi-Structured Interviews in Qualitative Research: Methodological Insights and Practical Considerations. *Journal of Qualitative Research Methods*, 14(4), pp. 231-245.

Semahegn, A., Torpey, K., Manu, A., Assefa, N., Tesfaye, G. and Ankomah, A., 2020. Psychotropic medication non-adherence and its associated factors among patients with major psychiatric disorders: a systematic review and meta-analysis. *Systematic Reviews*, *9*, pp.1-18.

Semrau, M., Evans-Lacko, S., Koschorke, M., Ashenafi, L. and Thornicroft, G., 2015. Stigma and discrimination related to mental illness in low-and middle-income countries. *Epidemiology and Psychiatric Sciences*, *24*(5), pp.382-394.

Serrant-Green, L., 2002. Black on Black: Methodological issues for black researchers working in minority ethnic. *Nurse Researcher*, *9*(4), pp.30-44.

Serrant, L., 2004. *Black Caribbean men, sexual health decisions and silences* (Doctoral dissertation, University of Nottingham).

Serrant-Green, L., 2011. The sound of 'silence': a framework for researching sensitive issues or marginalised perspectives in health. *Journal of Research in Nursing*, *16*(4), pp.347-360.

Seventh biennial report 1995-1997. https://archive.org/details/seventhbiennialr0000grea. Accessed 12 February 2023.

Sextou, P. and Smith, C., 2017. Drama is for Life! Recreational Drama Activities for the Elderly in the UK. *Text Matters: A Journal of Literature, Theory and Culture*, (7), pp.273-290.

Sharpley, M., Hutchinson, G., Murray, R. M. and McKenzie, K., 2001. Understanding the excess of psychosis among the African-Caribbean population in England: Review of Current hypotheses. *British Journal of Psychiatry, 178,* S60-S68.

Shaw, R., 2010. *Interpretative phenomenological analysis.* In: M. Forrester, ed. Doing Qualitative Research in Psychology. London: Sage Publications, pp. 177-201.

Shelter., 2016. *Research Report: Survey of Private Landlords*. Available at: https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/research_report_survey_of_private_landlords (Accessed: 13 September 2020).

Sinclair, S., Granberg, E. and Nilsson, P., 2023. The British Public's Preferences: Greater Support for Ukrainian Refugees Compared to Yemeni Refugees. *Journal of Refugee Studies*, 36(1), pp. 65-82.

Singh, S. P., 2016. Predictors of engagement in first episode psychosis. *Schizophrenia Research, 175* (1-3), 204-208.

Singh, S.P., 2021. Comprehensive Mental Health Action Plan 2013-2030: We must rise to the challenge. *Indian Journal of Psychiatry,* 63(5), pp.415-417

Singh, S.P. and Burns, T., 2006. Race and mental health: there is more to race than racism. *BMJ*, *333*(7569), pp.648-651.

Singh, S.P., Burns, T., Tyrer, P., Islam, Z., Parsons, H. and Crawford, M.J., 2014. Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine*, *44*(5), pp.997-1004.

Singh, S.P., Greenwood, N.A.N., White, S. and Churchill, R., 2007. Ethnicity and the mental health act 1983: systematic review. *The British Journal of Psychiatry*, *191*(2), pp.99-105.

Smedley, A. and Smedley, B. D., 2012. *Race in North America: Origin and Evolution of a Worldview*. Westview Press.

Smith, L.T. and Brown, T., 2013. 'Colonial legacies and mental health disparities in Australia: Evidence and implications', *Australian Journal of Social Issues***,** 48(4), pp. 395-411.

Smith, L. and Johnson, M., 2017. Clinician Attitudes and Mental Health Service Access: A Qualitative Study in the UK. *British Journal of Clinical Psychology,* 56(4), pp.345-362. Wiley-Blackwell.

Smith, H., 1955. Medicine in Africa as I have seen it. *African Affairs,* 54(214), pp.28-29.

Smith, J. and Osborn, M., 2008. *Interpretative phenomenological analysis.* In: J. Smith, ed. Qualitative Psychology: A Practical Guide to Research Methods. 2nd ed. London: Sage Publications, pp.53-80.

Smith, J.A., 2024. *Qualitative Psychology: A Practical Guide to Research Methods.* 4th ed. London: Sage Publications.

Smith, S., Gate, R., Ariyo, K., Saunders, R., Taylor, C., Bhui, K., Mavranezouli, I., Heslin, M., Song, Y.J.C., Rosenberg, S., Smith, B., Occhipinti, J.A., Mendoza, J., Freebairn, L., Skinner, A. and Hickie, I.B., 2022. Missing in action: the right to the highest attainable standard of mental health care. *International Journal of Mental Health Systems*, *16*(1), p.26.

Sobers, S.N., 2023. *Black Everyday Lives, Material Culture and Narrative: Tings in de House*. Routledge.

Special Hospital Service Authority., 1993. *Report of the Committee of Enquiry into the Death in Broadmoor Hospital of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients: 'Big, Black and Dangerous?'* (Chairman: Professor H. Prins). London: Special Hospitals Service Authority.

Stansfield, S., Clark, C., Bebbington, P., King, M., Jenkins, R. and Hinchliffe, S., 2016. Chapter 2: Common mental disorders. In S. McManus, P. Bebbington, R. Jenkins & T. Bhruga eds. *Mental Health and well-being in England: Adult Psychiatric Morbidity Survey 2014.* Leeds: NHS Digital.

Steele, S., Stuckler, D., McKee, M. and Pollock, A.M. 2014. 'The immigration bill: Extending charging regimes and scapegoating the vulnerable will pose risks to public health', *Journal of the Royal Society of Medicine*, 107(4), pp. 132–133.

Straiton, M. L., Ledesma, H. M. L. and Donnelly, T. T., 2018. It has not occurred to me to see a doctor for that kind of feeling: a qualitative study of Filipina immigrants' perceptions of help seeking for mental health problems. *BMC Women's Health*, *18*(1), 1-11.

Sturrock, J., 2008. *Structuralism*. John Wiley & Sons.

Sue, S., Cheng, J. K. Y., Saad, A. and Shih, M., 2019. Racial and Ethnic Disparities in Mental Healthcare: Historical Perspectives and Future Directions, *American Psychologist*, 74(1), pp.1-17.

Synergi Collaborative Centre., 2018. *Modernising the Mental Health Act: a missed opportunity to address ethnic inequalities.* Available at: https://legacy.synergicollaborativecentre.co.uk/modernising-the-mental-health-act-a-missed-opportunity-to-address-ethnic-inequalities/ (Accessed: 31 October 2020).

Swan, P. and Raphael, B., 1995. *Report on Indigenous and Torres Strait Islander mental health: "Ways Forward", part I and part II.* Canberra: Office of Indigenous and Torres Strait Health.

Taylor, D., 2020. COVID-19 and the Persistence of Racism: How the Pandemic Exposed Racial Bias in Attitudes and Policies. *Journal of Social Issues*, 76(4), pp. 929-944.

Taylor, E., 1998. A Primer on Critical Race Theory. *The Journal of Black in Higher Education* (19), 122-124.

Teferra, S. and Shibre, T., 2012. Perceived causes of severe mental disturbance and preferred interventions by the Borana semi-nomadic population in southern Ethiopia: a qualitative study. *BMC Psychiatry*, *12*, pp.1-9.

Templeton, A. R., 2013. Biological Races in Humans. *Studies in History and Philosophy of Biological and Biomedical Sciences,* 44(3), 262-271.

The Synergi Collaboration Centre., 2020. *Ethnic Inequalities in UK Mental Health Systems.* [online] Available at: https://www.synergicollaborationcentre.org/ethnic-inequalities-in-uk-mental-health-systems [Accessed 6 August 2024].

The Times and Sunday Times., 2023. 'Ministers at odds over visa fee rise to reduce immigration'. Available online at: https://www.thetimes.com/article/ministers-at-odds-over-visa-fee-rise-to-reduce-immigration-c2zvgd6tc (Accessed 20 January 2024).

Tilley, H., 2016. Medicine, empires, and ethics in colonial Africa. *AMA Journal of Ethics*, *18*(7), pp.743-753.

Times Higher Education., 2015. *Visa refusal fears 'force UK universities out of international markets'.* [online] Available at: https://www.timeshighereducation.com/news/visa-refusal-fears-force-uk-universities-out-of-international-markets (Accessed 6 August 2024).

