

From Research Participants to Research Partners: Exploring Female Migrant Mental Health Needs and Service Access in South England Through a Collaborative and Mixed Method Process

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A thesis submitted in partial fulfilment of the requirements of the University of Brighton and the University of Sussex for a programme of study undertaken at Brighton and Sussex Medical School for the degree of Doctor of Philosophy.

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Declaration

I hereby declare that the thesis entitled "*From Research Participants to Research Partners: Exploring Female Migrant Mental Health Needs and Service Access in South England Through a Collaborative and Mixed Method Process*", submitted for the degree of Doctor of Philosophy (PhD), is my original work and has not been submitted previously, in whole or in part, to any other university or institution for the award of any degree or diploma. I am aware of and understand the university's policy on plagiarism and certify that this thesis complies with those standards.

I confirm that this work was done wholly or mainly while in candidature for a postgraduate research degree at the Brighton and Sussex Medical School, in the Department of Primary Care & Public Health.

To the best of my knowledge, the thesis does not contain any material previously published or written by another person, except where due reference is made in the text of the thesis. Where I have consulted the published work of others, this is always clearly attributed. I have acknowledged all main sources of help.

Any contribution made to the research by others, with whom I have worked at Brighton and Sussex Medical School or elsewhere, is explicitly acknowledged in the thesis. I have also made clear the extent to which I have used the assistance of a third party, including for any language translation, language editing, proofreading, or formatting.

This thesis conforms to the required format and meets the requirements set out in the university's regulations.

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Abstract

Background: This thesis critically examines the mental health challenges and needs of female migrants, employing a mixed-methods approach. It had four primary objectives:

1. Establish a collaborative research framework for female migrant health.
2. Explore the obstacles and facilitators to accessing mental health support.
3. Examine key themes and coping strategies for mental health challenges.
4. Compare referral patterns and diagnostic severities between female migrants and their British-born counterparts.

Methods: The PhD included four work packages aligned with the research objectives:

1. Over 28 months, develop and utilise a collaborative research framework with a core co-production group of female migrants and professionals.
2. Conduct a systematic review analysing barriers and facilitators in mental health support, using a feminist perspective, complemented by a lived experience commentary.
3. Perform qualitative interviews with 18 female migrants, employing reflexive thematic analysis to understand their mental health needs and service access.
4. Analyse referral pathways and diagnostic severity through secondary analysis of patient data from the South London and Maudsley Mental Health Trust's Clinical Records Interactive Search, which encompassed 40,833 British-born women and 18,991 foreign-born women at the time of the research.

Findings: The co-designed Empowering Migrant Bridges: Active Research and Knowledge (EMBaRK) framework grounded in gender sensitivity, cultural security and participatory methods, guided the research and shaped the analysis.

Systematic review findings: The review identified 19 studies. Barriers included information scarcity, stigma, religious and cultural practices, and a lack of gender-specific considerations. Facilitators included gender-sensitive services, supportive general practitioners, and religious leaders.

Qualitative findings: Interviews confirmed these barriers, revealing how structural violence and systemic inequities exacerbate socio-economic disparities and cultural stigma. Interpreter limitations, distrust in services, and the male gaze further compounded access issues. Trust-building with providers, alongside faith and spirituality, emerged as essential facilitators of engagement.

Quantitative findings: Analysis of clinical records from 59,824 women revealed significant disparities. Foreign-born women were more likely to be referred through emergency pathways (OR = 1.331). Severity differences were driven by ethnicity, not migrant status alone. Despite lower odds of emergency referrals for Black women (OR = 0.771), their raw numbers remain high due to systemic, socio-economic, and cultural factors.

Conclusions: The EMBaRK process was central to addressing gendered and racialised healthcare disparities by embedding cultural security and lived experience at every stage of the research. This thesis highlights the critical need for inclusive, co-produced, and culturally sensitive healthcare that acknowledges structural violence and the intersecting challenges faced by female migrants. Addressing stigma, fostering trust, and promoting tailored

approaches to healthcare delivery can mitigate barriers and improve mental health outcomes for migrant populations.

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Chapter 1: Background to the PhD Project

1.1 Overarching rationale, research question, and theoretical framing

Migration is a deeply gendered phenomenon, with female migrants often confronting unique challenges that intersect with social, cultural, and economic inequalities (1,2). These challenges significantly impact their mental health and access to care, yet they remain underrepresented in both research and public policy (1,2). This thesis addresses this gap by exploring the mental health needs of female migrants in Southeast England, focusing on the barriers and facilitators they encounter in primary and community healthcare settings.

This thesis positions stigma as a central conceptual lens through which the mental health challenges faced by female migrants are examined. Stigma operates at the nexus of mental health and migration, intersecting with systemic inequities rooted in race, gender, and socioeconomic status (3–5). Introducing intersectionality as an overarching theoretical approach early in this thesis enables a comprehensive understanding of how multiple identities and structural oppressions converge to shape experiences of exclusion and discrimination (6). This approach builds on Goffman’s foundational work on stigma and Crenshaw’s conceptualisation of intersectionality, ensuring that the analysis remains rooted in the lived realities of female migrants.

The research is guided by the overarching question: *What are the mental health challenges and needs of female migrants?*

The research’s commitment is to answer this question by shifting the role of female migrants from passive participants to active collaborators in the research process. This thesis is deeply informed by feminist theoretical perspectives, which serve as its foundational framework. Feminist theory, with its commitment to analysing and challenging power structures, provides a critical lens for understanding the complexities of gender inequality (7). Specifically, this research draws upon feminist emphases on equity, understood as the just distribution of resources and opportunities (8); empowerment, which focuses on enabling individuals and groups to exercise agency and self-determination (9); and the critique of structural inequalities, which examines how systemic power imbalances perpetuate discrimination and disadvantage based on gender and its intersections with other social categories (6,10). Central to this framework is standpoint theory, which underscores that knowledge is socially situated and that marginalised groups, by their lived experiences,

possess a unique and valuable perspective on systems of power (11). For female migrants, this perspective emerges from their direct encounters with intersecting oppressions, including gender, race, class, and legal status. By centring these voices, this thesis seeks to uncover systemic barriers and identify opportunities for change.

Closely aligned with standpoint theory is intersectionality, a concept developed by Kimberlé Crenshaw (12) to illuminate how overlapping systems of oppression impact female migrants' mental health. Intersectionality reveals the compounding barriers faced by female migrants, such as cultural stigma, economic precarity, and restrictive immigration policies, offering a lens to understand their experiences in greater depth.

Incorporating insights from Black feminist thought, this thesis further explores how structural inequalities are experienced differently depending on race, ethnicity, and migration history. Scholars such as Patricia Hill Collins (11) and bell hooks (13) have highlighted the resilience and agency of marginalised women, emphasising the importance of community and collective action in addressing systemic barriers. These perspectives align with the principles of feminist participatory action research (FPAR) (14), which underpin the methodology of this thesis.

FPAR transforms the research process into a collaborative and empowering endeavour. Rooted in feminist principles, FPAR involves participants as co-researchers, ensuring their voices shape the research design, data collection, and interpretation of findings (14,15). This methodology not only amplifies the lived experiences of female migrants but also promotes social justice by fostering trust and accountability within the research process.

FPAR is particularly well-suited to researching female migrants as it fosters empowerment in marginalised communities by actively involving participants in every stage of the research process. This approach aligns with feminist principles by challenging traditional power dynamics in knowledge production, giving participants greater agency and voice (16,17). For female migrants, many of whom experience systemic barriers and social exclusion, FPAR provides an opportunity to co-create solutions that address their unique needs. It builds trust, recognises lived experiences as critical sources of knowledge, and ensures that research outcomes are both relevant and actionable.

The Empowering Migrant Bridges: Active Research and Knowledge (EMBaRK) framework, developed as part of the engagement processes across the different studies in the thesis,

operationalises these principles, providing a structured yet flexible approach to engaging marginalised communities.

1.2 Positionality as a male researcher

As a male researcher investigating the mental health needs of female migrants, I recognise the importance of positionality in shaping the research process and its outcomes. Positionality refers to how a researcher's identity, experiences, and social location influence the questions they ask, the methods they use, and their interactions with participants (18). This approach aligns with the feminist tradition of reflexivity (19). Throughout this PhD journey, my gender, cultural background, and professional positions have played a critical role in framing the research, interpreting the findings, and engaging with the co-researchers and participants.

Acknowledging my positionality begins with understanding the power dynamics inherent in conducting research with vulnerable populations. Female migrants often navigate multiple intersecting oppressions, including gender, race, and migration status, which shape their access to mental health services and their engagement with researchers. As a male researcher, I approached this work with a commitment to creating a research environment that prioritised respect, trust, and empowerment. This was achieved through FPAR, which actively involves participants as co-researchers, ensuring their voices shape the research design, data collection, and analysis. What I did find helpful though was the co-creation of the EMBaRK framework, or ways of working together, that helped foster shared understanding, mutual respect, support and discovery which helped everyone involved in the research journey.

My identity as a male researcher also brought certain privileges and challenges. On one hand, my professional affiliations and academic credentials afforded me access to resources and networks that supported the study. On the other hand, I was conscious of the potential for my gender to create barriers in building trust with female participants. To address this, I relied on the principles of FPAR, ensuring the research process was co-created with participants and guided by their perspectives. By doing so, I sought to minimise the hierarchical dynamics that can arise in traditional research settings.

Additionally, my personal experiences as a Black male researcher with lived experience of mental ill-health informed my understanding of systemic oppression and resilience. While my lived experiences do not mirror those of the participants, they provided a lens through which to empathise with their struggles and critique the structural inequities that perpetuate mental health disparities. This shared understanding of marginalisation, albeit from different

standpoints, deepened my commitment to conducting ethical, inclusive, and impactful research.

1.3 Mixed Methods Framework

Mixed methods research, which combines qualitative and quantitative approaches, provides a robust methodological framework for addressing complex research questions. Johnson, Onwuegbuzie, and Turner (2007) define mixed methods as the purposeful integration of qualitative and quantitative methods to harness their respective strengths and offset their limitations (20). A mixed-methods design was chosen to capture the multifaceted nature of female migrants' mental health challenges. This approach allowed for the integration of qualitative lived experiences and quantitative service data to provide a comprehensive understanding.

The decision to adopt a mixed-methods approach was informed by a growing body of literature advocating for its use in health research. Moran-Ellis et al. (2006) emphasise the importance of triangulation in enhancing validity by synthesising diverse data sources (21). Similarly, Morgan (2007) highlights pragmatism as a guiding philosophy for combining methods, prioritising the research question over epistemological divides (22). This literature provided a foundation for structuring the study, ensuring that each method contributed to a holistic understanding of the barriers and facilitators to female migrants' mental health.

The development of the EMBaRK framework, discussed in detail in Chapter 2, aligns with the mixed-methods approach by operationalising feminist participatory action research principles to centre participant agency and inclusivity.

Applying mixed methods in the thesis

The project was conducted in three interconnected phases, each designed to address a specific aspect of the overarching research question. The first phase, a systematic review (Chapter 3), synthesised existing literature to identify key barriers and facilitators to mental health service access for female migrants. This review also informed the design of the subsequent qualitative and quantitative studies by highlighting critical gaps in evidence. Building on this, the second phase (Chapter 4) used in-depth interviews to capture the lived experiences of female migrants, providing rich narratives that contextualised the systemic trends identified in the review. Finally, the third phase (Chapter 5) employed statistical analysis to examine disparities in mental health outcomes and service utilisation, offering a broader perspective

on patterns and inequities. This sequential design demonstrated the value of mixed methods in addressing the research question. Each phase contributed distinct insights, and their integration provided a comprehensive understanding of the research problem. For a complete overview of how these phases fit into the structure of the thesis, see Section 1.12, "Overview of the PhD Thesis."

Navigating challenges and conflicts

While mixed methods offer significant advantages, challenges arose in reconciling differing paradigms and findings. For example, quantitative data suggested improvements in service access, while qualitative narratives highlighted ongoing challenges, such as stigma and cultural barriers. As Moffatt et al. (2006) note, such conflicts are common in health research and require careful interpretation (23). In this thesis, these tensions were addressed through reflexive analysis, ensuring that both data sets were contextualised and given equal weight.

Pragmatism, as advocated by Morgan (2007), provided a useful lens for navigating these challenges (22). By focusing on the research question, rather than rigid adherence to methodological traditions, the thesis was able to synthesise diverse findings into a cohesive narrative. This approach also reinforced the principles of feminist participatory action research, ensuring that participants' voices remained central to the analysis.

Impact on the Thesis

The mixed-methods framework fundamentally shaped the thesis by enabling a multidimensional exploration of female migrants' mental health needs. It allowed for the integration of systemic trends with individual narratives, providing actionable insights for service design and policy. Moreover, the use of mixed methods strengthened the validity of the findings through triangulation and reinforced the thesis's commitment to inclusivity and equity.

By addressing both the strengths and challenges of mixed methods, this thesis contributes to the growing body of literature on combining qualitative and quantitative approaches in health research. The integration of these methods not only enriched the findings but also demonstrated their potential for tackling intersectional and systemic health disparities.

1.4 Contextualising migration and mental health

Worldwide there were an estimated 272 million international migrants in 2019, approximately 3.5% of the global population, according to the United Nations (24). The

International Organization for Migration (IOM) defines the term ‘migrant’ as an umbrella term to describe *“a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons”* (25). In recent years there has been a major increase in migrations globally (26), with Europe also seeing a significant rise in migration to and within its borders (27). Over 5.2 million individuals arrived on European shores by 2016 (28). In what has been termed the ‘migrant crisis’ arising from wars and political instabilities, mainly in the Middle East, Asia, and South America, over one million individuals sought refuge in Europe in 2015 alone (29). Due to the worldwide coronavirus 2019 pandemic forcing the closure of borders and country migration policies, migration to Europe slowed down, however, with the easing of restrictions on borders, there has been an increase in migration to Europe with over 50,000 international migrants recorded as arriving in Europe between January and August 2020 (30). By 2022, the European Union had issued 3.7 million new residence permits, a 700,000 rise since 2019 (31). According to the IOM, there were 875,000 new asylum applications, excluding Ukrainian applicants, in 2022, a rise of 52% since 2021 (31).

Although infrequently reported in news outlets or publicly acknowledged, female migrants make up over half (51.6%) of all European migrants (32). Female migrants account for over 74% of staff in the service industry, most in low-paid jobs (33). Similar figures of 70% of healthcare workers are female, with female migrants making a greater proportion, again in lower-paid jobs (34).

1.5 Consequences of the Coronavirus 2019 global pandemic and Brexit on female migrants

On the 11th of March 2020, the World Health Organisation (WHO) declared the coronavirus disease (COVID-19), caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a global pandemic (35). To mitigate the proliferation of the virus, the majority of nations worldwide enacted legislation to curtail movements and social interactions, resulting in approximately one-third of the global populace being subjected to various forms of restrictions (36). Influential global politicians placed the blame on migrants and ethnic groups for the origins and spread of COVID-19, for example, Salvini in Italy and Orbán in Hungary, engaged in xenophobic scapegoating, attributing the viral uptick to African and Iranian migrant communities (37,38). Donald Trump's "China virus" rhetoric in the United States of America similarly emphasised national origin, potentially exacerbating prejudice amongst ethnic minorities with attributes related to these accusations (36). These, and other

factors resulted in individual, structural, and societal barriers hindering the uptake of the vaccines through willingness and accessibility during the pandemic amongst migrant communities (39–41).

The implications of Brexit on female migrants have been profound, reshaping migration patterns and workforce dynamics in the UK. Post-Brexit immigration policies, such as the points-based system, have prioritised skilled labour while limiting pathways for low-skilled workers, disproportionately affecting female migrants employed in sectors like healthcare, hospitality, and domestic work (42). These shifts have created gaps in workforce participation, particularly in industries heavily reliant on EU migrant labour, and increased the reliance on non-EU migrants, many of whom face heightened systemic barriers such as precarious visa statuses and cultural stigmas. This context underscores the importance of addressing the structural and gendered inequities that shape female migrants' access to employment and healthcare services in the UK.

While the COVID-19 pandemic shaped the broader context of this research, including its impact on migrant health and access to services, this thesis situates its analysis within the ongoing structural and systemic challenges faced by female migrants. The pandemic's influence is noted primarily in terms of its methodological implications, discussed in Chapter 2.

1.6 Forcibly displaced women and girls

The reasons people migrate are varied and range from socio-political, environmental, demographic, and economic factors. By the end of 2019, the United Nations High Commissioner for Refugees (UNHCR) reported there were 79.5 million individuals who were forcibly displaced worldwide (43). Reasons for the enforced migration of individuals may include the effects of war, human rights violations, the economic collapse of countries and more recently the displacement effects of climate change (43,44). Most migrations occur within the borders of countries, with large numbers of migrations still occurring in low to middle-income countries according to the UNHCR (43,45). However, there has also been a rise in migration to high-income countries in the Global North with North America and high-income European countries now proving to be viable destinations given they offer the perception of safety, liberty, and potential financial stability (46,47). Children under the age of 18, in their inherent vulnerability, are increasingly exposed to the risks of perilous journeys undertaken to escape conflict or pursue economic opportunities. While boys account

for the majority of arrivals via Mediterranean maritime routes (82%), there has been a notable rise in the number of accompanied, unaccompanied, and separated girls arriving on European shores (48). This increase is evident in the rise from 28% in 2021 to 32% in 2022, highlighting the growing feminisation of this vulnerable population within migration flows (48).

Human trafficking is a rising global concern; it has been reported that 71% of all global trafficking involves women and girls, with children accounting for a third of all trafficking (49). Most end up in illegal and low-paying jobs, with millions of women globally ending up as victims of sex trafficking (50). Human trafficking has been considered a critical health issue due to its psychological, physical, and societal impact (51). Although COVID-19 slowed migration, criminal gangs have found innovative ways of smuggling people. The number of people who are victims of trafficking is not available, but an anecdotal case demonstrates how one criminal gang smuggled up to 10,000 individuals from France to the United Kingdom often through intimidation and unsafe travel conditions (52).

Between the time they leave their homeland and their arrival in their host nation, enforced migrants, including refugees, may often encounter stressful and/or traumatic situations that may impact their mental health (53). Whilst in transit, access to primary and secondary mental health services may be hampered by time constraints and language barriers (26). Once in host countries, refugees may be detained in detention centres. In addition, asylum seekers may have restricted access to support for their mental health compared to the host nation's population. Systems of support for asylum seekers are generally separate from the rest of the population and are mostly inadequately funded by the immigration authorities. Limited resources to support refugees means any unexpected increase in the number of refugees severely impacts the support that can be offered to refugees (54).

Additional psychosocial factors affecting the mental health of migrants, particularly refugees and asylum seekers, include the guilt of leaving loved ones, self and anticipated stigma, discrimination, poor housing conditions and restrictions on employment whilst awaiting immigration decisions, which in turn have an impact on health (53). Host nation immigration policy and the negative reporting of migrants by the media and the economic impact resulting in unemployment have given rise to hostility towards migrants, particularly refugees and people seeking asylum being accused of 'stealing' jobs, competing for housing, and being seen as exploiting and draining the welfare system (55–57).