Tracy, S. J., 2019. *Qualitative Research Methods: Collecting Evidence, Crafting Analysis, Communicating Impact* (2nd ed.). Wiley-Blackwell.

Travis, A., 2013. *Immigration bill: Theresa May defends plans to create 'hostile environment'.* The Guardian, 10 October. [online] Available at: https://www.theguardian.com/politics/2013/oct/10/immigration-bill-theresa-may-hostile-environment (Accessed 6 August 2024).

Travis, A., 2017a. *UK banks to check 70m bank accounts in search for illegal immigrants. The Guardian, 21 September.* [online] Available at: https://www.theguardian.com/uk-news/2017/sep/21/uk-banks-to-check-70m-bank-accounts-in-search-for-illegal-immigrants (Accessed: 6 August 2024).

Treitler, V.B., 2015. Social agency and white supremacy in immigration studies. *Sociology of race and ethnicity*, *1*(1), pp.153-165.

Truth and Reconciliation Commission of Canada., 2015. *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*. [online] Available at: http://www.trc.ca/assets/pdf/Volume_1_Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf (Accessed 6 August 2024).

U.S. Department of Health and Human Services., 2001. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.

UK Government., 2010. *Equality Act 2010 London:* The Stationery Office. Available at:

https://www.legislation.gov.uk/ukpga/2010/15/contents (Accessed: 10 April 2025).

UK Government., 2011. 'No Health without Mental Health', gov.uk, Available at: https://assets.publishing.service.gov.uk/media/5a7c8e91e5274a7b7e3213c2/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf (Accessed: 16 July 2024).

UK Government., 2015. Evaluation of the right to rent scheme. Available at: https://assets.publishing.service.gov.uk/media/5a7f88bded915d74e622b0c7/horr83.pdf (Accessed: 21 December 2023).

UK Government., 2016. 'NHS Debts and Immigration Enforcement', *gov.uk*, 11 February. Available at: https://www.gov.uk/government/publications/nhs-debt-and-immigration-enforcement (Accessed: 7 August 2024).

UK Government., 2017. Race Disparity Audit: Summary findings from the ethnicity facts and figures website. *Cabinet Office.* (Online) Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686071/Revised_RDA_report_March_2018.pdf [Accessed 15 June 2022].

UK Government., 2019. 'NHS entitlements: Migrant health guide', *gov.uk*, 23 October. Available at: https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide (Accessed: 7 August 2024).

UK Government., 2020. 'Diversity in the NHS: Ethnic Minority Representation Among Doctors', *gov.uk*, 14 September. Available at: https://www.gov.uk/government/publications/diversity-in-the-nhs-ethnic-minority-representation-among-doctors (Accessed: 7 August 2024).

UK Government., 2021. 'Commission on Race and Ethnic Disparities: The Report', *gov.uk*, 31 March. Available at: https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities (Accessed: 7 August 2024).

UK Government., 2022. 'Population of the UK by country of birth and nationality: 2021', *gov.uk*, [online]. Available at: https://www.gov.uk/government/statistics/population-of-the-uk-by-country-of-birth-and-nationality-2021 (Accessed: 7 August 2024).

UK Government., 2022. 'Access to mental health services', *gov.uk,* [online]. Available at: https://www.gov.uk/government/publications/access-to-mental-health-services (Accessed: 7 August 2024).

UK Government., 2022. How to access mental health services. Available at: https://www.nhs.uk/mental-health/social-care-and-your-rights/how-to-access-mental-health-services/

UK Government., 2022. Irregular Migration to the UK Year Ending December 2022. Available at: https://www.gov.uk/government/statistics/irregular-migration-to-the-uk-year-ending-december-2022 (Accessed: 10 April 2025).

UK Government., 2023. 'Stop and Search Data, April 2021 to March 2022', *gov.uk*, 15 January. Available at: https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-march-2022/stop-and-search (Accessed: 7 August 2024).

UK Government., 2023 https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/

UK Government., 2024. 'Home Office Immigration and Nationality Fees – 24 July 2024'. Available at: https://www.gov.uk/government/publications/visa-regulations-revised-table/home-office-immigration-and-nationality-fees-24-july-2024 (Accessed: 16 August 2024).

UK Parliamentary Office of Science and Technology., 2007. *Ethnicity and Health.* Millbank. London.

UK Parliamentary Office of Science and Technology., 2022. *Mental Health Act Reform – Race and Ethnic Inequalities.* Westminster. London. Available at: https://researchbriefings.files.parliament.uk/documents/POST-PN-0671/POST-PN-0671.pdf (Accessed: 24 May 2023).

United Nations Department of Economic and Social Affairs, Population Division, 2019. *World Population Prospects 2019: Highlights*. New York: United Nations.

United Nations Development Programme (UNDP), 2009. *Human Development Report 2009: Overcoming Barriers – Human Mobility and Development*. New York: UNDP.

United Nations Development Programme, 2020. *Human Development Report 2020: The Next Frontier – Human Development and the Anthropocene*. New York: UNDP.

Van Os, J., Castle, D.J., Takei, N., Der, G. and Murray, R.M., 1996. Psychotic illness in ethnic minorities: clarification from the 1991 census. *Psychological Medicine*, *26*(1), pp.203-208.

Van Wyk, B., 2012. *Research Design and Methods.* University of Western Cape.

Vogl, S., Schmidt, E., and Zantler, C., 2019. Comparing Telephone and Face-to-Face Semi-Structured Interviews in Fieldwork on Sensitive Topics: A Case Study on Family and

Health Lifestyles. *International Journal of Social Research Methodology*, 22(6), pp. 611-624.

Vos, T., Barber, R.M., Bell, B., Bertozzi-Villa, A., Biryukov, S., Bolliger, I., Charlson, F., Davis, A., Degenhardt, L., Dicker, D. and Duan, L., 2015. Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: A systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, *386*(9995), pp.743-800.

Wahl, O. F., 1997. Mental Health and Social Change: Implications for Africa. *African Journal of Psychiatry*, 8(3), pp.162-168.

Wainberg, M.L., Scorza, P., Shultz, J.M., Helpman, L., Mootz, J.J., Johnson, K.A., Neria, Y., Bradford, J.E., Oquendo, M.A. & Arbuckle, M.R., 2017. Challenges and opportunities in global mental health: a research-to-practice perspective. *Current Psychiatry Reports*, 19(5), p.28.

Wakida, E.K., Talib, Z.M., Akena, D., Okello, E.S., Kinengyere, A., Mindra, A. and Obua, C., 2018. Barriers and facilitators to the integration of mental health services into primary health care: a systematic review. *Systematic Reviews*, *7*, pp.1-13.

Walvin, J., 1992. *Slaves and Slavery: The British Colonial Experience*. Manchester: Manchester University Press.

Ward, E.C. and Heidrich, S.M., 2009. African American women's beliefs about mental illness, stigma, and preferred coping behaviours. *Research in Nursing & Health*, *32*(5), pp.480-492.

Wardle, H. and Obermuller, L., 2019. “Windrush generation” and “hostile environment”: symbols and lived experiences in Caribbean migration to the UK. *Migration and Society*, *2*(1), pp.81-89.

Watters, C. and Ingleby, D., 2004. Locations of care: Meeting the mental health and social care needs of refugees in Europe. *International Journal of Law and Psychiatry*, *27*(6), pp.549-570.

Webber, F., 2019. On the creation of the UK’s ‘hostile environment’. *Race & Class*, *60*(4), pp.76-87.

Weber, M., 1946. *From Max Weber: Essays in Sociology.* Oxford University Press.

Weber, L. and Bowling, B., 2008. Valiant beggars and global vagabonds: Select, eject, immobilize. *Theoretical Criminology*, *12*(3), pp.355-375.

Wesseling HL. 2010. Towards a history of decolonisation. *Itinerario.* 11(2): 95-106

Wessely, S., 2019. *Modernising the Mental Health Act – Final Report from the Independent Review*. London: Department of Health and Social Care.

White, A., 2002. *Social Focus in Brief: Ethnicity 2002*. London: Office for National Statistics.

Whitelaw, S., Matheson, C., Watson, H. and Harden, J., 2017. 'Grassroots Voluntary Organisations and Mental Health Service Delivery: A Funding Crisis?', *Journal of Community Mental Health*, 23(2), pp. 142-158.

Williams, D. and Williams-Morris, R., 2000. Racism and mental health: The African American experience. *Ethnicity & health*, *5*(3-4), pp.243-268.

Williams, M. and May, T., 1996. *Introduction to the Philosophy of Social Research.* London: UCL Press.