According to the International Labour Organisation (ILO) in 2017, out of the 164 million migrant workers, females accounted for 42% (58). Taking into consideration added figures of those not in employment, undocumented and forced migrants, this estimate is likely to be significantly higher, with estimates of 4.9 million unauthorised migrants in 2017 (59). Many undocumented female migrants are in the informal domestic employment sector without recourse to maternity and sick leave, which leaves them vulnerable to exploitation, isolation, and poor health (60). A significant portion of female migration is enforced and may be further complicated by gender-specific challenges that persist during transit, upon arrival, and throughout the integration process within their host countries (46,61). As has been mentioned, women and girls are at added risk of being trafficked, with 71% of all trafficked persons globally being women or girls (49). Additionally, there have been many instances where female refugees and asylum seekers have been subjected to abuse by those who are meant to be protecting them (62). One in five women seeking asylum has experienced gender-based abuse in the UK (63). Disclosure is sometimes not made due to a host of factors, some of which may include a lack of awareness of support mechanisms, threats, shame, guilt, and fears of being deported should they disclose the abuse (63). Additionally, there may be a general mistrust of authorities/police. These factors may increase the burden of mental illness amongst asylum-seeking and refugee women, particularly increased anxiety and worsening of existing mental health conditions (64). Starting with defining what a migrant is, and looking at the circumstances many female migrants face, particularly many moving from low-income countries to high-income countries, is essential. Therefore, there is a need to understand the definition of who is a migrant and the importance of socioeconomic status.

1.7.1 Defining a migrant within a United Kingdom Primary Care context

The definition of primary care for this thesis is adapted from the European Commission's Expert Panel on Effective Ways of Investing in Health (EXPH), which defines primary care as the *'provision of universally accessible, integrated, person-centred, comprehensive health and community services provided by a team of professionals accountable for addressing a large majority of personal health needs. These services are delivered in a sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall coordination and continuity of people's care'* (65).

This definition aligns closely with the World Health Organization's declarations of Alma Ata (66) and Astana (67), which emphasise primary care as the cornerstone of universal health

coverage, focusing on equity, community involvement, and person-centred care. The WHO definition further underscores primary care's role in addressing the social determinants of health, which is particularly pertinent to female migrants navigating complex healthcare systems. The choice to focus on primary care reflects its centrality in the UK healthcare system as the first point of contact for most patients, including migrants, and its potential to act as a gateway to comprehensive support.

The study of refugees and asylum seekers, while inherently encompassing migration, often grapples with definitions that can obscure the unique experiences of women and girls. The original United Nations definition of a refugee, for instance, reinforces a male-centric narrative through its exclusive use of male pronouns ("his," "himself"). The definition describes a refugee as someone who:

*'is outside the country of **his** [Emphasis added] nationality and is unable or, owing to such fear, is unwilling to avail **himself** [Emphasis added] of the protection of that country; or who, not having a nationality and being outside the country of **his** [Emphasis added] former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.'* (68).

This linguistic framing reflects the patriarchal structures within which international agreements were historically developed, privileging male experiences as universal and sidelining the specific vulnerabilities, needs, and agency of women and girls. It exemplifies what feminist scholars have termed "androcentric bias," wherein male perspectives dominate the framing of laws, policies, and narratives (7,19). This bias not only marginalises female experiences but also perpetuates structural inequalities by failing to acknowledge the intersectional realities of migration, including the compounded effects of gender, race, and socioeconomic status on displaced populations.

Moreover, the implications of such male-centric language are far-reaching. The omission of gender-specific considerations in foundational definitions risks normalising the exclusion of women from subsequent policies, interventions, and data collection practices. For example, women's distinct experiences of displacement - such as exposure to gender-based violence, trafficking, and exploitation - may be overlooked or underemphasised. The lack of inclusive language also undermines efforts to foster equitable responses to global migration crises, perpetuating a systemic invisibility of women's contributions and struggles within displaced populations.

In response to this critique, this thesis deliberately modifies the United Nations' definition of a migrant to centre the experiences of women and girls. Rather than adhering to a specific length of time for residence or movement, which can be exclusionary, the focus shifts to the act of displacement itself. This approach aligns with the overarching goal of repositioning females as the focal point of inquiry, ensuring their experiences are not overshadowed by overarching categories or male-centric language.

A new definition incorporating the United Nations' definition of a migrant:

For this thesis, a female migrant is defined as:

A woman or girl who has moved across an international border away from her habitual place of residence.

This definition, adapted from the UN's broader understanding of migration (69) intentionally omits any reference to the duration of stay or specific reasons for movement. By doing so, it allows for a more inclusive understanding of international female migration, acknowledging the diverse motivations and circumstances that may lead women and girls to leave their homes.

This modified definition is not merely semantic; it is a feminist intervention into a historically androcentric discourse. By explicitly centring on female experiences, the thesis challenges existing paradigms in migration research and advocates for a more inclusive approach that foregrounds the voices and realities of women within displaced populations. Furthermore, this reframing underscores the importance of language as a tool for equity, demonstrating how deliberate linguistic choices can disrupt systemic biases and contribute to more just and inclusive research practices.

1.7.2 Female migrants and socioeconomic status

The American Psychological Association's (APA) definition of socioeconomic status (SES) is more than just financial and educational attainment but includes the subjective perceptions of an individual's social class, social status, and social privilege (70). Quality of life and the opportunities and privileges offered within society for the individual may further determine a person's SES. Poverty stressors such as psychosocial and physical stressors are predictors of psychosocial and physical outcomes throughout the human lifespan (70).

There is a strong correlation between subjective SES and health outcomes, with subjective measures often proving to be more accurate predictors than traditional, objective markers (71). This suggests that assessing SES through a migrant woman's perception of her position within the host country may yield more insightful results than relying solely on education and prior financial status. For instance, a significant proportion of female migrants are ineligible for public funds. This financial reliance on others can render them vulnerable to coercion and entrapment in abusive relationships due to fear of deportation (72,73). Low subjective SES often translates to poorer living conditions. Many female migrants entering the UK on spousal visas face a mandatory cohabitation period before acquiring permanent residency (74,75). During this time, if the relationship turns abusive, these women may be ineligible for state support, forcing them to choose between enduring the abuse or finding alternative means of financial independence. However, their lack of documentation often restricts them to low-paying jobs (76).

Understanding the intersection of socioeconomic status, migrant status, and gender is crucial for evaluating access to mental health support within UK primary care, particularly from the perspective of female migrants. Individuals from minority ethnic backgrounds face a heightened risk of racial and health inequalities. Studies have shown this in areas like infant mortality and low birth weight among Black mothers, as well as poorer health outcomes during disasters and epidemics (77,78). Many migrant mothers who would have enjoyed a high SES in their countries of origin end up losing the protective subjective health status and end up with almost similar rates of health satisfaction as those from low SES (79).

1.7.3 The importance of socioeconomic status in society and health

Wealth and poverty are frequent indicators of socioeconomic status (SES). Greater financial resources associated with a higher SES often translate into opportunities for enhanced educational achievement, contributions to society, and a reduced likelihood of exposure to violence (80–86). Despite many facing financial hardships, female migrants have fewer opportunities for education than male migrants and the local population. However, given the right conditions, they can thrive (76). In 2018, a fifth of the population in the UK lived in poverty with 18% of children living in poverty. Those calculations were set to grow by as much as 7% by 2022 (87). That was before the COVID-19 era. Since then, many countries have been experiencing cost-of-living crises (88,89). Risk factors for poverty also include greater exposure to disease, crime, addictions, and lower life expectancies (39,90–93).

Professor Sir Michael Marmot's seminal 2005 paper (94) explored the relationship between SES and social inequalities. He highlighted the stark disparities in life expectancy at birth between wealthy and impoverished nations. For instance, Marmot noted that life expectancy in Sierra Leone, a low-income country, was a mere 34 years, compared to nearly 90 years in Japan, a highly industrialised and affluent nation (94). Marmot further argued that health outcomes are unequally distributed within countries. Individuals with greater financial resources typically have better access to healthcare services compared to those from lower socioeconomic backgrounds (95).

This disparity is evident in the prevalence of infectious diseases, which are largely preventable through adequate healthcare provision. Populations experiencing socio-economic disadvantage disproportionately suffer from these illnesses compared to those who are more affluent (71). These health inequalities often manifest early in life. In the United Kingdom, for example, over 18.8% of children live in poverty (70). This figure is even more concerning in the United States, where nearly a quarter (22.9%) of all children face poverty (70).

Delays in treatment and the complicities of health authorities, health professionals and payment systems have been attributed to high death rates in children from low SES (96). People from minoritised ethnic backgrounds were most often in need of support for mental health services but were likely to be excluded in the design and access of these services (96–98). Attitudes of professionals have also acted as a barrier to people from low SES accessing appropriate support. Individuals from low SES have often been seen as irrational, irresponsible, less likely to adhere to medical treatments, of low intelligence and the most likely to over-utilise services (99). Migrant mothers exhibit a higher likelihood of seeking primary care for their children's health concerns than for their own. Despite this proactive engagement with healthcare services for their families, they continue to encounter substantial barriers, including language barriers, lack of access to childcare, financial constraints on transportation, and limited knowledge of navigating the healthcare systems in their host countries (100). These health and economic disparities are a major public health concern.

1.8 Female migrants and mental health

Female migrants are at elevated risk of developing mental health disorders and experiencing gender-based inequalities during transit and resettlement in their host countries (101,102). As mentioned in the introductory paragraphs, there are inequalities in physical health access and provision for female migrants. Female migrants may face challenges including trauma, social

isolation, discrimination, financial hardship, gender-based violence, and fewer opportunities to access support than the general population (103–105). Female migrant populations face a range of distinct concerns, spanning sexual and reproductive healthcare, postnatal care, female genital mutilation (FGM), and mental health (93,106–108). These factors can heighten the risk of developing mental health disorders, although this risk may be somewhat mitigated by protective factors such as resilience, coping mechanisms, and social support (109). It is important to note, however, that these protective factors can be diminished within the context of female migrant populations. Forced migrants, in particular, and those in the perinatal phase, are disproportionately affected by post-traumatic stress disorder (PTSD) throughout their lives (101,104,110).

Besides PTSD, female migrants, particularly refugee women, are disproportionately at risk of prenatal depression. One study suggests that they are 37.5% more likely to experience perinatal depression than the host country's female population (104). A global study estimated that the prevalence of perinatal depressive disorders among female migrants is between 19% and 31%, which is significantly higher than the prevalence of depression (12–17%) in the general population of perinatal females (105). The burden of perinatal mental illness (depression, anxiety, and post-traumatic stress disorder) is disproportionately high among female migrants. Notably, one in four pregnant or postpartum female migrants experience perinatal depression, while one in five experience perinatal anxiety. Additionally, perinatal PTSD is reported in one in eleven female migrants (105). Furthermore, evidence indicates that forced migrants may be at a higher risk of perinatal mental illness compared to economic migrants (105).

The likelihood of developing mental health disorders is further intensified by the intricate interplay of immigration status, socioeconomic status, and gender. Despite heightened needs compared to their male counterparts and the general host population, utilisation of mental health services remains suboptimal among female migrant populations (111,112). In a study conducted in Sweden, length of stay determined the use of mental health services, with migrants from South of the Sahara and Asia utilising services less in the first 10 years of their stay compared to migrants from the Middle East and North Africa who utilised mental health support more during the same time (113). Conversely, in a study conducted in Germany, being of a migrant background did not determine the use of mental health support services (114). With much of recent primary care services being digitised, access to care and information has been problematic amongst some migrant populations (115). Some of the

reasons for the lower usage of primary care for migrants, particularly during the COVID-19 pandemic have been attributed to a lack of digital literacy, language barriers, misinformation, and costs of technology and data (39).

Female migrants may face further significant barriers to seeking mental health care, including fears related to coercive relationships, potential child removal, detention, or deportation. Additionally, lack of childcare options, time constraints, language barriers, and the financial burden of treatment can further impede access to necessary services (39,116).

1.9 Female migrants living in the Southeast of England

Southeast England, a region boasting a concentration of economic opportunities, major transportation hubs, and a multicultural population, serves as a focal point for understanding the dynamics of female migration. The region includes areas such as Kent, Surrey, and Sussex (117). Encompassing major coastal transit and entry points from Europe such as Dover, and Newhaven, and a major international airport (London Gatwick) the region acts as a gateway for diverse migration forms, including asylum-seeking, family reunion, work, and study. The geographical aspect of Southeast England significantly shapes the diversity of the female migrant population in terms of their countries of origin and makes a compelling case study for examining the integration, employment, and service access challenges they face, as well as exploring their mental health support needs in a diverse and dynamic socioeconomic landscape.

Quantifying the precise number and origin of these female migrants presents a significant challenge. The lack of a unified data source encompassing all migration forms hinders comprehensive analysis. According to the Office for National Statistics (ONS), in 2020, Southeast England had an estimated 1.7 million non-British-born residents, constituting around 18% of the region's total population (118). This figure represents a marked increase of 62.94% from 2011, with females forming a slight majority of 53%. Furthermore, a comparison with 2001 data reveals a 60% increase over a decade, highlighting a consistent upward trend in migrant numbers (119).

Despite these significant figures, a paucity of focused research and comprehensive data exists, particularly concerning the experiences and needs of female migrants in Southeast England. This gap is not merely academic; it has practical implications for providing targeted services and support. The region's importance as a point of entry and transit for migrants necessitates a more nuanced understanding of the demographic shifts and the specific

challenges faced by female migrants. These challenges may encompass access to healthcare, employment opportunities, cultural integration, and legal support.

Southeast England undeniably represents a critical region for examining migration patterns, particularly those concerning female migration. However, the current lack of detailed research and tailored services underscores the need for more in-depth analysis and targeted policy-making.

1.10 Defining stigma and its multifaceted role in mental health

While the aetiology of mental health challenges is multifaceted, the presence of stigmatising societal perceptions can act as a significant barrier to recovery and reintegration for affected individuals. There are many definitions of stigma. Perhaps the most frequently used definition of stigma is that proposed by the Canadian American Sociologist Erving Goffman. Goffman defined stigma as *an attribute that is deeply discrediting* which transforms a person from *a whole and usual person to a tainted, discounted one* (120).

Erving Goffman's seminal work, *Stigma: Notes on the Management of Spoiled Identity* (120), provides a foundational understanding of the concept of stigma. Goffman posits that stigma arises from discrepancies between an individual's identity and their perceived social identity. This disparity leads to the individual being perceived as less than the whole, viewed instead as a tainted or discounted entity (Goffman, 1963, p. 3). Furthermore, Goffman argues that this social identity becomes a deeply discrediting attribute (p. 13). His analysis primarily focuses on the external perceptions of others rather than an individual's self-perception.

However, applying Goffman's theory to the context of mental health necessitates a careful and nuanced approach. It is critical to acknowledge that stigma in mental health is a multifaceted issue, influenced by a variety of factors beyond mere knowledge or lack thereof. While a deficit in understanding mental health conditions is often suggested to contribute to negative attitudes or stigma (3), recent studies suggest a more complex relationship between knowledge and stigma. For instance, research in the field of psychosis indicates that increased knowledge about the condition does not necessarily lead to reduced stigmatisation but in some cases, might even exacerbate stigmatising attitudes (121). This paradox highlights the complexity of the stigma associated with mental health. Factors such as cultural norms, societal attitudes, personal experiences, and even the misuse of power can all play significant roles in the formation of stigma.

Furthermore, longitudinal studies are required to fully understand the dynamics of stigma in mental health. Short-term observations might not capture the nuanced ways in which stigma develops and changes over time. Therefore, while Goffman's framework offers valuable insights into the nature of stigma, applying his theory to mental health necessitates a cautious and layered approach, considering the array of factors that contribute to stigmatising attitudes in this area.

Thornicroft and colleagues state that stigma is an overarching term which encompasses three elements: i) ignorance, which relates to problems of knowledge, ii) prejudice, which relates to attitudes and iii) discrimination in the form of behaviour. Both definitions and other modern uses have their origins in the practices of the ancient Greco-Romanian cultures of marking or branding animals, slaves, and criminals. Therefore, stigma, [Latin] *stigmata*, signified the societal inferiority of marked or branded individuals (122).

Across millennia, mental illness has often been viewed as one of the most stigmatised labels (123) and is seen in a more negative light than physical illness (124). Proponents of the social model of stigma view stigma as a social construct (125). Different levels of stigma may be evoked by different labels, whilst the broader population categorises individuals through stereotypes, which may then lead to discrimination (126). The broader population may discriminate against individuals who have a mental illness through various means which can include, but are not limited to, offers for employment being few and restricted, with access to social housing, education and health services affected through discrimination (127,128).

Some individuals, in turn, will internalise this and develop self-stigma which results in negative consequences for them, including poorer quality of life and may lead to avoidance of help-seeking, self-isolation, endorsement of the label they have been attributed, and living up to the stereotype (129,130).

To demonstrate the prevalence of stigmatised attitudes towards mental illness, studies have indicated that up to a third of people in North America and Europe held highly stigmatised attitudes towards individuals with mental illness (131). Individuals who experience psychosis are amongst the most stigmatised in society (128,132). Harangozo et al. found that people with mental illnesses such as schizophrenia and depression who experience discrimination while seeking treatment for physical symptoms are less likely to seek further help. 17% of service users reported experiencing discrimination while seeking professional help, specifically within mental health settings (124). Globally, studies about mental health

attitudes have had consistently negative findings. Very few societies have reported positive attitudes towards individuals with mental health conditions (133).

To better understand the impact of stigma, it is important to understand conceptual understandings of the different stigma frameworks about mental health to identify the most appropriate to apply to this work.

A multitude of perspectives on stigma exist. Some of the most common models include the social, psychological, biological, and multidimensional models of stigma (*See Table 1*).

Table 1: Common models of stigma

Stigma Model	Key Assumptions	Proponents	Stigma framework	Factors related to stigma
Social models	Stigma is a social construct.	Goffman (1963)	Social Identity Theory	Labelling, Stereotyping, Social distance
		Scheff, T. J. (1966), Link & Phelan (2001)	Evolutionary and Social Cohesion Models	Labelling, stereotypes, prejudice, social norms, and media representations.
Psychological models	Individual cognition, emotion, and behaviour play a role in stigma.	Bandura, P. Corrigan et al.	The Social Cognitive Theory	Social learning, cognitive processes, emotional reactions
		Ilan Meyer (1995)	The Minority Stress Model	Experiences of prejudice and discrimination, Expectations of rejection, Identity concealment, Internalised stigma
Biological models	Biological factors including genetics, brain chemistry, and hormones have a role in the stigma.	Barrett, Wheatley, and Amodio	Brain Function	Activation of the amygdala, anterior cingulate cortex, and dorsolateral prefrontal cortex
		Pinker, Plomin and Turkheimer	Genetics	Genetic determinism, fear, and ignorance, negative or stereotypical media representations of individuals with genetic conditions
		Lorber, Fausto-Sterling, Fine	Hormones	Menstruation, pregnancy, menopause, hormone therapy
Multi-dimensional models	Biological, psychological, and social factors contribute to the stigmatisation processes.	Stangl et al (2019)	The Health Stigma and Discrimination Framework (HSDF)	Individual, social, and environmental factors
		Fox et al. (2018)	Mental Illness Stigma Framework (MISF)	Individual, social, and environmental factors

1.7.1 Social models of stigma

The models focus on the social factors contributing to experiencing stigma, for example, discrimination, and social exclusion. Much of the early learning on stigma owes to the work of sociologists, mainly Goffman.

The suggestion by Goffman attributes the source of stigma to the way others see us and not necessarily how we see ourselves. Criticism has been directed at this suggestion because it is seen as too deterministic without accounting for individuals resisting and challenging stigma (134). The theory is too focused on the individual without accounting for social structures in creating and maintaining stigma (135). More recently, Thornicroft and colleagues defined stigma as a mark or sign which discredits the individual by eliciting negative attitudes toward its bearer (3). The view by Link & Phelan is that social interactions are what create and maintain stigma; thus, stigma is a social construct brought about by labelling, stereotyping, separation, and discrimination (136).

1.7.2 Psychological models of stigma

These focus on the psychological factors that lead to stigmatisation, including self-stigma, internalised stigma, and social anxiety.