Williams, D. R. and Mohammed, S. A., 2009. Discrimination and Racial Health Disparities: Evidence and Needed Research. *Journal of Behavioural Medicine,* 32(1), pp.20-47.

Williams, D. R., Yu, Y., Jackson, J. S. and Anderson, N. B., 2014. Racial Differences in Physical and Mental Health: Socio-economic Status, Stress and Discrimination. *Journal of Health Psychology,* 19(3), pp.288-298.

Wolfe, P. (2006). Settler colonialism and the elimination of the native. *Journal of Genocide Research, 8*(4), 387-409.

World Bank, 2015. *Africa Development Indicators 2015*. Washington, D.C.: World Bank.

World Bank, 2021. *World Bank Country and Lending Groups*. Washington D.C.: World Bank.

World Health Organisation. 2020. Good Health and Wellbeing. Goal 3: Ensure healthy lives and promote well-being for all at all ages. Available at: https://www.un.org/sustainabledevelopment/health/ (Accessed 25 May 2024).

World Health Organisation., 2022. Mental health and COVID-19: Early evidence of the pandemic’s impact. Geneva: World Health Organization; 2022. Available at: Mental

Health and COVID-19: Early evidence of the pandemic’s impact (Accessed: 21 January 2023)

Yin, R. K., 2018. *Case Study Research and Applications: Design and Methods* (6th ed.). SAGE Publications.

Yosso, T.J., 2005. Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race Ethnicity and Education*, *8*(1), pp.69-91.

Young, R. J. C., 2001. *Postcolonialism: An Historical Introduction*. Blackwell Publishing.

Zhang, Y., Xu, Z.P. and Kibriya, S., 2021. The long-term effects of the slave trade on political violence in Sub-Saharan Africa. *Journal of Comparative Economics*, *49*(3), pp.776-800.

Zubrick, S.R., Lawrence, D., Silburn, S.R., Blair, E., Milroy, H., Wilkes, T., Eades, S., D'antoine, H., Read, A., Ishiguchi, P. and Doyle, S., 2004. *The Western Australian Aboriginal Child Health Survey: The Health of Aboriginal Children and Young People*. Perth: Curtin University of Technology and Telethon Institute for Child Health Research.

Appendices

Appendix i: Ethics Approval Form

NOTTINGHAM TRENT UNIVERSITY
SCHOOLS OF BUSINESS, LAW AND SOCIAL SCIENCES

APPLICATION FORM FOR ETHICAL APPROVAL OF A RESEARCH PROJECT–2020-21

For use by members of academic staff and postgraduate research students

PLEASE NOTE THAT IT NORMALLY TAKES BETWEEN 3-6 WEEKS TO PROCESS APPLICATIONS, DEPENDING ON WHETHER THE APPLICATION NEEDS TO GO TO A FULL MEETING OF BLSS SREC (PLEASE SEE GUIDANCE NOTE: BLSS/Ethics 01 – PAGE 6). IF YOU ARE ASKED TO REVISE YOUR APPLICATION, IT MAY TAKE LONGER.

Who should use this form?
This form is for use by academic staff and research degree students in the Schools of Business, Law and Social Sciences. If you are a student on a taught masters or undergraduate programme, you should follow the procedure laid down by your School REC.

If you are a PhD student, you shouldnormallyhave received project approval before you apply for ethical approval. If there is a problem with this seek advice from your PhD supervisor.

Please note, that if following your application for project approval you find that you need to revise your research plans such that this ethics application no longer covers all aspects of your intended project, you will need to submit a revised application for ethical approval.

Can I begin work before the project is ethically approved?
If your project requires ethical approval (see overleaf and Section 1) you **must not** undertake primary data collection until a favourable ethical opinion is received from the BLSS Schools Research Ethics Committee or from an external REC. Collecting primary data in the absence of ethical approval, or in the face of an adverse ethical opinion, may constitute a disciplinary offence.

If, after receiving ethical approval, factors beyond your control change your project such that the information provided in this form no longer holds, the approval will automatically become void, and you should re-apply for ethical approval.

Is there any help available to complete this form?
Yes. Guidance on filling in this form can be found in Guidance Note BLSS/Ethics 01. If you are a member of staff, you can find the guidance document on the research SharePoint site here. If you are a PhD or Professional Doctorate student please click this linkwhich will take you to NOW, and then follow this pathway to access the form: NOW Homepage > Student Communities > NTU Doctoral School > Content > Ethics Guidance. Professional doctorate students may also find guidance in their course learning rooms.

In this site, you will also find documents dealing with specific issues in research ethics, and some examples of participant information sheets and consent forms.

Further advice is available through Research Operations. Please email annabel.cali@ntu.ac.uk.

Please note that any subsequent amendments to approved projects need to be re-submitted to BLSS SREC for further consideration. Application forms and associated documentation, including issuance of approval, will be retained indefinitely. No research or personal data will be retained, with the exception of contact details of researchers.

Please make sure that you complete the Declaration at the end of the form.

Postgraduate research students must ask their Director of Studies/Lead Supervisor to countersign the form before it is submitted. Forms submitted without countersignatures will be returned.

Completing the Form

Which sections should I complete?
Different sections of this form should be completed for different kinds of projects:

If your project involves:	
Desk-research only, using only secondary or published sources	See Section 1.
An application to an external research ethics committee (for example, those relating to research in the NHS)	Complete Sections 1-4.
Collection and/or analysis of primary, unpublished data from, or about, identifiable, living human beings (either in laboratory or in non-laboratory settings)	Complete Sections 1-7. Please also complete the checklists in Sections 8–14 and provide information, as requested, if any of the checks are positive.
Collection and/or analysis of data about the behaviour of human beings, in situations where they might reasonably expect their behaviour not to be observed or recorded	
Collection and/or analysis of primary, unpublished data from, or about people who have recently died	
Collection and/or analysis of primary, unpublished data from, or about, existing agencies or organisations	
Investigation of wildlife in its natural habitat	Complete Sections 1-5 and 15.
Research with human tissues or body fluids	Do not complete this form. Please contact your School Associate Dean for Research to discuss alternative arrangements for ethical review.
Research with animals, other than in their natural settings.	Do not complete this form. Please contact your School Associate Dean for Research to discuss alternative arrangements for ethical review.

Please type or write legibly in dark ink. You are asked to keep your answers as brief as possible, but you should provide sufficient detail for members of the Research Ethics Committee to form a view on the ethics of your proposed research. Where it is necessary, you may use up to one continuation sheet for each section of the form.

Submitting the form

Email your application to:

Annabel Cali
Research Operations
Arkwright Room B113
Email: annabel.cali@ntu.ac.uk

1 Does this project need ethical approval?

	Yes	**No**
Does the project involve collecting and/or analysing primary or unpublished data from, or about, living human beings?	x	
Does it involve collecting and/or analysing primary or unpublished data about people who have recently died, other than data that is already in the public domain?		x
Does it involve collecting and/or analysing primary or unpublished data about or from organisations or agencies of any kind, other than data that is already in the public domain?		x
Does it involve research with non-human vertebrates in their natural settings or behavioural work involving invertebrate species not covered by the Animals (Scientific Procedures) Act 1986*? *The Animals (Scientific Procedures) Act 1986 was amended in 1993. As a result, the common octopus (octopus vulgaris), as an invertebrate species, is now covered by the act.		x
Does the project involve any of the following activities: 1) Access to websites normally prohibited on university servers, for example pornography or sites of organisations proscribed by the UK Government. 2) Investigation into extremism or radicalisation. 3) Accessing and using data of a potentially damaging nature which has been obtained from a source which may not have the requisite authority to provide it. Here, potentially damaging can mean anything from information on cases of domestic abuse to data on international spy networks. In case of uncertainty, please consult Research Operations or your School Associate Dean for Research. 4) The acquisition of security clearances, including the Official Secrets Act. Hereinafter referred to as '**Special Risk Research**'.		x

FOR STAFF ONLY: If you have answered NO to <u>all</u> the questions above, you do not need to submit your project for ethical approval.

FOR PhD/PROFESSIONAL DOCTORATE STUDENTS ONLY: If you have answered NO to <u>all</u> the questions above, please complete the section below.

Name
School
Name of Director of Studies/Lead Supervisor

Signed____(Student
)

Date____

I have read this form, and confirm that, due to the nature of the research, this project does not require the approval of a research ethics committee.