Social cognitive theory posits that negative stereotypes and prejudices can develop through social interactions and social learning (observation and experience) with stigmatised groups. These negative beliefs and attitudes can subsequently be internalised by members of the stigmatised group (137). This theoretical framework has proven useful in explaining the relationship between mental illness and help-seeking behaviours, as well as the uptake of treatments (138).

The Minority Stress Model is a theoretical framework model that explains how stigma can lead to several negative psychological and physical health outcomes, such as depression, anxiety, and substance abuse amongst minoritised groups, including people with disabilities, and racial, ethnic, and sexual minorities (139–142). For example, research suggests that lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals face chronic stressors such as prejudice, discrimination, the anticipation of rejection, and internalised stigma (141). These stressors can lead to the development of coping mechanisms, both positive and negative. Examples of such coping strategies include concealment, substance abuse, or help-seeking behaviours (141).

1.7.3 Biological models of stigma

These models emphasise biological factors such as genetics, brain function, and hormones as contributing to stigma.

Studies suggest that there are neurological changes in the amygdala, the right inferior frontal gyrus (IFG) and the ventromedial prefrontal cortex (vmPFC) for individuals experiencing emotions related to judgment, fear, and anxiety, which are all related to stigma (143–146). A study by Cohen et al (147). reports chronic psychological distress caused by effects such as discrimination led to high levels of cortisol in the body which caused negative health consequences for stigmatised individuals (147). Psychologically, the response to stigma for individuals with high levels of cortisol has a high probability of being manifested as anxiety or depression (148).

1.7.4 Multi-dimensional models of stigma

In recent years, there has been a shift from one-dimensional explanations of stigma to a focus on intersecting and related factors that may contribute to multi-constructs of stigma. These models are known as multi-dimensional models and may sometimes include biological, psychological, and social constructs in explaining stigma. Two well-known examples are the Health Stigma and Discrimination Framework (HSDF), developed by Stangl and colleagues (149), and Fox et al.'s Mental Illness Stigma Framework (MISF) (150).

The MISF is a useful model for understanding the different mechanisms of mental illness stigma. The framework proposes that mental health stigma can be experienced and perpetuated at the individual, interpersonal, and societal levels. The role of intersectionality between the perpetrators of stigma and the stigmatised is acknowledged in the process. Figure 1 summarises the key features of the MISF, giving examples relating to female migrants.

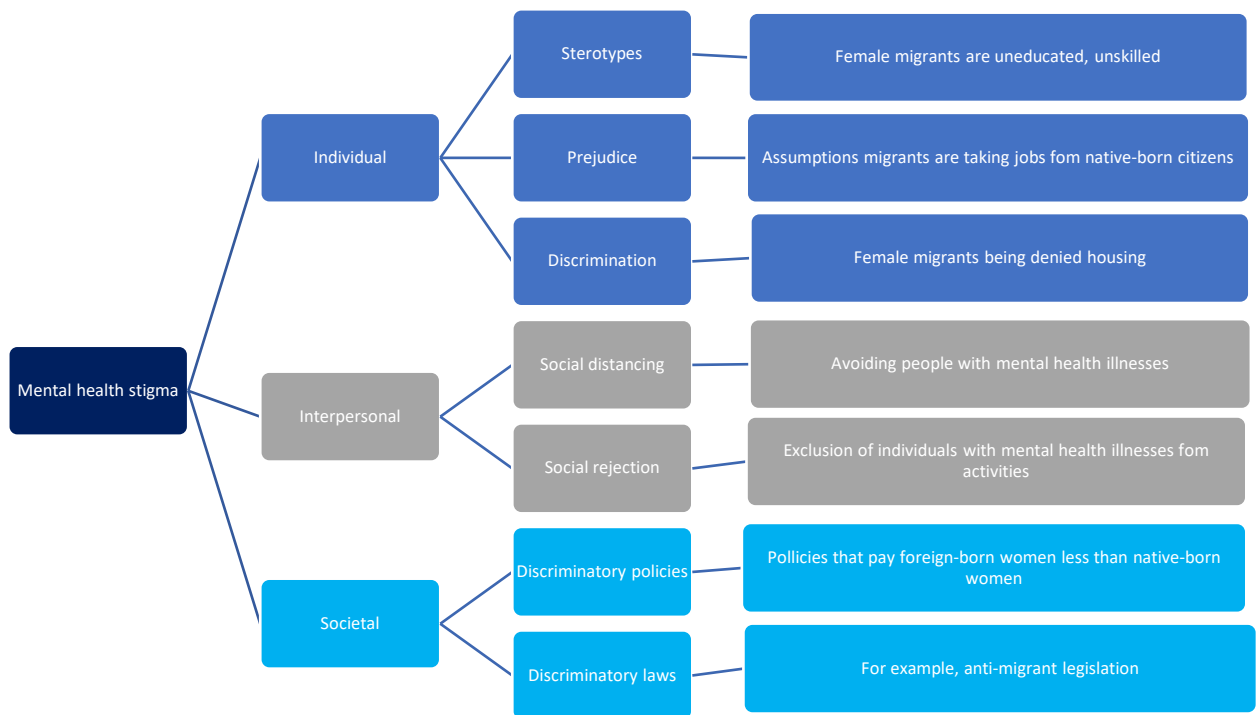


Figure 1: Summary of The Mental Illness Stigma Framework (MISF) related to female migrants

1.7.5 The Health Stigma and Discrimination Framework

The HSDF is a global framework investigating the impact of stigma on health outcomes in the context of socio-ecological spectrums, including individual, interpersonal, social, institutional, and structural components (149).

The key domains of the stigmatisation processes include stigma drivers and facilitators, manifestations, mechanisms of impact, and outcomes (*See Table 2*).

Table 2: The Health Stigma and Discrimination Framework components (149)

Domain	Definition	Categorisation	Example	Outcome
Drivers	Causal or motivating factors that cause stigma.	Stereotypes, prejudice, and fear.	Fear of infection, social judgement, concerns about productivity due to poor health or drug use.	Negative
Facilitators	Factors enabling or amplifying stigma.	Power imbalances, social norms, and health illiteracy	Health policy and social support or media representations.	Positive or negative
Manifestations	Lived and associative experiences of stigma by people or groups.	<p>Enacted stigma - actual experiences of discrimination or mistreatment due to a health condition.</p> <p>Anticipated stigma - fear or expectation of encountering stigma or discrimination in the future.</p> <p>Internalised stigma - Adopting or believing in negative views or labels about oneself or one's group.</p>	<p>¹HIV+ individuals refused employment due to their status.</p> <p>A person with a mental illness may conceal their disorder or avoid treatment due to social stigma.</p> <p>A diabetic person may experience self-blame or guilt for their disorder.</p>	Generally negative, but can be positive, e.g., motivation to help-seeking due to anticipated stigma.
Mechanisms of impact	The processes or pathways that link health stigma to different consequences for individuals, groups, or societies. They help us understand how health stigma affects outcomes.	<p>Social relationships - the forms and quality of social interactions and bonds established with others, E.g., Social rejection, avoidance, isolation, harassment, bullying, or poor understanding.</p> <p>Resource availability - the physical and financial resources that people access. E.g., income, health care, housing education, or employment.</p> <p>Stress: The psychological and physiological response people experience when encountering a problem or danger.</p> <p>Psychological and behavioural responses: The affective and cognitive processes individuals engage in when they encounter or expect stigmatisation.</p>	<p>A person with leprosy loses their social ties and support, which can harm their health and resources.</p> <p>People living with HIV may experience stigma and prejudice at work, which can impact their income security, and access to health and social care support.</p> <p>Anticipatory stress or fear of discrimination, leads to the activation of the ²HPA axis and the ³SNS, resulting in poor mental health, immunosuppression, and hormonal imbalances.</p> <p>Individuals may internalise negative beliefs, avoid or ruminate on stigma, strive for perfection, and seek help.</p>	Generally negative but can be positive, e.g., Self-compassion and empowerment in living with certain stigmatised conditions.
Outcomes	The results or impacts of health stigma on	Health-related outcomes - The physical and mental outcomes of stigma exposure or anticipation.	Treatment avoidance or non-adherence, impaired psychological well-being, increased stress, and elevated morbidity and mortality.	Generally negative but can be positive

Domain	Definition	Categorisation	Example	Outcome
	individuals, groups, or societies.	<p>Social outcomes encompass the intergroup and intragroup dynamics of individuals who encounter or expect stigma.</p> <p>Economic Outcomes: The financial and material resources of people experiencing or anticipating stigma.</p>	<p>People who face stigma may experience social exclusion, isolation, violence, bullying, lack of support from loved ones, and low self-esteem.</p> <p>The stigma of women who have aborted influences their employment, quality of life, and socioeconomic support.</p>	

Acronyms used in the table

¹HIV+ = Human immunodeficiency virus (positive)

²HPA = Hypothalamic-pituitary-adrenal

³ SNS = Sympathetic nervous system

The HSDF also includes strategies for reducing stigma which include contact, education, empowerment, protest, and policy change. The HSDF has been used in different geographic settings globally including Malaysia, The Netherlands, South Africa, the United States of America, and The United Kingdom. The HSDF has been used in several studies investigating the role of stigma in a wide range of health conditions and includes studies involving people with, cancer, leprosy, epilepsy, mental illness, HIV, and obesity (149,151,152).

Nwanaji-Enwerem et al. (2022) conducted a systematic review to examine the association between stigma and sleep deficiency (153). Their review, titled *Adapting the Health Stigma and Discrimination Framework to understand the association between stigma and sleep deficiency: A systematic review* (153), explores this link through the lens of the HSDF. The use of the framework provides a critical perspective for understanding the complex interplay between stigma, mental health, and the specific needs of female migrants. This review underscores the detrimental impact of stigma – internalised, perceived, or anticipated – on sleep health, particularly among marginalised groups like female migrants (153). This is significant because female migrants frequently encounter various forms of stigma, which can negatively affect their mental well-being. Understanding the broader impact of stigma, including its link to sleep disturbances, is crucial when considering the well-being of female migrants. As the review suggests, sleep deficiency is not merely a health concern; it can exacerbate existing mental health issues. Female migrants, already vulnerable due to migration stressors and cultural adjustments, may experience a significant compounding effect on their mental health if they suffer from stigma-related sleep problems.

Utilising the HSDF, stigma can be seen to have a negative impact on sleep through several mechanisms:

- **Labelling:** Individuals experiencing sleep problems may be labelled as "lazy" or "unmotivated" due to the tiredness and fatigue associated with their sleep difficulties. This labelling can lead to feelings of shame and discourage them from seeking help due to the stigma attached.
- **Stereotyping:** People with sleep problems may be stereotyped as less capable, which can affect their confidence and ability to manage their sleep issues.

- **Prejudice:** Prejudice can lead to individuals with sleep problems experiencing discrimination, making it harder for them to access resources and support to improve their sleep health.

1.11 Justification of the need to research female migrants' mental health

Female migrants contribute significantly to multiple sectors, influencing individuals, families, communities, and global economic systems. Particularly in the domain of domestic work, these individuals, who are predominantly female, play a crucial role in sustaining household functions. Despite their integral contributions, they often receive limited financial compensation. Their responsibilities frequently transcend traditional household tasks, including childcare and caregiving, thus facilitating the participation of other household members in the formal workforce.

Migrants who are exposed to adversity have a higher prevalence of anxiety, depression and PTSD compared to the host populations (154,155). Financial and socio-cultural factors have been identified as barriers for many migrants in accessing support for their mental health. A review on mental health access and psychosocial support concluded that much research is not clear on what the barriers are concerning access and help-seeking behaviours among many migrant populations (156). Faith and strengthening social relationships have been seen to alleviate signs of some mental health conditions in female migrant populations who have been exposed to adversity (157).

Language barriers may prevent research and service provision for identifying and addressing barriers for migrants to access mental health support (158). A suggested solution to overcoming language barriers in research and support is through the use of bilingual advocates/bilingual workers, interpreters, and translators; individuals who, in a UK context, speak English and another language which the research or support intends to address (158). However, due to the heterogeneity of migrant groups, research needs to consider the level of trauma, gender needs, religious considerations as well as researcher team capabilities including time and financial resources amongst a host of other considerations (159).

To enable research and provision of mental health services within primary care, where most newly arrived migrants find barriers to support (160), it is essential to seek an understanding of the barriers and the possible facilitators to access support for their mental health. To do so, it is also important to critically look at the current evidence base through a feminisms lens as this study seeks to expose gaps in research, service design and delivery affecting female

migrants, particularly their mental health relative to host nation populations. Understanding feminist theories and how they can be applied to whole migration systems may enable female migrants to access gender-aware and sensitive services that are commissioned to meet their needs. Additionally, it is important to understand how researchers define the term "migrant" concerning females in their research as this is essential in conceptualising and understanding issues related to female migrants. The insight gained from this thesis may help facilitate meaningful change in research, service provision and public attitudes towards female migrants, and mental health generally.

1.12 Overview of the PhD thesis

The thesis has been divided into 6 chapters: an introduction, a co-production chapter, a systematic literature review, a qualitative study involving female migrants which was informed by the literature review, a quantitative study involving analyses of an existing database which was influenced by the findings of the qualitative study and suggestions by the co-production group. A final discussion chapter brings together all aspects of the PhD alongside recommendations for co-produced mental health research and interventions for female migrants.

In *Chapter 1* an introduction is provided starting with the most recent statistics on migration in Europe and the UK and the consequences of the COVID-19 pandemic and its impact on female migration. Definitions of key migrant terms are introduced in this introductory chapter. Lastly, a brief critical discussion of the state of mental health research with migrant populations is presented. relationship between mental health and female migration is explored. Stigma was identified as a major potential barrier to accessing support and help-seeking behaviours.

Due to the mixed-method nature of this PhD, the methods used for each work package are embedded within their respective chapters. This includes the systematic review methodology in Chapter 3, qualitative study methods in Chapter 4, and quantitative data analysis in Chapter 5.

In *Chapter 2*, key concepts of involvement and co-production are introduced. The chapter introduces and gives practical examples of the implementation of a female migrant research framework. The chapter describes the involvement of experts by experience in the research protocol, commentaries on the systematic review and the additional co-interviewing and analysis of the qualitative study. In addition, the chapter includes considerations on the

research process with the female migrant co-production group. Additionally, it highlights steps undertaken within this PhD to destigmatise mental health and involve female migrants in research.

In *Chapter 3*, a peer-reviewed systematic review of the barriers and facilitators to seeking and accessing mental health support in primary care and the community among female migrants in Europe is presented. This chapter draws upon a synthesis of eight qualitative, six quantitative and five mixed methods studies relating to barriers and facilitators to accessing mental health support in primary care and the community. Thematic analysis was undertaken, and a feminist quality appraisal tool was applied. Barriers included inadequate dissemination of information regarding available support pathways, religious, and cultural practices and beliefs, and gender-specific needs not being addressed. However, services that were gender-sensitive, supportive religious leaders and general practitioners facilitated access. This published review (1) guided the next stage of the PhD, particularly chapters 4 and 5, by recommending the inclusion of female migrants in research through co-production and the destigmatisation of mental health and their involvement in research.

In *Chapter 4*, female migrant experiences and perceptions of mental health and support are explored through a qualitative interview study which was conducted across Kent, Surrey, and Sussex, in Southeast England. Stigma emerges as a cross-cutting barrier to help-seeking behaviours and support. The chapter describes the processes of including female migrant co-researchers and analysis of the interview scripts.

Chapter 5 analyses mental health referral and severity patterns between British-born and non-British-born women using the South London and Maudsley (SLaM) database. Data originated from the SLaM NHS Foundation Trust's Biomedical Research Centre Case Register. Key findings include differences in referral patterns, treatment approaches (more antipsychotics prescribed for non-British-born, antidepressants for British-born), and more hospital admissions/sections for non-British-born women, suggesting greater mental health severity.

In *Chapter 6*, a discussion of the overall PhD project is presented alongside recommendations from the findings and those suggested by female migrant research partners. Limitations of the project are presented. A reflexive statement by the PhD Candidate and a commentary by members of the Female Co-production Group are included in the chapter.

This thesis is guided by the overarching research question: *What are the mental health challenges and needs of female migrants?* Each chapter examines different dimensions of this question, employing a mixed-methods approach to provide a holistic understanding of female migrants' mental health experiences, barriers to accessing support, and facilitators of well-being.

Chapter 2: The design and implementation of an effective co-production and research approach to a PhD Project across the Southeast of England

2.1 Introduction

This chapter describes why and how co-production methods were employed within this PhD study. It also explores how female participatory action research can be integrated into a PhD project and provides insight into the processes of engaging female co-researchers who were from female-led migrant organisations, female migrants, female community researchers, female researchers, and providers of services for female migrants. A co-production group with varying levels of involvement was formed before data collection. The female migrant co-production group have proved to be an essential part of the PhD project seeking to actively co-produce non-stigmatising mental health research and solutions with and for female migrants living in Kent, Surrey, and Sussex (KSS) in Southeast England, and beyond.

A brief overview of key terms and definitions related to co-production, involvement, and participatory action research is presented as an introduction. The process of engaging individuals, communities and organisations is highlighted. The outcomes of this engagement are presented. A lived experience commentary by female co-researchers and a personal reflection on the process by the PhD Candidate to demonstrate the impact of the co-research process on the personal and professional development of the team is also included.

The key considerations of this section are:

- 1) To integrate principles of feminist participatory action research through the active engagement of female migrants, researchers, and community organisations that support female migrants in research on female migrant mental health. This first objective was achieved by the active recruitment of members of the co-production group.
- 2) Utilise co-production methods in investigating barriers and facilitators to mental health support. The second objective was set out a posteriori due to the abundance of literature indicating female migrants faced many barriers to access and support, however, there were also facilitators to support.
- 3) Assess the contribution of co-production in generating novel insights into the mental health experiences of female migrants. This objective aligned with the recommendations

put forward by the female migrant co-production group, alongside the supervisory team, advocating for the utilisation of co-production as a means of enriching research on this specific population.

- 4) Synthesise the lessons learned from co-production efforts involving female migrants and their support professionals. The aim was to systematically record each phase of the research process involving the co-production groups' experiences and perceptions. This documentation serves as a valuable resource for future research endeavours that consider engaging female migrants and other vulnerable populations as co-researchers.
- 5) Identify best practices and recommendations for future research involving female migrants as co-researchers. This objective seeks to identify procedures that may be converted into actionable processes in future research to enable inclusive and participatory methodologies that can be transferred to different settings.
- 6) Develop and validate a readily transferable framework facilitating the inclusion of populations traditionally marginalised from active research participation.

2.2.1 Public engagement in research

In recent years, globally there has been an acknowledgement of the benefits of actively involving patients, family, carers, and the public in research with an impact on the reduction of mortality, increasing adherence to medication and treatments and improved service delivery and patient safety (97,161,162). In the United Kingdom, service user involvement funding requirements now encourage evidence of service user involvement in health research projects (163,164). The aspects of involvement vary across research and may include the following according to the National Institute for Health and Care Research (NIHR) (165,166):

- Identifying & prioritising research
- Designing
- Development of the grant proposal
- Undertaking and managing in designing of information sheets, questionnaires, undertaking interviews
- Analysing and interpreting data and providing recommendations.
- Dissemination of research outputs, advising and joint presentations
- Implementation through advocacy and championing the adoption of research findings.

Public engagement in health can take many forms and may be viewed as a continuum, meaning engagement with patients and the public can have limited involvement or be in control of most aspects of involvement and research. It is therefore important to view involvement and engagement from a multidimensional viewpoint. The proposed multidimensional framework for patient and family engagement in healthcare is one framework that attempts to capture the differing levels of engagement (167). The framework identifies the higher end of the continuum with information sharing as a two-way cycle between patients, carers, and health professionals. The decision-making processes involve patients and carers. Additionally, support is offered for patients and carers in managing health conditions. Finally, this collaborative process has the potential to enhance health systems comprehensively. However, at the less engaged end of the spectrum, patient participation is limited, with individuals lacking access to their records, and decisions primarily driven by clinicians or policy. A summary of this multi-faceted continuum of engagement is illustrated in Figure 2 below.