Countersigned____________________________________ (Director of Studies/Lead Supervisor)

Date____

If you have answered YES to any of the questions above, please proceed to Section 2 below.

2 Information about the project

Title of Project: Exploring beliefs and perceptions towards uptake of mental health services among Black sub-Sahara African communities in the English West Midlands region
Name of Principal Investigator (PI): **Last Mafuba**
Names of co-investigators (CIs) (If any of the CIs are not employed at NTU, please give the name of their organisation):
How many additional research staff will be employed on the project? **0** Please give their names (if known) and their organisational affiliation:
Project start date: **01 October 2020**
Estimated end date of the project: **30 September 2023**
Who is funding the project? **Self** Has funding been confirmed? **Yes**
(For PhD and Professional Doctorate students only) Have you applied for and received project approval? **Yes** If so, please give date of approval: **27 April 2021**

(For PhD and Professional Doctorate students only) Please provide the name of your Director of Studies/Lead Supervisor and any other members of the supervisory team: **Dr Mathew Nyashanu – Director of Studies** **Professor Linda Gibson** **Dr Dung Jidong**
Which learned society's code of ethical practice is most relevant to your project? (*for example, the Social Research Association, the British Psychological Society, the Socio-legal Studies Association*)? **The British Psychological Society**

Does the project require Data and Barring Service (DBS) check (formerly CRB checks)

More information on DBS checks can be found by consulting document BLS Ethics 01 Guidance Staff and Students and/or from your Schools HR team (staff) or School Office (students):

	Yes	**No**
Does the project involve direct contact by any member of the research team with children, (under 18 years of age), vulnerable adults or adults in the custody of the criminal justice system?		**X**
If you have answered Yes to the above question, please explain the nature and frequency of the contact required by the project, and the circumstances in which it will be made. Please note that you may require DBS clearance and enquiries should be made of your Schools HR team to determine whether you do. This is not part of the BLSS SREC process; it must be obtained through Schools HR (staff) or your School Office (students). See section 3 in the Guidance Notes BLSS/Ethics 01.		

4 Is this project liable to scrutiny by external ethical review arrangements?

	Yes	**No**
Has a favourable ethical opinion been given for this project by an NHS or social care research ethics committee, or by any other external research ethics committee?		x
Will this project be submitted for ethical approval to an NHS or social care committee or any other external research ethics committee?		x

If you have answered YES to <u>either</u> of these questions, please sign the declaration at the end of the form and send a copy to Research Operations. Accompanying this should be a copy of the external body's ethical approval.

Ethical approval obtained at an institution with whom you are collaborating please note that it is the responsibility of researchers to remain vigilant for unethical behaviour (defined as being in opposition to the NTU Research Ethics Policy and Code of Practice for Research) of any members of the project team, regardless of institutional affiliation and the location of the ethics committee that has approved the research. If such concerns arise, researchers should inform the Chair of the most appropriate NTU REC along with their School ADR and line manager.

PhD/Professional Doctorate students must ask their Director of Studies/Lead Supervisor to countersign the form before submitting it.

Note - if you are applying to an NHS or Social Care REC, you are advised to consult Guidance Note BLSS/ Ethics 01

If you have answered NO to both these questions, please proceed to Section 5.

5 About the project

If the information required below is provided in a succinct form in a previous document, such as your application for external funding or for approval of a PhD/Professional Doctorate project you may submit this document (or preferably the relevant section from it) either in whole or partial answer to the questions below.

(i) What are the aims and objectives of the project (**maximum 250 words**)?

Research Aim

To explore beliefs and perceptions towards uptake of mental health services (MHS) among Black Sub-Sahara African (BSSA) communities in English West Midlands region.

Research Objectives
The main objective is to understand why uptake of MHS is low among BSSA communities. I will be looking to,

- **Identify socio-cultural and socio-economic issues that influence the uptake of MHS among BSSA communities.**
- **Identify beliefs and perceptions towards uptake of MHS among BSSA communities.**
- **Explore the challenges faced by MH professionals delivering MHS to BSSA communities considering their beliefs and perceptions towards MHS.**

The need to address this issue became apparent to me when I worked with asylum seekers, refugees and migrants at Coventry Refugee and Migrant Centre and Coventry Law Centre. I witnessed beneficiaries struggle to take up MHS. Later, when I researched into why recent female migrants experiencing domestic abuse do not engage the law for my Masters' thesis, I realised that high rates of MH problems existed among Black and ethnic minority communities but uptake of MHS were minimal. This motivated me in 2017, to register a social enterprise, Inini Initiative to support them tackle the challenges they face integrating into their new communities which often induces MH problems. The organisation offers advice, advocacy, one-to-one counselling therapy, information on services available and how they can be accessed and mental health and well-being training workshops. Some of Inini's beneficiaries have previously been detained under the Mental Health Act. I see them and others experiencing MH problems struggle to engage with mainstream MHS. Sadly, they often relapse and end up being re-detained. I work with various organisations that provide MHS to this community group and mainstream organisations confirm their difficulties in engaging Black and ethnic minority communities.

(ii) Briefly describe the principal methods, the sources of data or evidence to be used and the number and type of research participants who will be recruited to the project (**maximum 500 words**).

The study will take place in the English West Midlands. The location was chosen for its diverse communities; it has the largest ethnic minority population outside London (ONS, 2012). The Silences Framework (TSF) will be adopted to guide the research. Its ability to

expose additional perspectives (silences) in under-researched topics and marginalised communities (Serrant-Green, 2010) makes it a close fit for this study. More so, it values individual and group interpretations of events and views human experience as a key part of what people believe to be true (Serrant-Green, 2010) a reflexive stance this researcher holds. To support this theory the research will employ the Interpretative Phenomenological Analysis (IPA) method to collect and analyse data. This is an exploratory qualitative study method whose main aim is to provide detailed descriptions of personal lived experience (Pietkiewicz & Smith, 2014). One-to-one semi-structured interviews will be conducted with participants aged 18 – 65 years of BSSA heritage in a naturalistic conversation style. They will be recruited purposively through their community/faith group leadership and visits to specialised African establishments such as barber and food shops. The interviews will seek to produce rich understandings of socio-cultural and socio-economic issues of respondents and their beliefs and perceptions of MHS, and how these influence uptakes of MHS. Approximately 15 participants will be recruited. If saturation point is not achieved after interviewing this number recruitment will continue until it is. The interviews will be audio recorded and a verbatim transcription produced. Additionally, 4 MH professionals of no specific heritage will be recruited from grassroots and voluntary organisations that deliver MHS to BSSA communities to form a focus group. Findings from the interviews with BSSA participants will be presented to the focus group to discuss their implications for MH professionals delivering MHS to BSSA communities. Finally, a narrative account presenting the elicited themes and implications of findings for MH professionals delivering MHS to BSSA communities will be produced supported by quotations from research participants. Preferably data will be collected face-to-face and if not possible, MS Teams will be used to collect data virtually.

See attached Project Proposal for references.

(iii) What research instrument(s) will be used to collect data?

Semi-structured interviews. See interview schedule attached.

If you are using an externally validated scale, please specify:

If you are not using an externally validated scale, please attach a copy of the research instrument you will use to collect data (for example, a measurement scale, questionnaire, interview schedule, observation protocol for ethnographic work, or, in the case of unstructured data collection, a topic list).

6 Confidentiality, anonymity, security and retention of research data

	Yes	No
Are there any reasons why you cannot guarantee the full security and confidentiality of any personal, or confidential data collected for the project?	x	
Is there a significant possibility that any of your participants, or people associated with them, could be directly or indirectly identified in the outputs from this project?		x
Is there a significant possibility that confidential information could be traced back to a specific organisation or agency as a result of the way you write up the results of the project?		x
Will any members of the project team retain any personal or confidential data at the end of the project, other than in fully anonymised form?		x
If you have answered No to <u>any</u> of these questions, please explain briefly how you will ensure the confidentiality, anonymity and security of your research data, both during and after the project.		

Access to data will be restricted to me and my supervisory team. All personal information provided for the purpose of the research will be stored securely and kept private. It will be processed according to the NTU RDM Policy, Data Security – Portable Devices and Media Policy, Information Classification Policy, NTU Records Retention Policy and NTU Research Ethics Policy. Interview recordings will be kept on the secure NTU DataStore. Data and documentation will be held in separate folders. Data files will be organized by data type, then research activity. The format will be <project title>/<data collection description and number</>DDMMYYYY>. The files will be named based on the activity taking place within it and the date it happened e.g., interview 1 DDMMYYYY or interview 1 transcription DDMMYYYY. Where there is more than 1 version of data, I will use a numerical version number such as V1, V2 etc.