A Multidimensional Framework For Patient And Family Engagement In Health And Health Care

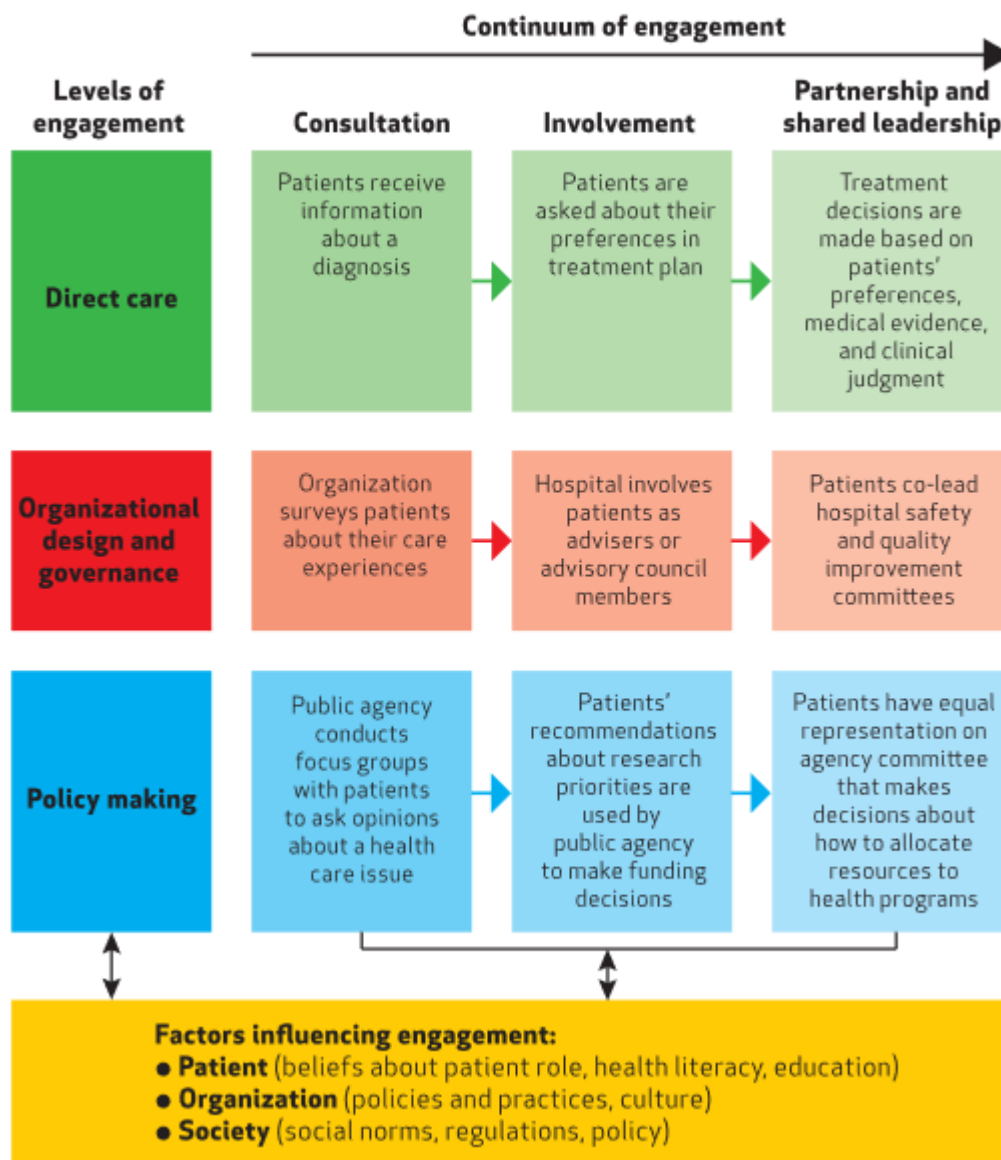


Figure 2: A Multidimensional Framework for Patient and Family Engagement in Health and Health. Reproduced with the kind permission of Project HOPE/Health Affairs from Carman et al (167)

Due to the many definitions and levels of engagement and involvement, there was a need for a consistent approach by researchers, funders, and the public to improve the quality and consistency of public involvement in research.

In 2016, a UK Public Involvement Standards Development Partnership was established to develop a consistent approach to public involvement in research. The standards were published in 2019. The partnership included representatives from the Chief Scientist Office (Scotland), Health and Care Research Wales, the Public Health Agency (Northern Ireland), and the then National Institute for Health Research (England). An independent expert was also involved in the development of the standards. The partnership established six values-based standards for public involvement in research (168): Inclusive Opportunities, Working Together, Support and Learning, Communications, Impact, and Governance (see Figure 3).



Figure 3: UK Standards for Public Involvement in Research

2.2.2 UK Standards for Public Involvement in Research

1. **Inclusive opportunities:** Public involvement should be inclusive and accessible to all. This includes involvement in research at the early stages. Barriers to involvement are addressed. Example barriers may include payment and accessibility to physical or digital meetings. Inclusivity also includes advertising opportunities to communities that may be affected by the research and ensuring choice and flexibility in opportunities. Additionally, transparency in involvement and upholding equality and diversity through the research process
2. **Working together:** Public involvement should be a collaborative process, with researchers and the public working together as equal partners. Purposes of public involvement should be jointly defined and recorded. The practical requirements and arrangements for joint working should be addressed. Exploration of different ways of working should be explored, including plans and activities being co-developed. Roles, responsibilities, and expectations should be clear for public involvement. Recognition of individuals' influence, ideas, and contributions.
3. **Support and learning:** Public involvement should provide opportunities for the public to learn and develop their skills and knowledge.
4. **Communications:** Public involvement should be communicated in a clear and accessible way.
5. **Impact:** Public involvement should have a positive impact on the research process and the outcomes of research.
6. **Governance:** Public involvement should be governed by clear and transparent processes.

2.2.3 A User-led framework to involvement: The National Survivor User Network 4Pi Standards

The National Survivor User Network (NSUN), a mental health user-led network, developed a framework for the involvement of service users and carers in their care (169). The framework is based on the following standards: principles, purpose, presence, process, and impact (4Pis). Elements of the PhD project were influenced by the methodology. By adopting the 4Pi framework, organisations that engage in service user involvement can effectively monitor and evaluate participation through:

Principles - The equal valuing of the contribution of service users and carers with that of the professionals in the room. In the case of the current PhD project, this relates to meaningful involvement by female migrants and organisations through decision-making and actions.

Purpose - Clarity of the reasons for employing co-production, clearly expected roles, and tasks. Communication and agreements were made on why the group was formed, to coproduce research relating to the mental health of female migrants residing in Kent, Surrey, and Sussex.

Presence - Involvement of diverse views and individuals. Throughout the research process, female migrants, organisations, and researchers were to be involved. Female migrants were given opportunities to be involved separately through regular meetings as this would empower them.

Process - This entails the meticulous planning of payment systems, recruitment, training, and support for service users and carers. For the current project, various payment systems, such as bank transfers or vouchers, were to be established. Customised training addressing the specific needs of the group, such as analysis training, was to be considered, discussed, and arranged.

Impact – Making involvement have meaning for service users and carers. The current project sought to have regular feedback from the female migrants, professionals, researchers, and community members on any impact their involvement had on a personal and professional level.

2.3.1 Defining involvement and engagement as a research process on a PhD

Building on Carman et al. (167) and the NIHR definitions of patient involvement and participation (163,164), this project conceptualises engagement as a *collaborative journey of discovery and empowerment*. This journey involves female migrants, their families, carers, or community members actively partnering with healthcare professionals, policymakers, commissioners, and researchers to co-create solutions addressing the holistic health needs of female migrants. This encompasses their social, cultural, and healthcare experiences and outcomes, with collaboration occurring at all levels of the research process, from design and governance to dissemination.

Within this framework, "female migrant involvement in research" is defined as *a journey co-created and navigated predominantly by female migrants themselves, alongside their allies*. This involves sharing decision-making power, fostering meaningful and respectful engagement, and working collaboratively towards collective solutions.

Furthermore, "patient participation" is reimagined as *an ongoing dialogue between female migrants and researchers*. Female migrants actively shape the research landscape through their unique insights, perceptions, and lived experiences, receiving feedback on their contributions in a reciprocal relationship that enriches the research process.

While the terms engagement, involvement, and participation are often used interchangeably, this project distinguishes them as distinct stages within the collaborative journey, ensuring clarity and precision in understanding the different levels of participation.

2.3.2 Crosscutting themes on involvement and engagement adapted for the PhD project

The Multidimensional Framework for Patient and Family Engagement in Health and Health Care by Carman et al. (2013), the UK Standards for Public Involvement in Research, and the NSUN 4Pi Standards share several overlapping principles. Notably, the concept of "co-production" in the UK Standards aligns with the "user-led involvement" principle of the 4Pi Standards. All three frameworks underscore the importance of meaningful engagement, emphasising reciprocity and support throughout the research process. Four key themes, adapted specifically for this PhD project, emerge from this analysis:

The importance of valuing the expertise of people with lived experience. All three frameworks highlight the importance of involving people with lived experience of physical or mental health conditions or social care services in every aspect of decision-making. In research, this may include designing the research questions, conducting interviews, co-analysis of data, writeup of findings, dissemination, and evaluation.

The significance of authentic collaboration. The frameworks also emphasise the need to go beyond consultation or tokenism and create meaningful involvement. The voices of people with lived experience are taken seriously, and respectfully and their views and experiences help shape the research.

The value of relationship-building. All three frameworks emphasise the importance of building relationships between people with lived experience and researchers for research purposes. In the broader context, researchers, policymakers, commissioners, and service deliverers create a climate of trust and mutual respect which enables meaningful involvement.

The necessity of resources and support. The frameworks also acknowledge that there must be adequate resources and support for meaningful involvement. In the research setting, this may include the cost of including lived experience participants in research proposals, the cost and time of training, and emotional and practical support. Emotional support may include 1:1 or group-facilitated discussions on the impact of involvement on individuals' well-being. Practical support may include providing accessible material and facilitating online or in-person opportunities that do not put the individual out of pocket.

Figure 4 below illustrates the common themes shared by Carman et al.'s (2013) research (167), the UK Standards for Public Involvement in Research (168), and the NSUN 4Pis (169) frameworks.

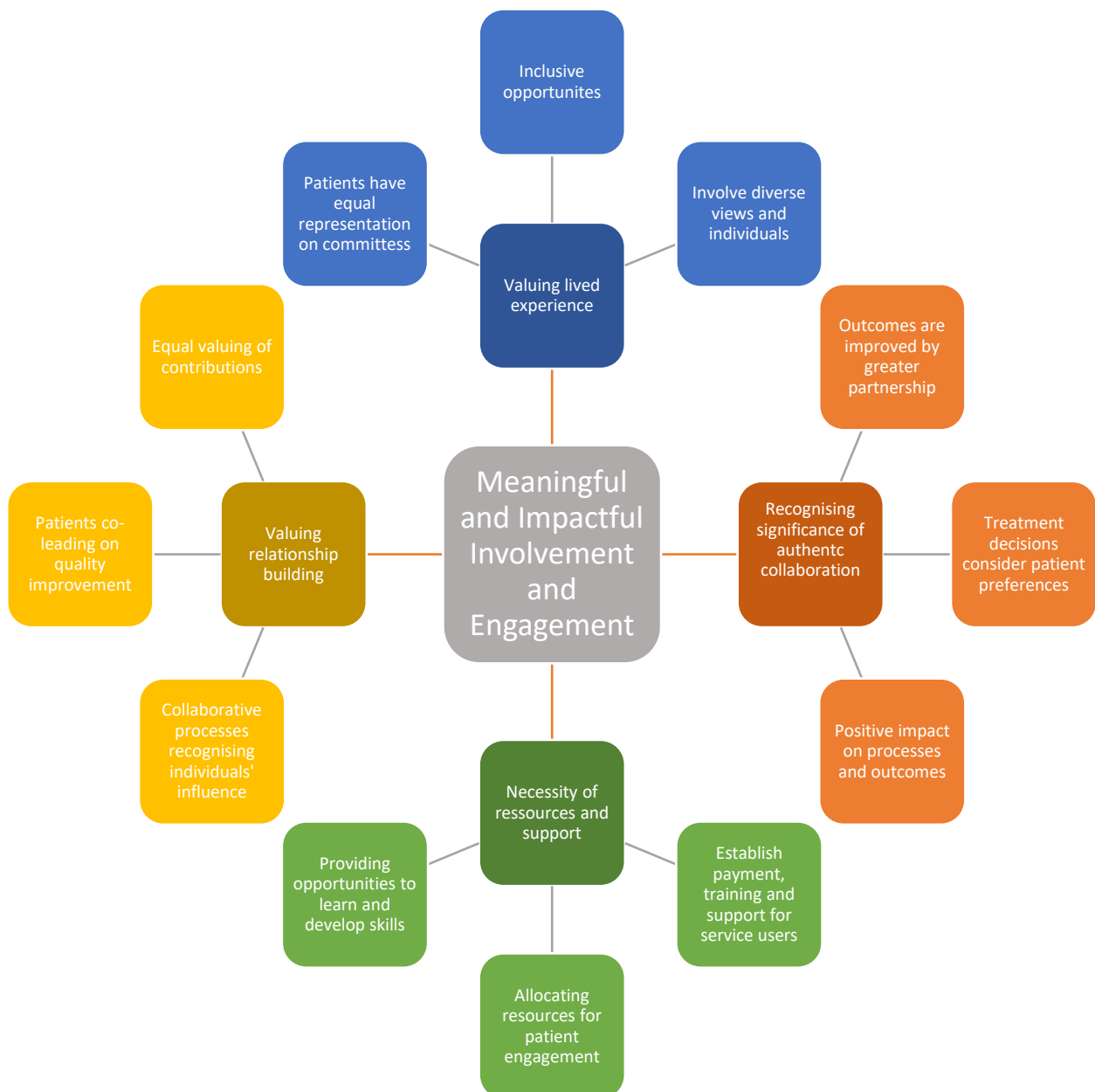


Figure 4: Crosscutting themes of 3 involvement and engagement frameworks utilised for the female migrant mental health PhD

The identified cross-cutting themes informed the development of principles guiding the engagement and involvement of female migrants and stakeholders in this PhD project. For this chapter, the term Patient and Public Involvement and Engagement (PPIE) is integrated into Empowering Migrant Bridges: Active Research and Knowledge (EMBaRK), incorporating elements of co-production and feminist methodologies. This term and its associated framework best encapsulate the collaborative nature of the process. For this PhD

project, the three involvement frameworks were synthesised (Figure 4), and EMBaRK was subsequently developed to guide all stages of the research. In the development of EMBaRK, the pivotal role played by the Female Migrant Co-production Group was central to its conception and effectiveness. The group was integrally involved in each stage of the EMBaRK process, from its initial conceptualisation to its implementation and ongoing refinement. The process has involved stepping back from the traditional academic-led research and giving prominence to having female migrant voices and opinions guide and engage the PhD Candidate in every step of the research process.

The EMBaRK process champions an unwavering commitment to fostering deliberate and continuous two-way communication throughout the research journey. It recognises the profound impact of race, ethnicity, and gender on both the research process and the group dynamics. By encouraging honest conversations and reflections on these sensitive topics, EMBaRK creates a space where diverse perspectives can be shared and integrated into the research journey. Unlike approaches that limit engagement to specific phases, EMBaRK actively cultivates open and honest dialogue from inception to completion and beyond, intending to utilise acquired knowledge and skills in future. It prioritises the establishment of safe spaces that are tridirectional, ensuring that all participants feel safe to speak their truths, safe to listen without judgment, and safe to simply be present. This approach fosters an environment of trust, respect, and inclusivity, where the complexities of identity and experience can be explored and understood.

This approach acknowledges that while individuals may feel comfortable or safe expressing themselves, it does not necessarily imply they feel comfortable or safe doing so irresponsibly. This commitment fosters transparency while empowering the participant group to contribute suggestions, guidance, and promotion efforts. Likewise, for the researcher to engage as an equal based on their research aims. As a result, the EMBaRK process cultivates a shared understanding of the research goals and outcomes among all stakeholders.

2.4 Creating a process for meaningful engagement on the PhD project

2.4.1 Research Context and Methodology

The research was conducted over a period that included the COVID-19 pandemic, which posed both challenges and opportunities. Data collection strategies were adapted to ensure the safety of participants and researchers, such as the increased use of remote interviews. These adaptations also highlighted the digital divide and other barriers faced by female migrants, which became part of the analysis.

The pandemic not only reshaped the study's logistics but also provided a unique lens through which to examine the vulnerabilities and resilience of female migrants in accessing healthcare. By navigating these complexities, the research underscored the enduring inequalities magnified by global crises, positioning the findings within a broader socio-political and temporal context.

2.4.2 Design

The EMBaRK approach was developed with the formation of the Female Migrant Co-production Group (FMCG). This foundational step involved bringing together female migrants and representatives from organisations supporting them, who were interested in contributing to the research. The FMCG played a crucial role in the subsequent stages of EMBaRK development, ensuring that their perspectives and experiences were central to the research process. Once the FMCG was established, the group collaborated in the co-development of the EMBaRK framework. This involved:

- 1) The formation of the core FMCG. The group comprised female migrants, as well as individuals and organisations working to support female migrants who were interested in being more involved in the research.
- 2) Together with the core FMCG, drafting a simple guiding framework for EMBaRK, which outlined the initial principles of EMBaRK. The group collaborated in establishing the procedures for the effective engagement of the FMCG in the research journey.
- 3) The implementation and refinement of EMBaRK as a continual process, which involved seeking, offering, and implementing meaningful engagement opportunities for the core FMCG on the PhD project.

- 4) Regular co-production meetings with the core group and 1:1s with core members (a total number of 33 meetings were held between 09/23 and 16/04/24). These included monthly meetings, reflective spaces, and occasional meetings outside of regular planned meetings, for example, training such as analysis workshops, and lived experience commentary writing to equip the co-researchers.
- 5) Dissemination meetings, which included wider group and individual meetings to plan blog and conference presentations.

2.4.3 The EMBaRK Process: Operationalising principles and procedures

The EMBaRK process was operationalised through two distinct components: guiding principles and procedural steps.

Principles: The foundational principles of EMBaRK, emphasising respect for the expertise and experiences of the FMCG, race and culture security, gender awareness and appreciation, confidentiality, trust, safety, anti-stigmatisation, equality of opportunity, and transparency, served as the core ethical and methodological bedrock of the engagement process throughout the PhD project.

Procedures: The procedural elements of EMBaRK involved:

- 1. Formation of the FMCG:** The establishment of the FMCG as an integral part of the research team, actively contributing to research design, data collection, and analysis.
- 2. Framework Development:** The articulation of the EMBaRK framework itself, encompassing the guiding principles and operational procedures.
- 3. Implementation and reflection:** The continuous application of EMBaRK throughout the project lifecycle and beyond.
- 4. Documentation:** The meticulous recording of EMBaRK meetings and stakeholder interactions by the PhD candidate.

As Figure 5 illustrates, these two components align seamlessly with the overarching themes identified within the three pre-existing engagement and involvement frameworks, demonstrating the robustness and comprehensive nature of the EMBaRK approach.

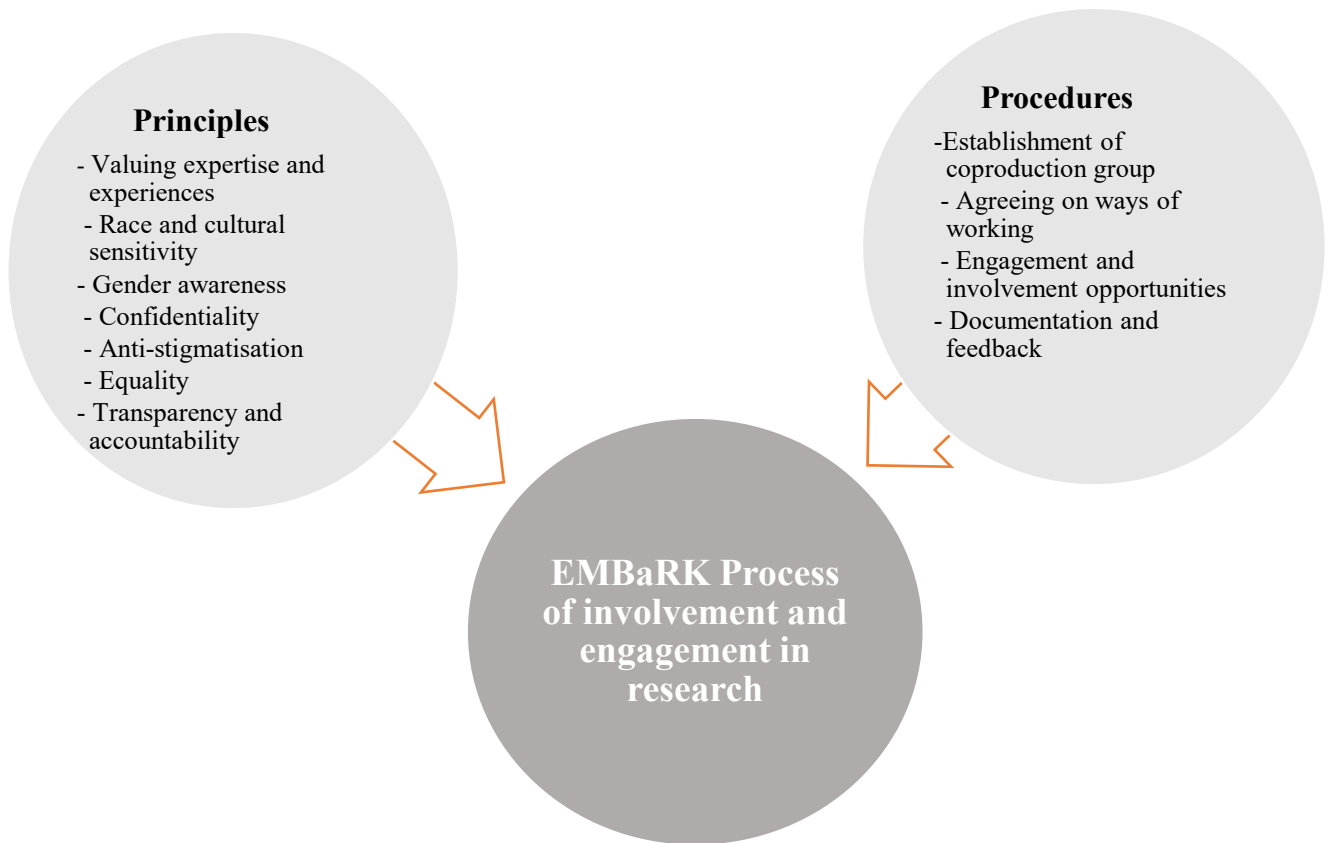


Figure 5: Components of the EMBaRK process

Strapline to the EMBaRK process representing a boat journey

The EMBaRK process metaphorically envisioned as a boat journey, involves the FMCG and academic researchers setting sail on an allegorical voyage. Before embarking, the team must ensure they are well-prepared with skills, knowledge and essential supplies, akin to a ship provisioning for a long journey. These supplies include:

- **Water:** Symbolising the continuous flow of experiences, communication and knowledge sharing throughout the research process.

- **Food:** Representing the sustenance of ideas, data collection, and analysis that nourish the research project.
- **Essentials:** Encompassing the necessary tools and resources, such as payment systems for participants, training materials for interviewers and ethical guidelines to ensure the research is conducted responsibly.

They must also agree on a captain (the research lead) and ensure there are enough crew members to operate the oars, which symbolise the tasks that propel the research forward, as it is impossible for a single person to manage both sides of the boat alone. However, the crew must be more than just a collection of individuals; they must forge a bond of trust and mutual respect. This entails getting to know one another deeper, understanding strengths and weaknesses, and fostering an environment where everyone feels safe and valued. In the unpredictable research waters, crewmates must rely on each other, sometimes sharing resources, and other times entrusting their well-being to the collective. This shared responsibility and camaraderie are essential for navigating the challenges ahead.

As the journey begins, the boat navigates through various conditions of the water, representing the challenges and dynamics of the research process. In calm waters, the team must remain vigilant to keep the boat moving forward, ensuring tasks are completed, and maintaining open communication through regular feedback. This phase emphasises the importance of keeping everyone informed and engaged.

However, when the waters become rough, the journey becomes a test of resilience and adaptability. Challenges such as limited funding, differing opinions, and group dynamics can create turbulence. In these moments, the team must draw on their collective strength and problem-solving abilities to navigate through the storm. The sun, stars, and moon serve as natural guides, providing solar power and acting as a compass to keep the boat on course. These celestial bodies symbolise the guiding principles and continuous evaluation that steer the research process.

The ultimate goal of this journey is to reach new shores—places where research questions are answered, and solutions are found. Leaving behind the land of trouble and uncertainty, the team aims to disembark at destinations of knowledge and understanding. These new shores represent the successful completion of the research, where the insights and answers discovered pave the way for progress and improvement.

This allegory aligns with both the migrant journey and the research process, highlighting the importance of preparation, collaboration, resilience, and adaptability. Through the EMBaRK process, the journey is not only about reaching the destination but also about growing and learning together along the way. An earlier conceptual representation of this allegorical journey is depicted in Figure 6..

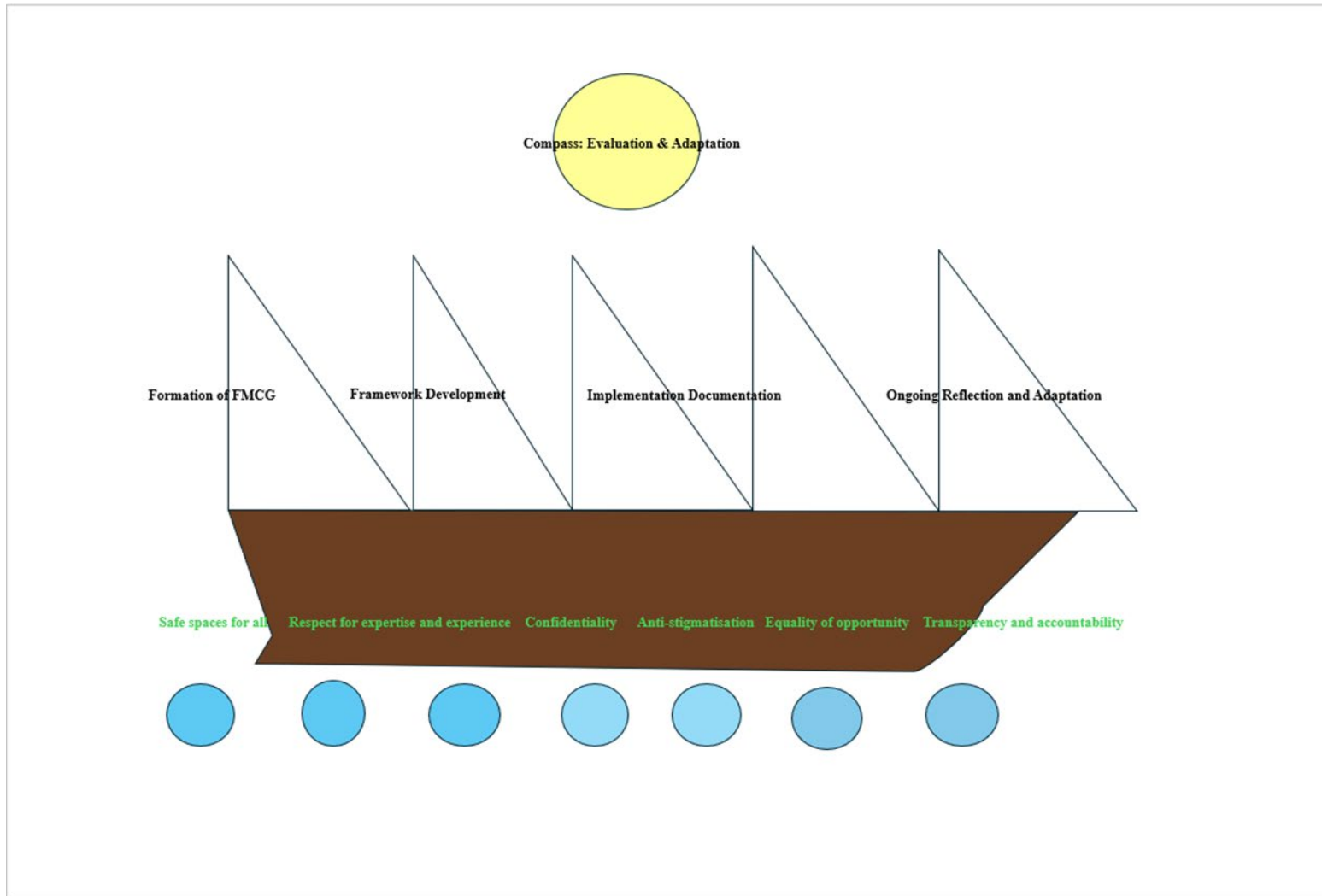


Figure 6: EMBaRK boat journey process

The EMBaRK processes implemented throughout the project are summarised in Table 3 below.

Table 3: Summary of EMBaRK process activities implemented throughout the PhD project

Stage	EMBaRK Activities	Stage of PhD Informed by EMBaRK
Stage 1: Planning the Journey	Pre-project consultation; stakeholder consultation; community partner meetings	Formulating research questions and target population
Stage 2: Charting the Course	Recruitment of co-production members and agreement on involvement processes; advertising; stakeholder consultation; community partner involvement and expert review	Recruitment of a co-production group and systematic review
Stage 3: Setting Sail	Developing the protocol, guidelines, and research questions with community partners and core female migrant co-production group involvement	Qualitative study design
Stage 4: Navigating the Waters	Undertaking/management of research with participants, stakeholders, community partners, and core female migrant co-production group involvement	The systematic review and qualitative study
Stage 5: Analysing the Voyage	Analysis of data with core female co-production group involvement	Qualitative study analysis and informing the direction the of subsequent quantitative study
Stage 6: Arrival, Reflection, and Celebration	Dissemination of research findings through conference presentations, journal publications, and public engagement events alongside community partners and female migrant co-production group	Qualitative, systematic review, quantitative study results, thesis draft, presentations, and journal articles.

2.5 Outcome of the EMBaRK process

The roles of the wider stakeholders and the FMCG were distinct yet complementary. The wider group primarily supported the study by facilitating recruitment, providing access to interviewing spaces, and assisting with dissemination. This involvement was instrumental in ensuring that the research reached diverse subgroups within the female migrant population.

In contrast, the FMCG actively contributed to the research process itself. This included input in shaping the recruitment materials, the structure and content of the interviews, co-interviewing, and the interpretation of findings. Additionally, their insights informed the development of the EMBaRK framework and guided decisions around ethical, gender and cultural considerations. The distinction between these roles was essential to maintaining the integrity of the co-creation process, ensuring that each group's contributions aligned with their expertise and capacity.

Co-production meetings are summarised in stages, from pre-project consultation to dissemination. Due to the extensive nature of the EMBaRK process, a comprehensive listing of all dates, meetings, and outcomes is beyond the scope of this section.

Consultations, engagement, and support for this project encompassed a diverse range of individuals and organisations geographically dispersed worldwide. Notably, collaborations transpired with stakeholders either originating from or residing in the following countries (listed alphabetically): Australia, Angola, Bosnia and Herzegovina, Brazil, Canada, China, Colombia, Congo, Eritrea, Ethiopia, France, Germany, Ghana, India, Iran, Iraq, Ireland, Jamaica, Japan, Kenya, Malaysia, Malta, Morocco, Mozambique, Netherlands, Nigeria, Northern Ireland, Nepal, Norway, Pakistan, Philippines, Poland, Portugal, Russia, Saudi Arabia, Somalia, South Africa, Spain, Sri Lanka, Sudan, Turkey, Uganda, Ukraine, United Kingdom, United States of America, Venezuela, Zambia, and Zimbabwe. None of the collaborators were involved as participants in the PhD project. While full details of engagement with all stakeholders geographically would go beyond the scope of this PhD project, Table 4 has been curated to showcase select examples of engagement with the

FMCG and other key stakeholders, as well as the valuable insights and outcomes garnered during this collaborative stage.

Table 4: Exemplar events and outputs from the co-production process

<i>Date</i>	<i>With Whom</i>	<i>Topic</i>	<i>Outcome</i>
12/20	AR mentor working with marginalised groups	General discussion and focus	Suggestions on incorporating female migrants focus and a feminist lens
02/21	AH (Academic)	Involvement	Support materials suggested for research, including journal articles
02/21	AT (Researcher)	Involvement	Suggestions on recruitment of females in research
03/21	IZ (female migrant researcher)	Resources	Research methods on vulnerable populations and recruitment strategies.
01/21	PM (feminist and academic)	Action research	Engagement and support throughout the PhD project and resources.
06/21	Core Group	Formal meeting	Recruitment and engagement strategies and engagement
10/21	WS (Support worker)	Migrant Support strategies	Suggestions and introductions to migrant support organisations in Surrey
07/21	CB - Bilingual advocate (BA) and female migrant	Advice on involving African women in research	Suggestions on recruitment of female migrants from the African diaspora
08/21	MG and YA (community-led organisation)	How to involve charities in research	Suggestions and introductions to migrant supporting organisations and a commitment to support the project
09/21	DG	Involvement	Strategies and introductions on recruitment and engagement
11/21	RL (female migrant-led organisation)	Involving female refugees in research	Suggestions and commitment to support in recruitment. Input and refinement of study materials
08/22	Core Group	Interview needs	Recording, receiving consent, training
08/22	Core Group		Input into a working definition of a female migrant for the project
10/22	Core Group	Recruitment Strategies	Further recruitment strategies and considerations
02/23	Core Group		Guidance on reporting country of origin sexuality and ethnicity when there is a contrast between ONS and self-identification
02/23	MH (academic)	Sleep issues discussion	Design of an interactive sleep session as identified by the FMCG and interviewees
03/23	Core Group	Sleep hygiene session	MH facilitated a discussion on sleep hygiene
04/23	Core Group	CRIS Study discussion	Suggestions by the FMCG on objectives of CRIS study
05/23	Core Group	Lived Experience (LX) Commentary Training	LX commentary training delivered by a UCL-based involvement coordinator to the FMCG

2.5.1 Stage 1: Pre-project consultation (Year 1)

The first stage of involvement in the PhD project was consultation with a wide range of stakeholders, including informal discussions with representative samples of the potential target audience - female migrants. Experts in the field were consulted on issues facing female migrants, methodology and any relevant literature in the field of migration. Experts in the field included general practitioners, mental health nurses, religious and community leaders, support workers, bilingual advocates, academics, and commissioners of services. The consultations comprised both individual interviews and short presentations delivered at formal meetings and community-led events. During this phase, following several recommendations and observations highlighting parallels between the PhD research journey and the migrant experience, a focus on relationship-building as a crucial element of both journeys was suggested. This emphasis on fostering connections underscored the importance of the EMBaRK process in facilitating meaningful engagement and knowledge exchange in the early stages of the shared journey.

2.5.2 Stage 2: Recruitment of co-production members and agreeing on the involvement processes (Year 1)

In the initial year, the primary focus was on recruiting members for the co-production group and establishing their roles and responsibilities within the project. Potential members were contacted primarily through face-to-face meetings, email correspondence, and telephone conversations. The PhD Candidate advertised the involvement opportunity for potential members through word of mouth, emailing organisations across Kent, Surrey, and Sussex. In this stage, efforts were directed towards engaging with female migrants and professionals who work with them. Expressions of interest to join as a co-researcher were actively sought. Following these initial efforts, detailed discussions were held with three female migrants and a professional who supports female migrants. These individuals expressed interest in exploring their potential contributions as co-researchers. The PhD Candidate subsequently delivered a presentation to ten community researchers employed by Diversity Resource International (DRI), a female migrant-led community organisation based in Lewes, East Sussex. DRI works with minoritised ethnic communities through Community Development, Community Research, and empowering marginalised communities. The PhD Candidate approached DRI to join the project as a community

partner. DRI advertised the opportunity extensively amongst its bilingual advocates. Five bilingual advocates volunteered for the role, with four of them constituting the core co-researcher team, the FMCG. A fifth advocate provided consultation on an as-needed basis. Due to the dynamic nature of long-term research projects, especially PhDs which can be between 3-7 years, and the recognition of potential issues such as childcare, work or migration back to their home country, involvement was discussed as being flexible with individuals able to contribute for however long they could. Organisation representatives were also recruited as co-production group members to the project for consultation, and support as and when required. One core member of the FMCG returned to her country of origin, while another contributed to the group for six months while temporarily relocating to her home country to care for elderly parents. In terms of nationality, the FMCG included women from China, Eritrea, Morocco, Nigeria, Uganda, Germany, Chile, The United States of America, the United Kingdom, and Zimbabwe. The youngest member of the group identified as being in her early 20s and the oldest being in their late 50s. The NIHR/Involve guidelines on paying public contributors were adopted and agreed upon with the core co-production group at a rate of £25 per hour, plus a £5 remote working fee for involvement in each online meeting as compensation for the time on the project which was hoped would compensate for mobile phone/internet data, electricity, contribution to childcare, and any other expenses deemed to be part of involvement (170). The initial sessions introduced and explored the principles of co-production and involvement (165,168,169), establishing a foundation for the research journey. Co-production, as a methodology, and EMBaRK, as both a methodological and ethical stance, serve as the twin pillars upon which this thesis rests. They underpin each stage of the research process, guiding the interactions between the lead researcher, co-researchers and participants, informing the analysis and interpretation of findings.

2.5.3 Stage 3: Developing co-produced protocol, guidelines, and research questions

The third stage of the EMBaRK journey involved the collaborative development of an ethics protocol for the qualitative study, the second empirical component of this thesis. This study was guided by recommendations from the systematic review and informed by discussions with the FMCG. The protocol, including a detailed description of the qualitative research project, collaborators, budget, timeline, and anticipated activities, was

submitted alongside other documentation to the Brighton and Sussex Medical School Research Governance and Ethics Committee (RGEC).

Among the suggestions put forth by the group was an emphasis on understanding individual interpretations of mental health. Initially, the PhD Candidate had planned to inquire about participants' experiences seeking mental health support. However, the FMCG recommended first exploring participants' understanding of *mental health* itself, as this could influence help-seeking behaviours for many female migrants. This modified approach stemmed from the recognition that perceptions of health and illness, treatment-seeking behaviour, and coping mechanisms can vary across cultures. Consequently, the meaning of mental illness might be a culturally dependent concept, potentially impacting the study's findings (171,172).