If the answer to any of these questions is YES, please explain:

- why it is necessary for the research to be conducted in the way you propose, such that the usual standards of confidentiality and security cannot be respected.
- what steps you will take to maximise confidentiality and security, within the constraints imposed by the research design.
- what steps you will take to ensure that participants understand and consent to the implications of these constraints.

Confidentiality will be maintained unless the participant reveals threats to harm themselves or others or break British law. The researcher may have to break confidentiality if they are seriously concerned for the participant's safety or the safety of someone else. The participant will be informed about this if it occurs. This is in line with the British Psychological Society's Code of Ethics and Conduct. This information will be included in the Participant Information Sheet for the participant to read before signing the consent form.

7 Informed consent

Please see Guidance Note BLSS/Ethics 02 for examples of model participant information sheets and participant consent forms, together with advice on how to use them

	Yes	No	N/A
Will all participants be fully informed before the project begins why the project is being conducted and what their participation will involve?	x		
Will every participant be required as a condition of their participation to give fully-informed consent to participating in the project, before it begins?	x		
Will all participants be fully informed about what data will be collected, and what will be done with this data during and after the project?	x		
If audio, video or photographic recording of participants are to be used, will fully-informed consent be secured as a condition of participation before recording begins? If yes, please provide further details below.	x		
Will every participant understand what rights they have to not take part, and/or to withdraw themselves and their data from the project if they do take part?	x		
Will they also understand that they do not need to give you reasons for exercising these rights and that there will be no repercussions as a result?	x		

Will the project involve deceiving or covert observation of participants? If YES, please provide a justification and explain the debrief process in the box below.		x	

If you have answered YES to <u>any</u> of the above questions, please explain briefly how you will implement your answers.

Participants will be randomly recruited by writing to BSSA community group and faith-based organisation leaderships. A Participant Information Sheet (PIS) detailing the study will be included. This will inform participants what participation in the study will involve including, that participation is voluntary, maintenance of their confidentiality, that they are free to pull out of the study anytime at no repercussions even after submitting their responses and that findings to the study may be published. If they are still interested in participating after reading the PIS they will be asked to complete and sign a consent form to confirm their willingness to participate. They will also be asked to give their consent verbally just before taking the interview.

You are required to attach copies of your participant information sheet and consent form as evidence of your plans.

PIS and consent form attached.

If You have answered NO to <u>any</u> of questions 1-6 above, please explain:

- the reason for you proposing to conduct the project without ensuring that all of its participants give prior fully-informed consent; and
- why you consider that reason to be sufficient justification to proceed on this basis.

8 Risk of harm – to researchers, individual participants and participating organisations

(If there is any possibility that the project involves significant risks to researchers, you are advised to consult section 8 of Guidance Note BLSS/Ethics 01 on the assessment and management of risk, and to submit a risk assessment form to the relevant authority).

	Yes	**No**
Could your research be classified as Special Risk research (see section 1 of this application form). If so, please consult Section 8 of Guidance Note BLSS/Ethics 01for more information. If Yes, your application will be required to be endorsed by your School Associate Dean for Research (please see foot of this application document). This applies to both members of staff and Postgraduate Research Students.		**x**
Does your project involve collecting data on a face-to-face basis*		**x**
• If you have answered yes to the above question* has your COVID-19 Face-to-Face Risk Assessment been inspected by Health and Safety?		

• If you have answered yes to the above question* has your COVID-19 Face-to-Face Risk Assessment been signed by the Head of Department?		
Is there any foreseeable risk that your project may lead to:	**Yes**	**No**
• Physical harm to participants or researchers?		x
• Psychological or emotional distress to participants?	x	
• Harm to the reputation of participants, or their employers, or of any other persons or organisations?		x

If you have answered YES to the question on Special Risk research, please explain/confirm:

- Explain why it is necessary to conduct the research in such a way as to qualify it as Special Risk research.
- If applicable, confirm that access to websites which may be proscribed by the UK Government or may be subject to surveillance by security services will be undertaken using the University network.
- Explain what, if any, steps will be taken, in addition to those listed in Section 6, to ensure that data obtained during the research project will be stored securely.
- If applicable, confirm that the transmission of data obtained during the research project to any co-investigators outside of the University network will be in encrypted format and using Zend, which encrypts files during transmission.
- If applicable, explain why the transportation of research data or materials is required and that an encrypted memory stick will be used where such transportation is necessary or unavoidable.

If you have answered YES to this question* please complete the COVID-19 Face-to-Face Risk Assessment template

If you have answered YES to any of the remaining questions, please explain:

- the nature of the risks involved, and why it is academically necessary for the project to incur them;
- how you propose to mitigate them;
- the arrangements by which you will ensure that participants understand and consent to these risks;
- any arrangements you will make to refer participants to sources of help, if they are seriously distressed or harmed as a result of taking part in the project;
- your arrangements for recording and reporting any adverse consequences of the research.

The research requires participants to provide detailed descriptions of lived experiences and this may evoke traumatic experiences leading to psychological or emotional distress in participants. The PIS will inform participants on this. Prior to issuing the consent form I will ask potential participants some questions to determine whether they are experiencing acute emotional distress that could make participation too risky (see Risk Protocol Form attached). Participants will also be issued with a list of Mental Health Support Services Information (see attached). I will be responsible for ensuring that interviews are carried out in a safe space. During the interview I will use my counselling skills and experience as a mental health practitioner to monitor how the interview is affecting the participant. This should help me determine when participation is affecting participants psychologically such as taking note when participants avoid talking about certain issues, start feeling awkward, ashamed, or become very emotional. This is not anticipated but should it happen, I will stop the interview and check if the participant is okay to continue. They will also be reminded they are free to withdraw from the interview with no repercussions. The participant will be referred to mental health professionals. A mental health practitioner will be on call in curse support is needed immediately.

9 Risk of disclosure of criminal offences, harm or potential harm

If the project is likely to involve work with children, or the discovery of physical or mental abuse of children, you should consult section 9 of the Guidance Note: BLSS/Ethics 01before completing this section of the form.

	Yes	No
Is there a significant risk that the project will lead participants to disclose evidence of previous criminal offences, or their intention to commit criminal offences?		x
Is there a significant risk that the project will lead participants to disclose evidence that children or vulnerable adults are being harmed, or are at risk of harm?		x
Is there a significant risk that the project will lead participants to disclose evidence of serious risk of other types of harm?		x
If you have answered YES to <u>any</u> of these questions, please explain: • why it is academically necessary for these risks to be incurred; • what actions you would take, if such disclosures were to occur; • whether you will take advice before taking these actions, and from whom; • what information you will give participants about the possible consequences of disclosing information about criminal offences or risks of harm.		

10 Payment of participants

	Yes	No
Do you intend to offer participants cash payments or any other kind of inducements or compensation for taking part in your project? If the answer is NO, please proceed to section 11.		x
Is there any significant possibility that such inducements will cause participants to consent to risks that they might not otherwise find acceptable?		
Is there any significant possibility that the prospect of such inducements will systematically skew the data provided by participants in any way?		
Will you inform participants that accepting inducements does not negate their right to withdraw from the project?		
If you have answered YES to <u>any</u> of these questions, please explain: • the nature of the inducements or the amount of the payments that will be offered; • the reasons why it is necessary to offer them; • why you consider that they are ethically and methodologically acceptable.		

11 Capacity to give valid consent

Please note, from October 2007 research involving people who are mentally incapacitated and cannot give valid consent must be cleared through the NHS research ethics procedures, not through a university REC

Do you propose to recruit any participants from the following groups?	**Yes**	**No**
• Children under 18 years of age.		x
• People with learning difficulties.		x
• People with communication difficulties, including difficulties arising from limited facility with the English language.		x
• Very infirm people.		x
• To your knowledge, people with mental health problems or other medical problems that may impair their cognitive abilities.		x
• Any other people who may not be able fully to understand the nature of the research and the implications for them of participating in it.		x
If you have answered YES to any of these questions, please explain how you will ensure that the interests and wishes of participants (and in the case of children, the wishes of their parents or guardians) are understood and taken into account.		

12 Is participation genuinely voluntary?

Do you propose to recruit participants from the following groups?	**Yes**	**No**
• Employees or students of NTU or of organisation(s) that are formal collaborators in the project.		x
• Can your research be considered to be pedagogic research, as defined as the use of student-related data for academic research purposes? See section 12 of BLSS Ethics 01 Guidance Document for further detail, particularly the distinction from learning analytics.		x
• Employees recruited through other business, voluntary or public sector organisations.		x
• Pupils or students recruited through educational institutions other than NTU.		x
• Clients recruited through voluntary or public services.	x	
• People who are resident in social care or medical establishments.		x
• People recruited by virtue of their employment in the police or armed services.		x

- People in the custody of the criminal justice system.		x
- Other people who may not feel empowered to refuse to participate in the research.		x

If you have answered YES to question 2, please explain how you will ensure voluntary participation, informed consent and clarification of your role as researcher as distinct from teacher.

If you have answered YES to <u>any</u> of these questions, please explain how your participants will be recruited, and what steps you will take to ensure that their participation in this project is genuinely voluntary.

Information about the project in the form of a Participant Information Sheet (PIS) will be circulated to participants through their community/faith group leadership and visits to specialised African establishments such as barber and food shops. Only those interested in taking part will be contacted. The PIS will fully explain that their involvement is no way linked to them being members of their faith/community groups but that of being of Black sub-Sahara African origin. They will be reminded their involvement is voluntary, and that they can withdraw at any time without any repercussions. If they are agreeable to continue with participation, they will be asked to confirm this by signing a consent form and verbally consenting just before the interview.

13 Online and Internet Research

If you intend to conduct any part of your project online, please consult Guidance Note BLSS/Ethics 03 before completing this section

	Yes	**No**
Will any part of your project involve collecting data by means of electronic media, such as the internet or email?		x
Is there a significant possibility that the project will encourage children under 18 to access inappropriate websites, or correspond with people who pose risk of harm?		x
Is there a significant possibility that the project will cause participants to become distressed or harmed, in ways that may not be apparent to the researcher(s)?		x
Will the project incur any other risks that arise specifically from the use of electronic media?		x

If you have answered YES to <u>any</u> of these questions, please explain:

- why you propose to use electronic media;
- how you propose to address the risks associated with online/internet research, especially those flagged above (if relevant).

Please ensure that your answers to other questions in this form address them in ways that are relevant to online research.

14 Other ethical risks

	Yes	No
Are there any other ethical issues or risks of harm raised by your project that have not been covered by previous questions?		X
If you have answered YES, please explain: o the nature of these issues and risks; o why you need to incur them; o and how you propose to deal with them. Note that if your professional code of conduct requires you to report misconduct in other members of your profession, you should deal with any risks that your research might trigger this obligation in this section.		

15 Research with non-human vertebrates in their natural settings or behavioural work involving invertebrate species not covered by the Animals Scientific Procedures Act (1986).

The Animals (Scientific Procedures) Act 1986 was amended in 1993. As a result, the common octopus (octopus vulgaris), as an invertebrate species, is now covered by the act.)

	Yes	No
Will any part of your project involve the study of animals in their natural habitat?		**x**
Will your project involve the recording of behaviour of animals in a non-natural setting that is outside of the control of the researcher?		**x**
Will your field work involve any direct intervention other than recording the behaviour of the animals available for observation?		**x**
Is the species you plan to research endangered, locally rare or part of a sensitive ecosystem protected by legislation?		**x**
Is there any significant possibility that the welfare of the target species or those sharing the local environment/habitat will be detrimentally affected?		**x**
Is there any significant possibility that the habitat of the animals will be damaged by the project, such that their health and survival will be endangered?		**x**
Will project work involve intervention work in a non-natural setting in relation to invertebrate species other than *octopus vulgaris*?		**x**

If you have answered YES to any of these questions, please explain:

- the reasons for conducting the project in the way you propose, and the academic benefits that will flow from it;
- the nature of the risks to the animals and their habitat;
- how you propose to mitigate these risks.

Principal Investigator’s Declaration

Please tick **all** the boxes relevant to your project and sign the form below.

PhD/Professional Doctorate students must ask their Director of Studies/Lead Supervisor to countersign it before it is submitted.

I request that this project is exempt from review by the BLSS Schools Research Ethics Committee, because it will be, or has been, reviewed by an external REC. I have completed Sections 1-4 and attach/will attach a copy of the favourable ethical review issued by the external REC Please give the name of the external REC here:	
I request a statement of ethical approval from the BLSS Schools Research Ethics Committee and confirm that I have answered all relevant questions in this form honestly.	x
I confirm that I will carry out the project in the ways described above, and that I will request a fresh ethical approval if the project subsequently changes in ways that materially affect the information I have given in this form.	x
I confirm that I have read and agree to abide by the code of research ethics issued by the relevant national learned society, and that I have ensured that all members of my research team (if any) also do so.	x
I confirm that I have read and agree to abide by the University’s Research Data Management Policy, and that I have ensured that those members of my research team (if any) who are employees of NTU also do so.	x
I confirm that I have read and agree to abide by the University’s Research Integrity policies, and that I have ensured that those members of my research team (if any) who are employees of NTU also do so.	x
I confirm that I have read the appropriate guidance documents: BLSS Ethics 01 (Staff and Students General Guidelines) BLSS Ethics 02 (Informed Consent) BLSS Ethics 03 (Online Research)	x
I confirm that I have completed all sections of the application form as appropriate.	x
I confirm that I have attached a copy of the Participant Information Sheet, Consent Form, Questionnaire and any other relevant documentation as appropriate.	x
I confirm that I have signed and dated the application form.	x
PhD/Professional Doctorate students only: I confirm that I have ensured that my application form has been endorsed by my Director of Studies/Lead Supervisor.	x
PhD/Professional Doctorate students only: I confirm that I already have project approval.	x

Mafuba

Signed____(Principal Investigator or student)

01 August 2021
Date____

I have read this form and confirm that it covers all the ethical issues raised by this project fully and frankly. I also confirm that these issues have been discussed with the PGR and will continue to be reviewed in the course of supervision.

Countersigned: Dr Mathew Nyashanu Signature ___________(Director of Studies/Lead Supervisor)

Date_____9th of August 2021

Note: If you are submitting this form by email, you should type your name in the signature space: an email attachment sent from your university inbox will be assumed to have been virtually signed by you.

If you are a student and are submitting this form by email, please attach an email from your Director of Studies/Lead Supervisor confirming that they are prepared to make the declaration above and to countersign this form: this email will be taken as a virtual countersignature.

Special Risk Research Only

I have read this form and confirm that appropriate steps have been taken to mitigate the special risks associated with the proposed project.

Countersigned____________________________________(School Associate Dean for Research)

Date____

Appendix ii: Participant Information Sheet

NOTTINGHAM
TRENT UNIVERSITY

School of Social Sciences, Nottingham Trent University

Participant Information Sheet - Offline

Title of Project: Exploring beliefs and perceptions towards uptake of mental health services among Black sub-Sahara African communities in the English West Midlands region

Name of Researcher: Last Mafuba

Name of Supervisors: Dr Mathew Nyashanu, Professor Linda Gibson, Dr Dung Jidong

Invitation

You are being invited to take part in this PhD research project. Before you decide if you would like to take part, it is important you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the project's purpose?

This research project aims to explore beliefs and perceptions towards uptake of mental health services among Black sub-Sahara African communities in the English West Midlands region. The researcher is seeking to have a deeper understanding of the following.

- What socio-cultural and socio-economic issues influence the uptake of mental health services among Black sub-Sahara African communities?
- What beliefs and perceptions do Black sub-Sahara African communities hold towards uptake of mental health services?
- What are the challenges and implications for mental health professionals working with Black sub-Sahara African communities?

Why have I been chosen?

In order to maximise the researcher's listening and the breadth and diversity of respondents they wish to listen to as many voices as possible. As someone who is a member of the Black sub-Sahara African community living in the English West Midlands region, they would like to hear your general view and, what beliefs and perceptions you have towards the uptake of mental health services.

Do I have to take part?

No – you do not need to take part in this research if you do not want to.
The decision is up to you. If you do decide to take part, you will be asked to read a consent form and give your consent verbally before you start the interview. This means that you have understood the information presented here and that you still wish to take part. You will also be asked to give your consent for the researcher to use quotes from your interview in the final research report.

If you decide to take part in the interview and change your mind later this is okay. You are free to leave the interview at any time, even if the interview has already started, without explanation and with no repercussions whatsoever. If you decide to withdraw from the interview, all the answers you gave will not be written up, and in turn will be destroyed. You have the right to choose not to answer any of the questions the interviewer asks you – please let the researcher know if this is the case.