After the initial meeting, a draft topic guide was sent to two other female migrant co-researchers. A further meeting was arranged with an additional co-researcher who supports female migrants but had not been able to attend any meetings with the wider group. This meeting took place over Zoom as she was not physically in the United Kingdom at the time and this meeting lasted an hour. The co-researcher made further suggestions and largely agreed with the input of the other co-researchers. An example suggestion that was considered helpful was to reduce the number of languages that were to be accommodated through interpretation and translation based on the budget and timeframe. Other changes suggested were for the use of consistent terminology when describing the research, for example, consistency in stating '*female migrants*', rather than interchanging with '*migrant females*' or '*newcomers*'.

The draft was circulated to AR, a researcher with extensive experience working with female migrants and other marginalised populations, including individuals on the autistic spectrum, with neurodevelopmental disorders, and those who identify as LGBTQ+. AR's valuable feedback included a suggestion to focus on the nuances of different migrant statuses and to extend the residence requirement from two to five years. This ensured the study captured the experiences of women who may have moved out of the KSS area but whose perspectives remained relevant. She further highlighted that length of stay might not always correspond with self-perceptions of migrant status. For example, some women with permanent residency due to long-term residence in the UK might not identify as migrants.

After incorporating AR's comments, the revised draft was forwarded to the supervision team for further input and refinement. Finally, to assess its suitability for interviewing female migrants, the draft was sent to community organisations directly supporting the project: Diversity Resource International (East Sussex), Ethnic Minorities in Canterbury (EMIC) (Kent), and the Refugee Buddy Project (Rother, Wealden, and Hastings). An accompanying message was '*How suitable would these questions be if they were to be asked to your clients/female migrants whom you are supporting/working with?*'. The organisations responded positively and suggested minor edits, mainly on generalising mental health to include well-being, rather than being clinical in definitions of mental health. The topic guide was sent to the FMCG members for further comments. Finally, the topic guide was sent to the supervision team for final comments and approval. The supervision team approved the final version of the topic guide which can be found as Appendix B in the appendices section.

After several drafts to the RGEC, ethics was approved through the support of the FMCG, including the use of terminology, and support for interviewing participants who would prefer a female interviewer to the male PhD Candidate.

2.5.4 Stage 4: Undertaking/management of the research (Year 2 onwards)

The fourth stage of the EMBaRK journey involved navigating the interview aspects of the study. This phase encompassed the active recruitment of participants and the collection of data through interviews. A crucial need identified through discussions in the co-production meetings was the emotional and practical support of the FMCG. This led to the collaborative development of a distress protocol (Appendix D: Distress Protocol for Interview Study) for members' awareness, outlining steps for well-being and providing information on external support services. Furthermore, one-to-one and group support was offered to members should they require it.

Ongoing consultation with stakeholders and the core co-production group led to the implementation of various participatory and engagement activities, including refining the research questions and exploring ways to enhance participation interest and engagement. The issue of stigma featured prominently in these discussions, with stakeholders

highlighting the challenges it poses to individuals seeking support. The female migrants consulted also expressed that they sometimes found it difficult to discuss their mental health struggles due to feelings of shame or judgment from their communities, healthcare professionals, and family members. Further discussions within the core co-production group focused on how to provide feedback to participants, both upon completion of data collection and after analysis and initial findings.

Co-production group members actively promoted the study within their networks, with one co-researcher reaching out to over 1,000 individuals across East Sussex through her contacts and newsletters to recruit female migrants for the qualitative study. Bilingual core group members also participated in the co-interviewing process, with three interviews conducted jointly by the PhD candidate and a member of the core FMCG.

2.5.5 Stage 5: Analysis of data

The fifth stage of the EMBaRK journey involved the analysis of qualitative interview data, forming the foundation for the thesis's qualitative chapter. To equip the FMCG members for this stage, the PhD candidate conducted a half-day training session on thematic analysis in early 2022. Throughout this phase, the FMCG remained actively engaged, contributing to the development of a coding framework. Two members of the group collaboratively developed a framework, which was then applied to the remaining interviews. They actively participated in code selection and offered suggestions to refine the framework.

To further empower the group, a session facilitated by Vicky Nicholls, the Service User and Carer Involvement Co-ordinator for the Mental Health Policy Research Unit at University College London, provided supplementary training on research and involvement. This included guidance on writing lived experience commentaries, which have since been integrated into all study write-ups for the PhD project, encompassing the systematic review, qualitative study, and quantitative investigation

2.5.6 Stage 6: Dissemination of research findings

The fifth and final stage of the EMBaRK journey involves the dissemination of both the EMBaRK process itself and the research findings, a journey that is still ongoing. This phase encompasses the presentation of the EMBaRK process at conferences, the publication of research articles, and the development of a public engagement programme. Throughout this stage, the co-production group remains actively involved. Some of the dissemination activities include:

- A lived experience commentary by members of the FMCG on the systematic review *'Barriers and Facilitators to Seeking and Accessing Mental Health Support in Primary Care and the Community Among Female Migrants in Europe: A "Feminisms" Systematic Review'* which has been published in the journal: *International Journal for Equity in Health* (1). The lived experience commentary is included in the extended review in Chapter 2 of the current thesis.
- Facilitated discussion on barriers to Asylum Seeker access to mental healthcare at the Kings College London Journal Club on the 21st of April 2021. This was a coproduced presentation.
- Presenting preliminary co-produced findings of current PhD project to BSMS PGR Conference in May 2021. Presentation co-produced with a member of the FMCG.
- Community Researchers Event for a community partner where the PhD Candidate emphasised the importance of co-research of academics and community researchers.
- Coproducing slides for a KSS Community of Practice event on Unaccompanied Asylum-Seeking Children and Female Migrants on the 10th of February 2022.
- Various community engagement events including the International Mother Language event where the PhD Candidate and the co-production group co-worked on the presentation.
- National Institute for Health and Care Research national webinar on mental health and social inclusion presentation of the systematic review and qualitative study on the 21st of June 2023. The slides were co-produced with one member of the FMCG. Two members attended the event to support the PhD Candidate.
- Teaching sessions related to inequalities faced by female migrants and opportunities to address some of the inequalities. All slides relating to female migrants were co-

produced with various team members of the FMCG. The PhD Candidate was invited as a guest lecturer on the following MSc modules at Brighton and Sussex Medical School:

- 10/21: Principles of Public Health: Health Inequities Structural Racism and its Impact on Health Outcomes. The lecture centred on migrant populations experiencing racism and how as a result this impacted help-seeking behaviours and contributed to low levels of satisfaction and outcomes.

- Principles of Public Health: Potential Solutions for Addressing Health Inequities. This lecture explored the impact of health promotion and educational strategies to implement public health policies and specific examples around health promotion amongst female migrants in physical and mental health.

- Principles of Public Health: Overview on Mental Health and Mental Health Care. Examples were given on causes of mental health disorders in the overall population as well as specific groups. Availability and accessibility of support were discussed.

- At the invitation of the lecture team on the module Contemporary Social Inequalities: Race and Health Inequalities at the University of Brighton, the PhD Candidate adapted previous slides co-produced with members of the FMCG for the lecture.

- 12/21 - The PhD Candidate presented preliminary results of the systematic review on barriers and facilitators for female migrants at the Work in Progress (WIP) seminar series encouraging researchers to present their current research to get feedback from colleagues. The presentation was co-produced with a member of the FMCG.
- 01/05/24 – Presented findings from the qualitative study of the PhD project at the BSMS Health Inequalities Symposium. The presentation was titled “Unmitigated Communion: Strength, Vulnerability, and the Mental Health of Female Migrants in Southeast England”.
- Co-authorship with the FMCG and submission of a manuscript titled “Strength and Vulnerability: Mental health and unmitigated communion among female migrants in Southeast England. A qualitative study”. The research paper was awaiting acceptance by the target journal at the time of submission of the PhD thesis.
- 11/06/24 - Presentation of PhD project at the BSMS Postgraduate Researcher and Early Career Researcher Conference. The presentation title was ‘Co-creating Solutions:

Migrant Women's Mental Health: Overview of a PhD Project seeking to address mental health inequalities’.

- The anticipated completion of the doctoral project will not hinder the continued co-production of future outputs, such as conference presentations and co-authored publications. For instance:
 - A co-authored abstract was submitted and accepted for presentation at the 38th Annual Conference of the European Health Psychology Society to be held in Cascais, Portugal in September 2024. The title of the talk was “*Stigma as a barrier to accessing support among female migrants in Southeast England. A qualitative study*”.
 - A member of the FMCG was invited to collaborate on developing presentation materials and co-deliver a session at the Kent Surrey Sussex Applied Research Collaboration (ARC KSS) Researcher Week in early September 2024. The session, titled “*Beyond the Ivory Tower: Building Bridges with Community Research*”, was co-led by the PhD Candidate and the FMCG member. It highlighted the impact of the EMBaRK process on the PhD project.

Throughout these engagements and activities, the PhD candidate collaborated with the core members of the FMCG in developing presentation and engagement strategies (See Appendix E: Co-produced presentation examples).

2.5.7 Stage 7: Further engagement and suggestions for future research

The female migrant co-production group convened regularly throughout the PhD project, with 15 meetings dedicated exclusively to the core group. Monthly meetings were arranged where possible, with non-regular attendees varying throughout the PhD project. The group members provided suggestions for all the phases of the PhD project. While examining the perceptions and experiences of mental health among female migrants was deemed crucial, the FMCG members, in collaboration with the primary PhD supervisor, proposed a valuable addition: comparing these experiences with those of British-born females. This led to the development of Chapter 5, the quantitative study, which analyses the clinical records of both groups to explore differences in care pathways to mental health support. The FMCG further suggested conducting a similar qualitative study, but this time encompassing all women identifying as female across Kent, Surrey, and Sussex.

Unfortunately, due to the time and financial constraints inherent to a PhD project, and the primary focus remaining on female migrants, this broader study was not feasible. However, it represents a valuable avenue for future research beyond the scope of this PhD.

As the research progresses, the intention is to thoroughly evaluate EMBaRK, with a focus on its efficacy and impact. This post hoc evaluation, co-designed and guided by the insights of the FMCG, will provide valuable data on EMBaRK's utility in mental health research and its potential adaptability to other contexts. The group's ongoing involvement will be crucial in this evaluative phase, ensuring that the framework remains relevant and effective. Moreover, there are plans to refine EMBaRK for application in various settings beyond mental health research.

2.6 Discussion on the EMBaRK process

The EMBaRK process was a complex and iterative process that involved a wide range of stakeholders, including professionals, community-led organisations, and female migrants. Consultation with a variety of experts and stakeholders, including female migrants, to gather their input on the research questions and methodology was a first step. The recruitment stage, in which the PhD Candidate recruited a core co-production group of female migrants to work with him on the project, followed. The core co-production group actively engaged regularly to discuss the research process by providing feedback on the research design, and data collection methods, and contributing to the analysis, and dissemination of the research findings. A similar study involving co-production with vulnerable populations has benefited from the insight of members with lived mental health experience (173).

One of the key strengths of the EMBaRK process was how it allowed the PhD Candidate to build trust and rapport with various groups of female migrant participants, including asylum-seeking individuals, refugees, economic migrants, and undocumented individuals. This was essential for collecting sensitive data about their mental health and gender-specific needs, as the emphasis was on safety and a supportive environment for participants to share their experiences. The PhD Candidate appreciated the value females contributed in some activities, for example, recruitment where the PhD Candidate as a male would have

found it difficult to recruit some of the more vulnerable female participants. Having a female assure them and highlight they were part of the study team made it more likely for potential participants to volunteer to be interviewed. Drawing upon feminist theories and critical pedagogy, particularly feminist standpoint theory (11), feminist participatory action research (174), intersectional feminism (12), unmitigated communion theory (175), and Paulo Freire's critical pedagogy (176) the male researcher's engagement with the FMCG was informed by considerations of power differentials and privilege within the research context. An example reflection was when one of the group's members constantly referred to the PhD Candidate as "Mr P.". When asked why not just address using his first name, the group member stated, *'Where I come from you being older, being a man in such a position, I have to show you respect'*. The PhD Candidate engaged in a dialogue with the group member, acknowledging their mutual admiration and emphasising the power of the group member's knowledge and experience. This recognition positioned the group member as an equal partner in the research endeavour, potentially even more adept at understanding the mental health needs of female migrants than the PhD Candidate. Throughout the PhD journey, such instances of reciprocal learning and empowerment were documented in a private diary and subjected to reflective analysis.

However, implementing the EMaRK process on the PhD project also presented some challenges. One challenge was the time commitment required from the core co-production group members and community partners. Some members of the group were compelled to relocate outside of the UK or change employment during the project, specifically as a direct consequence of the COVID-19 pandemic and Brexit. Female-specific conditions, including pregnancy, limited some forms of involvement for some members of the group. The PhD Candidate's persistent anxiety regarding the potential for misrepresentation or misappropriation of the female participants' lived experiences and viewpoints, coupled with the possibility of negative external critique, presented a significant challenge within the PhD project. This was particularly pronounced due to the adaption of an innovative, time-sensitive methodological approach through the EMBaRK process. This worry was discussed extensively during supervision sessions. Financial limitations unfortunately necessitated a research engagement process contingent upon available funding. This inherent limitation inevitably curtailed the frequency and duration of meetings, and the

capacity to undertake tasks beyond those formally scheduled. Furthermore, a lack of resources limited the provision of additional support for the FMCG, thereby hindering the regularity of reflective sessions.

Overall, the engagement process was a valuable experience that helped to improve the quality of the research findings on the PhD journey. The FMCG offered invaluable input on the research design, data collection, and analysis phases. They served as a consistent source of guidance and a reference point for determining the trajectory of the co-produced elements within the PhD process.

The thesis, however, distinguishes between two key domains: patient involvement (PI) in individual healthcare settings and PI in research processes. While these domains share principles of patient-centredness, collaboration, and empowerment, their applications diverge. Clinical PI frameworks often focus on enabling patients to make informed decisions about their care, whereas research PI frameworks, such as those endorsed by the NIHR, prioritise the inclusion of patients and public members in co-designing and shaping research agendas.

In this thesis, the integration of PI principles into the EMBaRK framework sought to bridge these domains. For example, the FMCG drew upon its members' experiences in healthcare to inform the research process, ensuring that the study design and dissemination strategies resonated with their lived realities. This intersectionality between healthcare PI and Research Community Engagement and Involvement (RCEI) underscores the importance of embedding cultural and contextual relevance in both areas, a key contribution of this research

2.7 Conclusion

The engagement processes described in this chapter, characterised by extensive use of the EMBaRK framework, are proposed as a model for other research projects seeking to co-create research with marginalised populations. By involving stakeholders throughout the research journey, researchers can ensure that their work is relevant, trustworthy, and impactful within their field of study. The EMBaRK process has been integral to the success of this PhD project, ensuring that the research is relevant, meaningful, ethical, informative, and well-informed.

A crucial aspect of this approach has been the emphasis on transparent reporting to ensure that the research authentically reflects and includes the voices of female migrants. Continuous feedback to the co-production group, stakeholders, community partners, and participating female migrants was essential to making the study successful and meaningful. The EMBaRK process represents an ongoing dialogue between the PhD Candidate, the core co-production group, stakeholders, and female migrants, ensuring that the research remains grounded in their lived experiences and priorities.

Chapter 3: Barriers and facilitators to seeking and accessing mental health support in primary care and the community among female migrants in Europe: A “Feminisms” systematic review

Chapter 3 is the extended version of a published review titled *Barriers and Facilitators to Seeking and Accessing Mental Health Support in Primary Care and the Community Among Female Migrants in Europe: A “Feminisms” Systematic Review*.

Nyikavaranda P, Pantelic M, Jones CJ, Paudyal P, Tunks A, Llewellyn CD. Barriers and facilitators to seeking and accessing mental health support in primary care and the community among female migrants in Europe: a “feminisms” systematic review. *Int J Equity Health* [Internet]. 2023 Sep 26;22(1):196. Available from: <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-023-01990-8> (Refer to study Protocol in Appendix A).

3.1 Abstract

Background: Recent years have seen record levels of migration to Europe. Female migrants are at heightened risk of developing mental health disorders, yet they face barriers to accessing mental health services in their host countries. This systematic review aims to summarise the barriers and facilitators to accessing mental health support for female migrants in Europe.

Methods: The review follows PRISMA guidelines, and the protocol was pre-published on PROSPERO. Six electronic databases were searched: CINAHL, Global Health Database, Medline, PsycARTICLES, PsycINFO and Web of Science. Thematic analysis was undertaken on the identified studies. A feminist quality appraisal tool was applied.

Results: Eight qualitative, six quantitative and five mixed methods studies were identified. Barriers included a lack of information, stigma, religious and cultural practices and beliefs, and a lack of consideration of gender-specific needs within the health system. Gender-sensitive services, supportive general practitioners and religious leaders facilitated access.

Conclusions: The design of mental health research, services, policies, and commissioning of support for migrants must consider female migrant needs. Mental health support services must be culturally aware and gender sensitive.

Registration: The review protocol was registered on the International Prospective Register of Systematic Reviews (PROSPERO, registration number CRD42021235571)

Keywords: Female migrants. Refugees. Asylum seekers. Mental Health. Access. Primary care

3.2 Introduction

A growing body of evidence suggests that females within newly arrived migrant populations experience a heightened vulnerability to developing diagnosable mental health conditions (46,177–179). This risk factor appears to be independent of the specific migratory category, encompassing labour migrants, individuals relocating for family reasons, refugees, and asylum seekers. Notably, this vulnerability is observed when compared to both their male migrant counterparts and the general population (64,108,114). Some migrant populations have unique challenges, for example, their lack of legal status may limit access to appropriate support such as in the case of undocumented and asylum-seeking mothers who fear deportation should they seek support (180,181). Studies have reported differences in mental health outcomes among different migrant populations (107,182). However, consideration for the similarities in the experience of migrant populations in accessing support from a gendered perspective has not always been so. There are near-similar experiences from a gendered perspective of the different female migrant populations in access and treatment compared to male counterparts and the general population (102,183–185). Rather than migrant status differences, gender issues need to be brought to the fore as most studies suggest gender is a strong predictor of health outcomes e.g., mental health, cancer screening, and smoking cessation (155,183,186,187). Research has been criticised for potentially overlooking the specific experiences of marginalised groups within broader categories like 'women' or 'minorities,' for example Indigenous female migrants crossing into the United States of America are effectively invisible due to being classed as Latinx or Indians (188). Within the definition of who is a migrant, this can also be problematic (189). This systematic review specifically sought out research that disaggregated data by relevant demographic factors, such as migration status and ethnicity, to capture the nuanced experiences of different groups, ensuring a more comprehensive understanding of female migrant mental health. In so doing, Referral to secondary mental health services and service utilisation amongst female migrants is low, and one of the reasons for this might be the lack of and inadequacy of support structures specifically designed for female migrants (155,190). Good coordination and provision of adequate services have improved mental health outcomes (191). Furthermore, female migrants have shown resilience, coping mechanisms, and posttraumatic growth after facing challenges pre- and post-migration (192–194). Studies have investigated migration in the context of grouping second-generation young people, labour migrants, asylum seekers

and refugees under an umbrella term of ‘migrant groups’ (195,196). Whilst international law affords differing levels of protection and assistance to economic/labour migrants and asylum seekers, the distinction between these groups may not always be readily apparent within EU member states (68,197,198). Individuals coming from the same country may also have different migrant group statuses. For example, following the dissolution of the Soviet Union in 1991, individuals from the former Union of Soviet Socialist Republics (USSR) countries (e.g., 1990s-2000s) who ended up being economic migrants, refugees, or moving for family reunification in Switzerland fell under the ‘migrant’ umbrella (199). Migrant workers, refugees and asylum-seeking individuals experience similar barriers to accessing support for their mental health in host countries (200–203). The added layer of having a label of ‘*migrant*’ or ‘*immigrant*’ for a population that is traditionally faced with more inequalities compared to host populations demonstrates the intersectional, yet often complicated nature of female migrants placed in different categories.