What do I have to do?

You will be asked to take part in an interview. This will be conducted by the researcher.

The interview will last between 60 – 90 minutes, depending on how long you wish to talk for. You can take a break or choose to end the interview at any time.

At the start of the interview, you will be asked to provide some basic personal information, such as your age, gender, ethnicity, contact details, mental health details and access to mental health services. The interview will be recorded using a digital audio recorder. The recording of the audio will be kept strictly confidential. This means no-one besides the researcher and her supervisory team will be able to listen to it. The researcher will use the audio recording to type up the interview word-for-word. When doing this, the researcher will make sure they remove any names or information that could be used to identify you. This means that any personal information such as age, gender etc will not be included on the written version of the interview and will stored separately.

The written version of the interview will be analysed and used to produce the final research report. No information which could be used to identify you will be included in the research report. After your interview is typed up, the audio recording will be destroyed.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those participating in the research, it is hoped that this work will have a beneficial impact on how mental health services in the English West Midlands region are designed and delivered. Taking part in this research will be useful in giving you an opportunity to tell us about your general view, beliefs and perceptions towards uptake of mental health services. In doing so, you will be helping the researcher to better understand how well mental health services in the English West Midlands region are meeting the needs of people from Black sub-Sahara African communities.

Are there any possible risks for taking part?

The aim is to make the interview feel like a relaxed conversation, which you will hopefully find interesting and enjoyable. However, it is possible that you might find some of your experiences difficult or upsetting to talk about. If you feel uncomfortable answering a question it is important that you are aware that you only need to answer those questions that you wish to. If you begin to feel upset, the interviewer will pause the interview to check whether you are okay and give you some time to decide whether you would like to continue with the interview. You can end the interview at any point, and you can withdraw your data from the study 7 days after the date of your interview.

If there have been any issues raised, as a result of participating in this research, that you feel you wish to talk to someone about please contact a confidential mental health support service in your local area. An information sheet detailing free, 24-hour helplines, text and online support can be found in the Mental Health Support Information sheet provided alongside this Participant Information Sheet.

Will my taking part in this research be kept confidential?

All of the personal information you provide for the purpose of this research will be stored securely and kept private. It will be processed in line with Nottingham Trent University Research Data Management Policy and treated in accordance with the General Data Protection Regulations (GDPR), the Data Protection Act 2018 and the British Psychological Society's Code of Ethics (2018).

If you agree to the interview being audio-recorded, the recording will be kept on a secure computer server belonging to Nottingham Trent University (NTU DataStore). When stored, it will be labelled using a unique interview number rather than a name so that it cannot be identified as your interview audio-recording. The only people who will access the audio recording will be the researcher and their supervisors to produce the final research report. If any material from your interview such as, word for word quotes is used in the final report, this will be done anonymously. If you are referred to in the final report, you will be assigned a participant ID number to maintain your anonymity.

Your data will be anonymised as quickly as possible after data collection. Your data may be withdrawn from the study a week following the completion of the interview. This means it will not be possible to withdraw your answers to questions after this point. Please contact the researcher no later than seven days of the date of the interview quoting your participant ID number which will be given to you at the end of the interview. After this date the data will be de-identified. This means any information which could be used to identify you will be removed from the written version of the interview. Once this has been done, it will no longer be possible to remove your data as it will not be possible to identify or link it to you.

All the information you provide will be kept private unless there is a risk of harm to you or someone else/or you disclose intent to commit a criminal offence. You will be informed about this if it occurs. This is in line with the British Psychological Society's Code of Ethics and Conduct.

What will happen to the results of the study?

The results of this study will be reported in the researcher's PhD dissertation and possibly be published in journal publications and conference presentations. The final report will be shared with the Coventry and Warwickshire NHS Partnership Trust working together group.

What happens if the research stops earlier than expected?

Should the research stop earlier than planned and you are affected in any way we will tell you and explain why.

Who is organising the funding of the research?

The researcher is self-funding this project.

Who has ethically reviewed the project?

This project has been ethically reviewed and approved by Nottingham Trent University's Ethics Review Committee.

Who should I contact if I want further information?

Researcher: Last Mafuba
Mobile number: 07783 957105
Email Address: last.mafuba2020@my.ntu.ac.uk

Making a Complaint

If you are unhappy with any aspect of this research, please first contact the researcher, Last Mafuba at last.mafuba@my.ntu.ac.uk

If you still have concerns and wish to make a formal complaint, please email the following:

Dr Mathew Nyashanu – Mathew.nyashanu@ntu.ac.uk
Professor Linda Gibson – linda.gibson@ntu.ac.uk
Dr Dung Jidong – dung.jidong@ntu.ac.uk

In your email, please provide information about the research project, specify the name of the researcher and detail the nature of your complaint.

Thank you for taking time to read this Participant Information Sheet

Appendix iii: Informed Consent Form

NOTTINGHAM
TRENT UNIVERSITY

INFORMED CONSENT FORM

Research Project Title: Exploring beliefs and perceptions towards uptake of mental health services among Black sub-Sahara African communities in the English West Midlands region

Thank you for agreeing to be interviewed as part of the above research project. Ethical procedures for academic research undertaken from English institutions require that interviewees explicitly agree to being interviewed and how the information contained in their interview will be used.

There is no time limit to this interview, it may be as long or as short as you need. Most interviews last 60 – 90 minutes. We do not anticipate that there are any risks associated with your participation, but you have the right to stop the interview or withdraw from the research anytime.

This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation. Would you therefore read the accompanying information sheet and then sign this form to certify that you approve the following?

- The interview will be recorded, and a transcript will be produced.
- You will be sent the transcript and given the opportunity to correct any factual errors.
- The transcript of the interview will be analysed by Last Mafuba as lead research investigator.
- Access to the interview transcript will be limited to Last Mafuba and her supervisory team; Dr Mathew Nyashanu, Professor Linda Gibson and Dr Dung Jidong.
- Any summary interview content, or direct quotations from the interview, that are made available through academic publication or other academic outlets will be anonymised so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is removed.
- The actual recording will be destroyed once the research project is complete.

Quotation Agreement

I also understand that my words may be quoted directly. With regards to the quoted, please initial next to any of the statements that you agree with.

	I wish to review the notes, transcripts, or other data collected during the research pertaining to my participation.
	I agree to be quoted directly.
	I agree to be quoted directly if my name is not published and a made-up name (pseudonym) is used.
	I agree the researchers may publish documents that contain quotations by me.

All or part of your interview may be used:

- In academic papers, policy papers or new articles.
- In an archive of the project as noted above.

By signing this form, I agree that;

1. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time.
2. The transcribed interview or extracts from it may be used as described above
3. I have read the information sheet
4. I don't expect to receive any benefit or payment for my participation.
5. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality.
6. I have been able to ask questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

____

Print Name

____

Participant's Signature Date

____

Researcher's Signature Date

Appendix iv: Data Collection Questionnaire

SEMI-STRUCTURED QUESTIONS INTERVIEW SCHEDULE

Ground Rules

Please state

- The approximate duration of the interview
- That the interview will be asking for individuals' beliefs and perceptions towards mental health services in the English West Midlands. There is no right or wrong answer.
- That the participant is free to leave the interview at any time, whether that be to withdraw from the study entirely, or to take a break
- If they would like to ask any questions throughout, not to hesitate to ask the researcher.

Demographic Information Interview

1. What is your name?

2. How old are you?

3. What is your gender?

4. What is the first part of your post code?

Main Interview

Understanding the socio-cultural and socio-economic issues faced by participants

1. What country are you from and what brought you to England?
   Prompts

2. What type of accommodation do you live in?
   Prompts

3. Do you go out to work or are you at home?
   Prompts

Understanding what socio-cultural and socio-economic issues influence the uptake of mental health services?

4. Can you tell me whether you think your experiences in the UK have influenced your well-being and personal development? If so, how?
   Prompts

Understanding participants' beliefs and perceptions towards uptake of mental health services.

5. If a doctor told you that you were suffering from depression, what would you do?
   Prompts

6. Have you or someone you know had any experiences with mental health services? If so, what do you think about them?
   Prompts

7. What are the things your culture does that help with mental illness such as, sadness, anxiety or bad experiences?
   Prompts

8. Do you have any questions for me about mental health services or is there something you want to tell me that we haven't talked about?

Appendix v: Mental Health Support Services Information

Mental Health Support Services

Help and support is available right now if you need it. You do not have to struggle with difficult feelings alone.