In the context of inequalities faced by females and the different groupings of female migrants, it is necessary to investigate the experiences and perceptions of migrants identified as female, accounting for their migration status but not discounting their common experiences as women. For the current review, we use the terms ‘migrant’ and ‘newcomer populations’ as a grouping of these different categories, however, we acknowledge differences in experiences and status and how these may impact mental health access throughout the review.

Migration research largely focuses on men (204), which has led to services being designed with male migrants in mind and little input from and consideration for female migrant populations. Indeed, whilst male migrants utilise mental health services less than the general population, female migrants make disproportionately less use of these services compared to the male migrant population (114). A male narrative-dominated review of perceptions and experiences of access does not reflect female migrant views in understanding the collective experiences and perceptions of females with a migrant label regardless of migrant status. Inequalities are found among class, race, sexuality, gender, and power. Within these different inequalities, the group traditionally labelled as ‘*female*’ has faced even more inequalities within these inequalities (102,184,185,205). The review acknowledges the controversies within feminist theories and gender studies (206). Additionally, it challenges the stereotypical views of migrant males being ‘*a risk*’ and female migrants being ‘*at risk*’ as widely reported by the press which feeds into negative or stereotypical public perceptions of migrants (205).

Therefore, the present review takes a generalist approach to discussing issues affecting females including gender and sex, and the intersection between race, class, gender, and identity. Conclusions of female migrant issues have formed largely due to historic, colonial, and often racialised thinking without the need to understand the direct views and experiences of female migrants who may have more than just “migrant” as a label as they can be female and have different sexualities and religions (12,15,207,208).

The review seeks to highlight the inequalities faced by women and girls from newcomer populations. It uses a ‘*feminisms*’ lens, which seeks to add to the attempts within feminist theories of defining, establishing, and achieving personal, social, political, and economic rights for women and girls through the focus on gender as a system influenced by migration and intersectionality (209). Incorporating transnational and intersectional feminisms and decolonial perspectives, in the words of Dr Nof Nasser-Eddin, is to ‘*look at the system or systems of oppression that make our struggles much more unified*’ (210). This means investigating what unifies the different female migrant populations as opposed to categorising them by migrant status, thus weakening the need to address their struggles, for ‘*sisterhood is global*’(211).

This review aims to address important gaps in the literature by identifying the barriers and facilitators to help-seeking and accessing mental health (MH) support for female migrants. The review employs a feminisms lens to identify issues relating to constructs of feminist theories raised within these studies and how these influence research, policy, provision of services and access routes to support the mental health of female migrants (174,204,212–214).

This systematic review addresses the overarching research question by identifying barriers and facilitators to mental health support for female migrants. By synthesising existing evidence, the review provides foundational insights into the unique challenges faced by female migrants, informing subsequent stages of this research.

The EMBaRK framework guided the systematic review by foregrounding lived experiences to identify critical gaps in the literature. This approach ensured that the findings highlighted underrepresented themes relevant to female migrants’ mental health.

3.3 Methods

This study followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) (215). The review protocol was registered on the International Prospective Register of Systematic Reviews (PROSPERO, registration number CRD42021235571).

3.3.1 Eligibility

Studies were considered eligible for the review if they included i) female participants who identified as migrants, asylum seekers or refugees, and data could be extrapolated on female experiences where both genders were included, ii) focused on any common mental health conditions (CMHCs) (e.g., PTSD, depression, and anxiety disorders) and iii) perceived barriers and facilitators to accessing formal or informal mental health support. Formal mental health support, within the scope of this review, is defined by structured appointments, time limitations, and professional expertise. It is delivered by trained professionals, such as physicians, psychologists, social workers, and psychiatrists. In contrast, informal help is characterised by emotional intimacy, companionship, and reciprocity. The informal help is often provided by friends, family members, and religious or community support groups. Similar definitions have been used in other studies (216–218). Primary care is the first point of contact for healthcare, providing comprehensive, integrated, person-centred services to meet the majority of personal health needs (65). Access to community and primary care support is mostly for CMHCs (219,220), hence, the review focuses on CMHCs.

No limitation was applied to participants' age, date of study publication or design. Within Europe, 27 countries comprise the European Union (EU) and the EU single market countries outside of the EU: Iceland, Liechtenstein, Norway, Switzerland, and the United Kingdom (UK) were included (221). The review focused on Europe due to several factors, including:

- Greater homogeneity in healthcare policies and practices across European countries, facilitating comparison and analysis.
- The free movement of people within the European Economic Area, creating a specific context for migrant health.
- Europe's status as a major destination for migrants from diverse socioeconomic and geographic backgrounds, posing unique challenges to healthcare provision.

The settings considered for the study were primary care, which included general practitioners (GPs) and community care, including informal and formal support. Example subject index terms included: female migrants, access, mental health, primary care, community health services, and Europe.

3.3.2 Search strategy

To identify relevant articles, the research team employed the SPIDER search tool, an acronym for Sample, Phenomenon of Interest, Design, Evaluation, and Research Type. SPIDER, designed by Alison Cooke and her colleagues is specifically designed to identify relevant qualitative and mixed-method studies (222). Index terms were combined with Boolean operators (*See* Table 5).

Table 5: SPIDER search strategy

SPIDER	Search Terms
Sample	refugee* OR asylum OR migrant* OR immigrant* OR emigrant* OR displac* person* OR displac* population* OR migrat* OR (minority ethnic groups) OR Exile*

Phenomenon of Interest	<p>AND</p> <p>(Mental illness) OR (mental disorder) OR (common mental health problems) OR (mood disorder) OR (emotional problems) OR trauma OR distress OR anxiety* OR depress* OR stress OR (common mental health symptoms) OR (major depressive disorder) OR (mental health problem) OR wellbeing OR well-being OR (low mood) OR dysthymia OR phobia* OR (panic disorder) OR (post-traumatic disorder) OR (posttraumatic stress disorder) OR PTSD</p> <p>AND</p> <p>(Psychological Therapy) OR IAPT OR (Improving Access to Psychological Therapies) OR GP OR (general practice*) OR (primary care) OR (mental health services) OR (Psychological Treatment) OR psychothera* OR counselling OR CBT OR (cognitive behavioural therapy) OR psych* OR (community intervention) OR (peer support) OR (community engagement) OR CMHT OR (Community Mental Health Team) or (Community support)</p> <p>AND</p> <p>Access* OR Exclusion OR (Low representation) OR Non-attendance OR Help-seek* OR (Failure to attend) OR (service utilisation) OR (treatment participation) OR (treatment engagement) OR (unmet need) OR (service engagement) OR attend* barriers OR (treatment seeking) OR non-referral OR self-referral OR (support seek*) OR Uptake OR (pathways to care) OR (Health Service Access*) OR seek* help OR (seek* support) OR (seek* treatment) OR Stigma</p>
Design	
Evaluation	Barrier* OR Facilitator*
Research Type	Qualitative or Quantitative

3.3.3 Study screening and selection

Reviewers PN and AT independently screened titles and abstracts from six electronic databases, from their inception to 10 March 2021. Subsequently, both PN and AT independently evaluated all full texts for inclusion. The final list of articles was then shared with CDL, CJJ, PP, and MP for a final suitability assessment. In May 2022, PN conducted updated searches and discussed potential inclusions with the review team.

The databases searched were: CINAHL, Global Health Database, Medline, PsycARTICLES, PsycINFO, and Web of Science. Additionally, a search of references from relevant reviews and a 'reverse citation' exercise on Google Scholar was undertaken to identify subsequent citations of the included articles.

3.3.4 Quality assessment and presentation

The Mixed Methods Appraisal Tool (MMAT), Version 2018, was utilised to conduct a critical appraisal of the reporting quality within the included studies. The MMAT was chosen because it is a multi-purpose tool that can be used for qualitative research, randomised controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies (223). The MMAT is used to assess the quality of the reporting of a study, rather than the quality of the study itself. Therefore, no paper was rejected based solely on its quality assessment.

Two independent reviewers (PN and AT) appraised all included papers, utilising the MMAT. The reviewers' scores were then compared, and any discrepancies were discussed. This process ensured that the quality assessment was reliable and consistent.

The Feminist Quality Appraisal Tool by Morgan and colleagues (2017) was selected for appraisal from a feminist perspective as it draws upon feminisms including radical, constructionist, and intersectional perspectives (224). Furthermore, as it investigates constructs of gender, it also seeks to address health inequalities based on gender in this instance, as the exclusion of female knowledge and experiences in a male-dominated knowledge and experience world may lead to the very inequalities being sought to be eradicated (214). Definitions have been abridged from the study by Morgan and colleagues (2017). This is a subjective measurement of study quality; however, it benefits the review process as it is not restricted to choosing between implicit and explicit components of studies. PN and AT independently assessed the included studies in discussion with the rest of the review team.

3.3.5 Analysis

The text of the included articles was imported into QSR International's NVivo 12 qualitative data analysis software (225). For any studies incorporating quantitative data, key outcomes and researcher interpretations were extracted independently by PN, with the results subsequently verified by CDL, CJJ, MP, and PP. Inductive thematic analysis was used to present prominent themes from the qualitative studies (226). Through data familiarisation of the findings and author interpretations, these generated codes were synthesised to prominent themes.

Lived Experience contribution to the review

A collaborative group comprising female migrants and professionals engaged in their support convened to deliberate upon the challenges confronting female migrants. This discourse culminated in the formulation of a preliminary analytical framework for research into the mental health of female migrants (refer to Chapter 2). The group has sustained its involvement in subsequent investigations on this subject matter.

3.4 Results

Of the 806 papers identified through database searches, 20 titles underwent independent full-text review by two reviewers (PN and AT). Initially, 17 were included in the review following this stage (Figure 6). The reasons for excluding many of the studies were because they did not meet the inclusion criteria, for example, not being written in English, not having a primary focus on mental health, or only including secondary care data. Additionally, some studies were excluded because they were duplicates or not relevant to the research question.

On further screening and discussion between reviewers, two studies were excluded because they did not involve the collection of data from migrants, and another study was excluded as it did not differentiate data gathered according to gender. An updated search identified four additional studies for consideration. Two of these were rejected for not meeting the criteria (e.g., being a review or conducted in an ineligible geographical setting). However, after further discussions to resolve disagreements, an additional two studies were included, bringing the final number of studies in the systematic review to 19.

The full list of excluded studies and the process of identifying studies for inclusion in this review are detailed in the PRISMA flow diagram (*See* Figure 6).

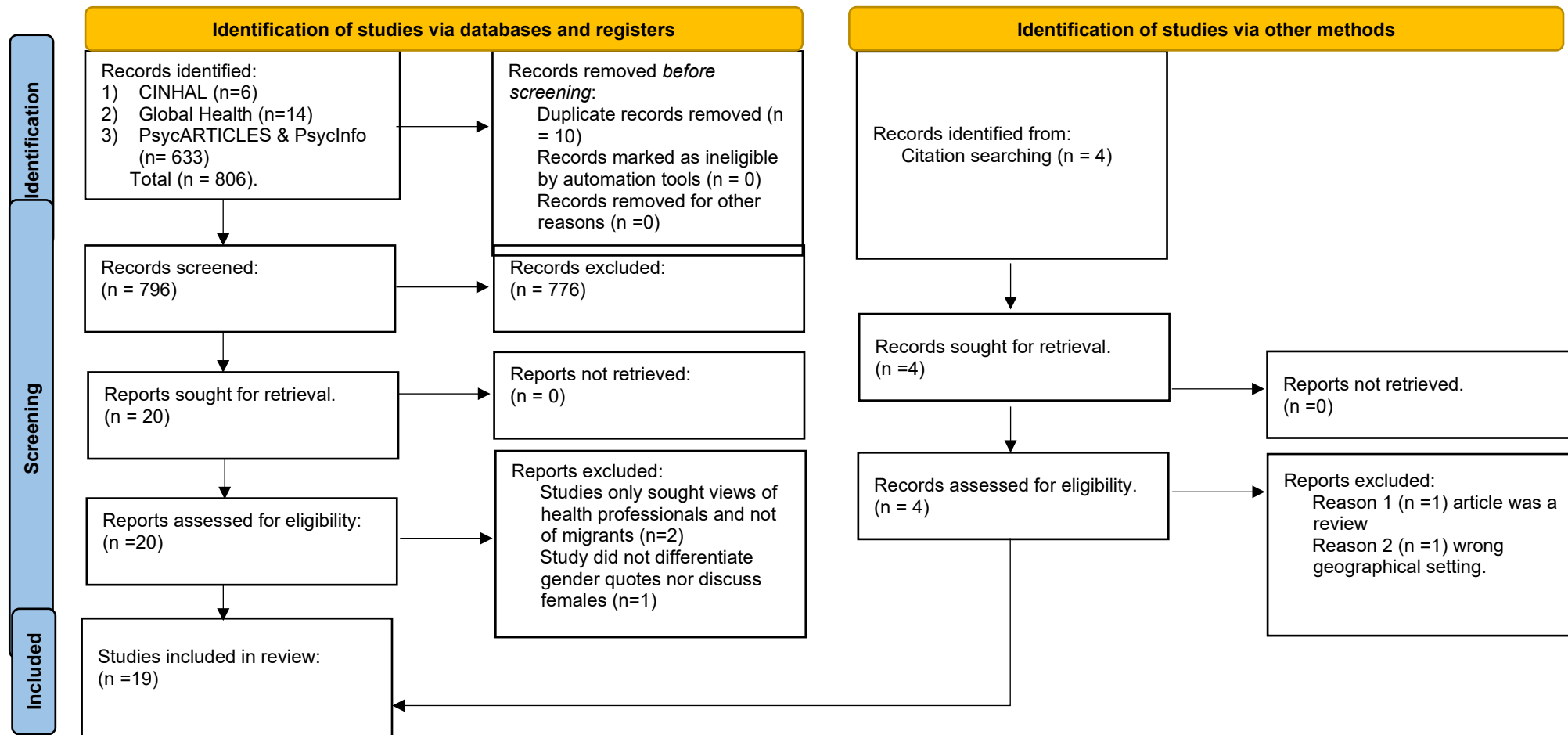


Figure 7: PRISMA flow diagram of systematic review search results

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: <http://www.prisma-statement.org/>

Key study characteristics were extracted and summarised (Table 6). The included studies were conducted in Austria, Finland, Germany, Italy, Norway, Sweden, Switzerland, The Netherlands, and the United Kingdom. One particular study (227) encompassed several European countries, including Slovenia, Croatia, Hungary and Italy. A further study included data from Syrian refugees in Egypt, Sweden, and Germany. This article was included in the review as its primary research countries were in Europe (228). Eight papers were qualitative (227,229–235), six papers were quantitative (187,236–240), with the remaining five papers utilising mixed-method approaches (228,241–244).

Table 6: Study characteristics

Author, year, country	Study design and setting Study setting	Participants Characteristics	Migrant Status Definition	Barriers and facilitators	Key Findings	% of females
Markova et al. (2020) Norway (238)	Design: Quantitative Setting: Direct contact through digital means was used, including social media platforms.	Participants: Native comparison Norwegian students ($n=250$) Russia ($n=151$), Poland ($n=109$), Pakistan ($n=117$), Somalia ($n=100$),	non-provided	Facilitators: Religious leaders Traditional and informal sources of support (friends etc..) as gatekeepers to support. Internet forums	Traditional help sources for ¹ MH were endorsed more by immigrants from Pakistan and Somalia than any other immigrant group in the study of native people from Norway.	^b G1*=69% ^c G2=87% G3=77% G4=69% G5=44%
Linney et al. (2020) UK (231)	Design: Qualitative focus group Setting: Community-driven, co-produced with the Somali community in Bristol to address rising suicides within the Somali community in Bristol	Participants: Focus groups were held with separate groups for males and females N=23 ² m ($n=12$) ³ f ($n=11$)	non-provided	Barriers: Stigma Language barriers, lack of continuity and long waiting times. Lack of knowledge of MH illnesses. Facilitators: education, training, and awareness Increased services and older Somalis to talk to	The community provided ideas for improvements in mental illness recognition and accessing culturally safe support services	47.8%
Kiselev et al. (2020) Switzerland (230)	Design: Qualitative Setting: The study was part of the ⁴ STRENGTHS project, evaluating the adaptation, implementation and scaling up of ⁵ PM+	Participants: ($n=5$) Healthcare providers ($n=5$) and stakeholders ($n=5$)	Syrian Key Informants - refugees and asylum seekers who had arrived after the outbreak of the Syrian war	Barriers: Language, gatekeeper-associated problems, lack of resources, lack of awareness, fear of stigma and a mismatch between the local health system and perceived needs	Multiple structural and socio-cultural barriers, with socio-cultural barriers being perceived as more pronounced.	60%
Mölsä et al. (2019) Finland (245)	Design: Mixed Methods Setting: Somalis living in Helsinki with matching to Finnish pairs through the National Register.	Participants: 128 Somalis, f($n=75$), m($n=53$) 128 matched Finnish pairs, f($n=75$), m($n=53$) All participants between the ages of 50- 80	non-provided	Barriers: language, health professionals' ignorance and insensitivity. Lack of knowledge of services, and the stigma of MH within Somali society.	The Somali group had significantly lower access to personal/family doctors at healthcare centres. They used more nursing services than Finnish patients. Preference for traditional care, most commonly	58.5%

Author, year, country	Study design and setting Study setting	Participants Characteristics	Migrant Status Definition	Barriers and facilitators	Key Findings	% of females
				Structural inequalities – Somalis did not have access to private doctors. Facilitators: sheikhs and imams	religious healing, for MH problems by most Somalis.	
Grupp et al. (2019) Germany (241)	Design: Mixed Methods Setting: A survey using paper-and-pencil and online assessments. approached in their accommodation facilities.	Participants: <i>n</i> = 119 asylum seekers from seven Sub-Saharan African countries, mainly Eritrea (<i>n</i> = 41), Somalia (<i>n</i> = 36), and Cameroon (<i>n</i> = 25). Each focus group had around 50% females.	Asylum seekers had to have flight experience and an origin in a Sub-Saharan African country.	Barriers: structural and cultural barriers to seeking medical and psychological treatment. Lack of knowledge of services Facilitators: Family and friends, religious leaders, preference for ⁶ G.Ps.	Asylum seekers showed a high intention to seek religious, medical, and psychological treatment for symptoms of ⁷ PTSD. Higher preference to seek help from religious authorities and GP.	±30%
Kohlenberger et al. (2019) Austria (246)	Design: Quantitative Setting: Captured from a nationally representative survey of the population of ⁸ ATHIS and ⁹ ReHIS.	Participants: 515 persons <u>Characteristics:</u> 18-61 years Syrians (54%) Iraqis (16%) Afghans (23%) Other citizenship (7%) <u>Gender:</u> F(<i>n</i> =73), M (<i>n</i> =447)	non-provided	Barriers: conflicting schedules, long waiting lists, lack of knowledge, language problems Facilitators: High usage of day-care services	Refugees used hospitals and day-care services more than the average Austrian but less specialised services afterwards. Women reported more use of services than men and more unmet needs than men.	14%
Straiton et al. (2019) Norway (187)	Design: Quantitative Setting: National register-based cohort study utilising dynamic population - women living in Norway between 2009-2013 and diagnosed with at least one mood disorder were included.	Participants: Age: 16-67 years 1,834,822 women	<u>Migrant</u> - Born outside of Norway with two non-Norwegian-born parents. <u>Descendant</u> - born in Norway, with two non-Norwegian-born parents. <u>The majority</u> - all other women, including Norwegian born with at least one Norwegian parent and foreign-born with at	Barriers: stigma, language differences, the Western conceptualisation of MH disorders, consultation fees. Facilitators: length of stay likely to lessen barriers to access.	Migrant and descendant women were less likely to use outpatient MH services. Female migrants had fewer follow up consultations for their MH compared to the descendant and majority of Norwegian women.	100%