Phone a helpline

These free helplines are there to help when you're feeling down or desperate.
Unless it says otherwise, they're open 24 hours a day, every day.
You can also call these helplines for advice if you’re worried about someone else.
Information:

Samaritans – for everyone
Call 116 123
Email jo@samaritans.org

Campaign Against Living Miserably (CALM)
Call 0800 58 58 58 – 5pm to midnight every day
Visit the webchat page

Papyrus – for people under 35
Call 0800 068 41 41 – 9am to midnight every day
Text 07860 039967
Email pat@papyrus-uk.org

Childline – for children and young people under 19
Call 0800 1111 – the number will not show up on your phone bill

SOS Silence of Suicide – for everyone
Call 0300 1020 505 – 4pm to midnight every day

Message a text line

If you do not want to talk to someone over the phone, these text lines are open 24 hours a day, every day.

Shout Crisis Text Line – for everyone
Text “SHOUT” to 85258

YoungMinds Crisis Messenger – for people under 19
Text “YM” to 85258

Are you a young person who needs help? Text BREATHE to 85258 for free and confidential support. **Stop.Breathe.Think** is a free and confidential mental health service where young people can talk or text about anything.

Urgent all-age Mental Health support – provided by Coventry and Warwickshire Partnership NHS Trust

NHS Mental Health Crisis Service: Telephone Number: Free phone 08081 966798 (Hours of operation: 24 hours a day, seven days a week).

Description: This crisis service is aligned to our Mental Health Access Hubs, and when you contact us, we will explore with you the nature of your crisis and assess with you if we need to make arrangements for you to visit us or for us to come and visit you at your home. This service is operated by a range of experienced NHS staff and clinicians with specific expertise in crisis and de-escalation interventions. If you call us, we will be able to guide you to service offers available to you across Coventry and Warwickshire.

Specific Information for Children and Young People -- Rise Crisis & Home Treatment Team: Telephone Number Free phone 08081 966798 (select Option 2)

Description: The Rise Crisis & Home Treatment team (Coventry & Warwickshire Partnership NHS Trust) provides multi-disciplinary support to children and young people (under 18s) who present in mental health crisis.

Other sources of Mental Health Support

For mental health support, we also recommend looking at the Stay Alive app.

If you are concerned about the mental health of someone you know, please see some advice and guidance from Shining a Light on Suicide.

Coventry Safe Haven is open 6pm - 11pm every day. Book an appointment on 07850 901146.

For urgent calls for children and young people who are experiencing a mental health crisis please contact the Rise Crisis Team between 8am-8pm 7 days a week. Outside of these hours our advice-only service is available, enabling support 24-hours a day, 7-days a week. More information about children and young people's mental health can be found on the Rise website.

The Rise Crisis & Home Treatment team (Coventry & Warwickshire Partnership NHS Trust) provide multi-disciplinary support to children and young people (under 18s) who present in mental health crisis.

Birmingham and Solihull Urgent Mental Health Helpline (line managed by MIND)

If urgent mental health help is needed you can ring 0121 262 3555 for advice and support. This line is available 24 hours, 7 days a week and can be used whether you are known to our services or not.

Wolverhampton Mental Health support

People living in the Black Country now have easier access to a specialist mental health helpline with the introduction of a new **freephone number**.

The NHS mental health crisis helpline is run by Black Country Healthcare NHS Foundation Trust and is open 24 hours a day, seven days a week and is open to people of all ages – including children and young people.

Particularly suited to those who feel like they need urgent help, the helpline is manned by specialist mental health staff that will provide advice, support and signposting over the phone.

Existing service users are encouraged to maintain their usual route of contact.

People can access the 24/7 freephone number by calling 0800 008 6516.

Alongside those in crisis, for more common mental health problems such as low mood, depression, anxiety and stress people can self-refer to Healthy Minds / Improving Access to Psychological Therapies (IAPT) services.

Dudley Talking Therapies, Tel: 0800 953 0404

http://www.dwmh.nhs.uk/dudley-talking-therapy-service/

Sandwell Healthy Minds, Tel: 0303 033 9903

https://www.sandwellhealthyminds.nhs.uk/

Walsall Talking Therapies, Tel: 0800 953 0995

http://www.dwmh.nhs.uk/walsall-talking-therapies-service/

Wolverhampton Healthy Minds, Tel: 0800 923 0222 or 01902 441 856

https://www.wolverhamptonhealthyminds.nhs.uk/

Talk to someone you trust

Let family or friends know what's going on for you. They may be able to offer support and help keep you safe.

There's no right or wrong way to talk about suicidal feelings – starting the conversation is what's important.

Who else you can talk to?

If you find it difficult to talk to someone you know, you could:

- **call a GP** – ask for an emergency appointment
- **call 111** out of hours – they will help you find the support and help you need

Appendix vi: Risk Assessment Questionnaire

RISK ASSESSMENT

Screening Interview

The researcher will ask the following questions to determine whether potential participants are experiencing acute emotional distress that would make participation too risky.

1. Are you experiencing any of the following?

    - Significant stress
    - Severe emotional problems
    - Alcohol/drug addiction
    - Thoughts of harming yourself

2. Have you had any recent psychiatric hospitalisations in the last 12 months?

3. Are you taking any prescribed medication?

4. Are there any reasons you can think of that might make participating in an interview about your life experiences in England and mental health services too stressful for you?

If an individual shows signs of acute emotional distress the researcher will say **no** to participation. They will state that the university will not allow it. Otherwise, if no signs of emotional distress are detected individuals will be asked to read and sign the consent form.

Appendix vii: Constructing Experiential Statements Sample

An extract from the Table of Experiential Themes (PETs) for Kodjo.

Experiential Statements	Interview Content	Exploratory Notes
Disturbed/embarrassed by the fact that he is unemployed and has to hustle to make ends meet.	**Interviewer:** No, you're not working. Okay. So, it's more like you just stay at home or what do you do? **Participant:** Um, (long pause) I just know how to survive **Interviewer** <giggles> you just know how to survive?	Um, (long pause) I just know how to survive
As a man he looks for ways to sustain himself	**Participant** (shows discomfort). Yeah. Yeah. Okay. I just consider myself a man. I just know how to survive. **Interviewer** Yeah, no, I do understand. I do understand there… why is it that you, you cannot work, but have to, to learn how to, to survive?	I just consider myself a man.
He does not have the right to work in England.	**Participant** (reluctant to respond at first) Yeah. It's because at the moment, um, I'm undocumented.	It's because at the moment, um, I'm undocumented.

Appendix viii: Participants' Data Clusters

An extract from Jabu's data clusters

1. **Challenges of being an asylum seeker**

    - Living in shared accommodation with other asylum seekers and migrants – page 2
    - Based on my current circumstances, I'm grateful for where I'm staying – page 2
    - Blames HO for his current situation – page 3
    - I cannot do many things for myself at the moment until my situation gets regularised – page 3
    - Frustrated about HO policies that is a barrier to many things for him – page 3
    - I don't have my own kitchen – page 3
    - Immigration is like a disability almost – page 4
    - I feel stuck and disabled socially – page 4
    - My options are limited – page 4
    - I've met other people in the same situation
    - Receives information and advice from CRMC regarding immigration – page 6

2. **Challenges of integration**

    - Grassroots orgs like Inini are good for my mental health because I come out of the house and spend time with peers which is something I enjoy – page 7
    - I found it uncomfortable at first because of language barriers – page 8
    - English is not my first language – page 8
    - That itself is a cultural shock and a cultural change for me – page 8
    - I had to adapt to a new culture – page 8
    - I had to learn a new language and culture – page 9
    - I was quick to learn and adapt because of my young age – page 9
    - As a kid you soak in things much quicker – page 9
    - I became more integrated quickly – page 9
    - I found myself somehow accepting the culture much quicker than I realised – page 9
    - The other challenge is he struggled to bond with his mother because they were separated when he was only 3 years for almost 10 years – page 10
    - That was the first time meeting my mother – page 10
    - When I came here it was first time actually seeing her proper face-to-face – page 10
    - So that was the thing I had to deal with as well. Not having that emotional bond with my mother – page 10
    - I don't have memories of growing up with mum like the ones that people have with mothers – page 11
    - She used to provide for me – page 11
    - I knew I had a mother somewhere, but that bond was not there – page 11
    - It was an emotional issue – page 12

- I was a kid and growing up I knew other kids had their mums – page 12