Author, year, country	Study design and setting Study setting	Participants Characteristics	Migrant Status Definition	Barriers and facilitators	Key Findings	% of females
			least one Norwegian parent)			
Carruthers & Pippa (2019) UK (236)	Design: Quantitative Setting: Data from two G.P. practices in South London.	Participants: (n=35) Male (n=20) Female (n=15). Mean age=35	Identified asylum seekers and refugees	Barriers: language issues and lack of interpreters, stigma, immigration concerns and information sharing.	High frequencies in psychiatric problems in refugees and asylum seekers but lesser referrals and use of secondary care compared to the UK average.	42.8%
Burchert et al. (2019) Germany, Sweden, and Egypt (228)	Design: Mixed Methods Setting: ¹⁰ SBS designed by the ¹¹ WHO to help Syrian refugees access health systems in host countries.	Participants: n=36 An equal number of men and women were interviewed in their host country. Mean age = 33.8 years (<i>SD</i> =10.9)	Non-provided	Barriers: unacceptance of MH problems low technical literacy Lack of trust in apps Limited language skills High cost of smartphones and mobile data packages Facilitators: training and tutorials	Findings indicate the potential of e-health interventions in supporting the MH of refugees.	50%
Van Loenen et al. (2018) 7 EU Countries (227)	Design: Qualitative Setting: Fieldwork conducted in refugee reception centres in Greece, Slovenia, Croatia, Hungary, the Netherlands, Italy, and Austria	Participants: - 98 refugees: male (n=65), female (n=33) and 25 - 25 Healthcare workers: male (n=9) and female (n=16)	Refugees and other migrants without permanent residence permits	Barriers: Lack of information, lack of trust, time pressure, stigma, complex health and administrative systems, lack of continuity of care, language differences, gender, and culturally specific access to health care. Facilitators: interpreters and culturally competent health providers.	Refugees wished for compassionate health care provision and formal interpreters. They also hoped for information on healthcare provision and health promotion.	33.6%
Fox & Hiam (2018) UK (234)	Design: Qualitative Setting: 2 Case Studies of females living in the United Kingdom but have both been refused asylum. One is homeless. Both	Participants: Three females, Mariam (28), originally from Eritrea, Josephine (37) who fled from Uganda and Deidre, from The Caribbean.	Separate box of definitions for immigration status including: Refugee: Someone whose asylum	Barriers: Hostile environment policies and practices, Lack of proper information and knowledge on rights of asylum seekers and failed asylum seekers by bother providers	Recent policy changes compromise the healthcare needs of refugees, asylum seekers and failed asylum seekers.	100%

Author, year, country	Study design and setting Study setting	Participants Characteristics	Migrant Status Definition	Barriers and facilitators	Key Findings	% of females
	have suffered physical and mental abuse and exhibit signs of mental health trauma.	Both are identified as refused asylum seekers.	application has been successful; the Government recognises they are unable to return to their country of origin owing to a well-founded fear of being persecuted for reasons provided for in the Refugee Convention 1951 or European Convention on Human Rights. Refused asylum seeker person whose asylum application has been unsuccessful. Asylum seeker: A person who has left their country of origin and applied for asylum in another country but whose application has not yet been concluded.	(G.P.s and asylum or failed asylum seekers). Facilitators: Doctors of The World, Red Cross, and churches		
Papadopoulos et al. (2017) UK (244)	Design: Mixed Methods Setting: Estimated 25,000-30,000 Ethiopian refugees in the UK at the time of the study. The study applied a multi-method participatory approach which included members of the Ethiopian community.	Participants: Ethiopians resident in the UK (<i>n</i> =106)	Asylum seeker - a person who has applied to the ¹² IND to be recognised as a refugee but who has not yet received a decision or is in the process of appealing against an initial rejection of his or her claim.	Barriers: language problems Poor understanding of primary healthcare support. Postmigratory stress	Culturally competent services should be provided to migrants as postmigratory stress can lead to poorer health outcomes.	52%

Author, year, country	Study design and setting Study setting	Participants Characteristics	Migrant Status Definition	Barriers and facilitators	Key Findings	% of females
Pooremamali & Eklund (2017) Sweden (240)	Design: Quantitative Setting: Sweden has two types of day centres accessed by people with MH: meeting place-oriented and work-oriented centres.	Participants: (<i>n</i> =125) Immigrant background (<i>n</i> =56) Native Swedes (<i>n</i> =69) Migrants living in Sweden 11-45 yrs. (M=27, SD=9). Country of origin (<i>n</i> =29) Born in Sweden but considered migrant (<i>n</i> =15)	Being born outside of Sweden and/or having at least one parent born in another country” “Immigrant background”	Barriers: low educational attainment, disempowerment, low self-esteem, dissatisfaction with everyday activities. Stigma and discrimination Facilitators: Integration due to length of stay.	Being of immigrant background and having an MH illness was a negative factor to empowerment.	59%
Morgan et al. (2017) UK (239)	Design: Quantitative Setting: The UK is host to an increasing refugee and migrant population, however, continues to put restrictions on them on employment, housing, benefits, and detention for some during the process.	Participants: (<i>n</i> =97) Mean age 33.8 (SD=8.4), range 18-59 years 57% refused asylum (<i>n</i> =55) Countries of origin (<i>n</i> =25) Female (<i>n</i> =46), Male (<i>n</i> =51)	non-provided	Barriers: Financial, housing, Unsecure immigration status, Isolation Facilitators: information on acculturation including English language classes, Perceptions of democracy and freedom.	Both sets of participants, asylum seekers and those who were refused asylum reported levels of anxiety, stress, depression, and PTSD. Those who were refused asylum scored higher on depression and anxiety.	47%
Ali et al. (2016) UK (229)	Design: Qualitative Setting: Lower referral rates to ¹³ CAHMS for children from ethnic minority backgrounds. Pakistanis make up the largest ethnic minority in Peterborough.	Participant ages: 11-19yrs. Four focus groups (FG). *FG1 - boys (<i>n</i> =10) *FG2 – girls (<i>n</i> =7) FG3 boys (<i>n</i> =7) FG4 – girls (<i>n</i> =9)	Participants held or were descendants of Pakistani passport holders. Parents were in transnational marriages.	Barriers: Lack of information on accessing support, stigma Facilitators: Religious leaders, mentoring schemes with older students and information from the internet	Participants had poor awareness of MH services and treatment options. Culturally appropriate awareness of MH and support that was gender-specific were suggested.	48.4%
Loewenthal et al. (2012) UK (232)	Design: Qualitative Setting: Bengali, Urdu, Tamil, and Somali-speaking communities recruited through their community associations	Participants: Bengali: 1 st focus group f (<i>n</i> =8). 2 nd focus group f (<i>n</i> =4) m (<i>n</i> =2) Urdu: 1 st focus group f (<i>n</i> =15), 2 nd group, m (<i>n</i> =6) Tamil: 1 st group m(<i>n</i> =10) 2 nd group f(<i>n</i> =8) Somali: 1 st group f(<i>n</i> =14) 2 nd group m(<i>n</i> =10) Validation interviews: Bengali f (<i>n</i> =4) m (<i>n</i> =2), Urdu f(<i>n</i> =3), m (<i>n</i> =3), Tamil m(<i>n</i> =4), f(<i>n</i> =2), Somali m(<i>n</i> =3), f(<i>n</i> =3)	non-provided	Barriers: Understanding of MH issues and availability of MH services Cultural barriers Stigma Disclosure of MH problems Facilitators: community-based interventions. Awareness-raising forums. Religious leaders	Participants did not fully understand common conceptualisations about MH issues, nor did they know how to seek mental health support.	59.2%

Author, year, country	Study design and setting Study setting	Participants Characteristics	Migrant Status Definition	Barriers and facilitators	Key Findings	% of females
Tabassum et al. (2009) UK (247)	Design: Qualitative Setting: The study was conducted in Darnall, Sheffield, with high unemployment and deprivation with few white residents. Interviews were held in participants' homes. Females were interviewed with the whole family present due to cultural considerations.	Participants: Males ($n=22$) 1 st Generation females ($n=29$) 2 nd Generation females ($n=23$) Four individuals did not participate due to a lack of conceptual knowledge of mental health (m=1, 1 st gen f=1, 2 nd gen f = 2)	First-generation women born and grew up in Pakistan. Second-generation women born and grew up in the UK.	Barriers: lack of proficiency in English Stigma Isolation due to cultural proscription Racism Reluctance to involve others in support. Facilitators: faith healers, G.P. and Family support	The Western conceptualisation of MH may not be the same as Pakistani understanding. Stress at home was cited as the most likely cause of mental illness. G.P. consultations were favoured for accessing support, particularly by males, though the emphasis was on physical health symptoms even though it may have been for mental health.	70.2%
Whittaker et al. (2005) UK (235)	Design: Qualitative. A cross-sectional study of participant individual and group interviews Setting: Participants were recruited from a Somali community centre	Participants: Five females. The study included females born in Somalia who had been residing in the UK since childhood or adolescence. Additionally, a participant born in the UK was included, with separate analysis and discussion provided to enrich the study.	Female refugees born in North Somalia. To the participant born in the UK: "not a refugee but was born in the UK to a refugee family".	Barriers: Religion, the intersection between culture and religion, stigma Facilitators: Resilience, religion family and community	The intersections of religion and culture may impede access to support. The complexities involved in seeking services, arising from fear of disclosure, stereotyping, and individual beliefs, present significant clinical implications for the provision of service options.	100%
Knipscheer & Kleber (2001) The Netherlands (242)	Design: Mixed Methods Setting: Recruitment through two summer festivals in Amsterdam and The Hague. Additional data was gathered through outpatient MH* services.	Participants: Study 1: Surinamese citizens in the general population ($n = 292$) m ($n=163$), f ($n=129$) Study 2: Surinamese (Hindustan Surinamese Dutch, Creole Surinamese Dutch, mixed Chinese, and Javanese background) and inclusion of 89 indigenous Dutch for comparisons. F ($n=145$), M ($n=40$)	People who have recently migrated from Surinam to the Netherlands.	Facilitators: Familiarity with community MH centres Friends and family Barriers: low education Prejudice and misconceptions about CMHC. Lack of support information.	Length of residence is an important predictor of both behaviour and attitudes, with the more recently migrated most in need of education on the utility of Dutch MH services.	S1=44% S2=78%

Terms used in the table:

¹MH= Mental health

²m=Male

³f= Female

⁴ The STRENGTHS project = Scaling up psychological interventions with Syrian Refugees

*G1, *G2 = Group 1, Group 2...

⁵PM+ = Problem Management Plus

⁶GP = General Practitioner

⁷PTSD = Post Traumatic Stress Disorder

⁸Austria, Austrian Health Interview Survey

⁹ Refugee Health and Integration Survey

¹⁰Step-by-Step

¹¹WHO = World Health Organization

¹²Immigration and Nationality Directorate

¹³CMHC = Community Mental Health Care:

*FG1, *FG2... = Focus Group 1, Focus Group 2, ...

The studies with the highest proportion of female migrants were comprised entirely of women (100%) ((187,234,235), while the study with the lowest proportion of female migrants included only 14% (237). The study with data on the largest number of individuals was conducted by Straiton et al (187), involving clinical records of 1,834,822 women. Conversely, the study with the smallest number of participants was by Fox and Haim (234), with only 3 female participants. Qualitative methods were predominantly employed, with 8 studies (227,229–232,234,235,247) utilising this approach. Quantitative methods were used in 6 studies (187,236–240), and mixed methods were applied in 5 studies (228,241,242,244,245).

Community-based settings were the most common for data collection, with 11 studies conducted in these environments (228–232,235,238,241,242,244,247). Primary care settings were utilised in 5 studies (187,227,234,236,237), while a combination of primary care and community settings was employed in 3 studies (239,240,245). However, it is crucial to recognise that the definition of primary care is inherently subjective, and some studies may encompass both community and primary care settings within their scope.

3.4.1 Mixed Methods Appraisal Tool (MMAT)

There were no significant differences in the studies independently assessed using the Mixed Methods Appraisal Tool (MMAT) by the two reviewers involved in the appraisal process (AT and PN). As per the study design, no papers were excluded due to study quality. All the papers were assessed as having good study quality. The results of the appraisal are presented below (*See Table 7*).

Table 7: MMAT scoring

	Qualitative				
	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis & interpretation?
Ali et al. (2016)	Y	Y	Y	Y	Y
Kiselev et al. (2020)	Y	Y	Y	Y	Y
Linney et al. (2020)	Y	Y	Y	Y	Y
Loewenthal et al. (2012)	Y	Y	Y	Y	Y
Tabassum et al. (2009)	Y	Y	Y	Y	Y
Van Loenen et al. (2018)	Y	Y	Y	Y	Y
	Quantitative				
	4.1. Is the sampling strategy relevant to address the research question?	4.2. Is the sample representative of the target population?	4.3. Are the measurements appropriate?	4.4. Is the risk of nonresponse bias low?	4.5. Is the statistical analysis appropriate to answer the research question?
Carruthers & Pippa (2019)	Y	Y	Y	Y	Y
Kohlenberger et al. (2019)	Y	Y	Y	Y	Y
Markova et al. (2020)	Y	Y	Y	N	Y
Morgan et al. (2017)	Y	Y	Y	U	Y
Pooremamali & Eklund (2017)	Y	Y	Y	U	Y
Straiton et al. (2019)	Y	Y	Y	Y	Y
	Mixed Methods				
	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Burchet et al. (2019)	Y	Y	U	U	Y
Grupp et al. (2019)	Y	Y	Y	U	Y
Knipscheer and Kleber (2001)	Y	Y	Y	U	Y
Mölsä et al. (2019)	Y	Y	Y	U	Y
Papadopoulos et al. (2017)	Y	Y	Y	U	Y

Key: Y=Yes, N=No, U=Unsure/Undecided/Unclear

3.4.2 Advancing research on female migrants through lived experience

The female migrant co-production group (FMCG) members who contributed to the current review initially discussed the barriers and facilitators to mental health care support based on their lived experiences. These discussions informed the research question. Following the initial review, the FMCG reconvened to discuss the identified themes. Based on these discussions, the FMCG recommended that future studies should investigate female migrants' understanding of the term "*mental health*" and explore their experiences with General Practitioner (GP) support, as the initial review highlighted its widespread use.

To facilitate this, the FMCG suggested specific interview questions aimed at gaining a deeper understanding of these experiences. Consequently, a comprehensive framework was developed to detail the process and inform potential questions. Refer to Appendix B for the initial framework for analysis.

We aimed to assess the methodological approaches of including lived experience perspectives in migrant research. We specifically examined whether the primary studies within this systematic review included lived experience perspectives in the study team or data collection methods. We only analysed the methods sections of studies to identify mentions of lived experience during data collection and excluded any mentions in the discussion sections. This allowed us to focus on the methodological approach of including lived experience in migrant research.

Several studies explicitly described the recruitment of co-researchers with lived migrant experiences in their methods sections (228,230–232,235,238,241,242,244,245,248). For example, Papadopoulos et al. (2004) recruited and trained eight Ethiopian research assistants who conducted all interviews in Amharic. Similarly, Burchert et al. (2019) collected data using trained Arabic native speakers. Linney et al. (2020) and Mantovani et al. (2017) utilised community partners and trained community well-being champions, respectively.

3.4.3 Theme summary and interpretation of results

The themes which were identified regarding barriers to accessing mental health support by female migrants in primary and community care were: lack of access to appropriate information, cultural barriers, stigma, and structural, and gender-specific barriers. Gender-appropriate/sensitive services were seen as enhancing the likelihood of access to support. GP services were regarded as facilitators of access and support, as many female migrants

expressed a willingness to utilise these services. Further potential facilitators were identified including culturally appropriate services, gender-specific support, and religious leaders. The themes are summarised in Table 8.

Table 8: Key themes and sub-themes

Barrier Themes	Barriers Sub-themes
Access to information	<ul style="list-style-type: none"> • Individuals do not know where to obtain information. • Services not providing readily accessible information. • Services not aware of up-to-date information and guidance
Cultural and Spiritual barriers	<ul style="list-style-type: none"> • Religious and cultural practices • Religious and cultural beliefs • Intersection of religion and culture
Stigma	<ul style="list-style-type: none"> • Self-stigma of MH. • The societal stigma of MH, including that of family members with MH ill-health. • Institutional stigma, including negative beliefs of reasons why migrants access MH services
Structural barriers	<ul style="list-style-type: none"> • Service delivery does not consider gender. • Service delivery not supporting certain types of migrants. • Lack of interpretation services • ‘Hostile environment’ policies and practices
Gender-specific issues	<ul style="list-style-type: none"> • Poor quality of research papers informing service and policy. • Poor understanding of differences between gender and cultural needs when delivering MH support. • Prioritisation of male health needs • Prioritisation of male voices in research • Intersectionality
Facilitator Themes	Facilitators Sub-themes
Religiosity, Community, and religious leaders	<ul style="list-style-type: none"> • The willingness of female migrants to discuss mental and spiritual health. • Spiritual leader awareness of mental health conditions • Supportive friends and family
Gender-sensitive support	<ul style="list-style-type: none"> • Availability of culturally and gender-sensitive mental health support. • Peer support from other female migrants
Education settings as facilitators	<ul style="list-style-type: none"> • Subjects such as Psychology increased awareness of MH • Social aspects of educational environments increased chances to access support compared to isolated settings.
Resilience and adaptability	<ul style="list-style-type: none"> • Resilience as a factor in the increased likelihood of seeking support. • Adaptability and acculturation to a new environment.

3.4.4 Barriers to seeking and accessing mental health support

Accessing Support Information. Participants in two studies highlighted information access as a significant issue (230,242). A study conducted in the UK found limited information on the identification of mental health disorders and seeking community support amongst young school-aged Pakistani females: *'I don't think they tell us like early enough, you know when you've found out then they tell you. I think there should be something where you find out before a little.'* (FG, Young female) (230). This apparent lack of information was not confined to young school-aged females, as one 34-year-old female from Eritrea expressed frustration at not knowing whom to talk to about her mental well-being due to a lack of awareness around which services are appropriate to access for mental health support: *'Who is my contact person regarding this inner anxiety?'* (241). Three further studies included observations by researchers on information availability and access as a barrier to support for mental health for female migrants (228,234,246,247). For older female migrants, the barrier to accessing information for their mental health using technology was two-fold: firstly, an inability to use modern technology such as a smartphone to search for information, and secondly, an over-reliance on sons or grandsons to access information through technology which meant the loss of privacy and independence (228). Similarly, a study affirmed this notion by stating that most first-generation women had limited educational backgrounds, such as the minimum ability to read the Quran which they could not do, thus access to information that required reading was considered a barrier (247).

Religious and Cultural Intersectional Barriers. One study highlighted the dilemma young female migrants faced when engaging with male spiritual leaders within their communities in their host countries. On one hand, they could seek support for their spiritual needs, however, when it came to their mental health, gender was seen as a barrier as *"girls cannot talk to a man"* (FG2, Girl 5) (229). The belief in spiritual manifestations to explain behaviour was seen as re-enforcing stigma and an overreliance on religious and societal explanations for poor mental health, for example, *'Those of us from a Black background...if anybody tells you that you have a mental health issue you are ready to fight them for saying that. I mean...because we relate mental health to insanity, a total level of insanity'* (Female, African). Some of the related treatment options included prayer and whipping to drive off the evil spirits (229,247,248). Younger migrants who traditionally rely on their parents for support had trouble adjusting to being independent in their host countries (244).

One study mentioned the impact of ‘*power relationships between men and women in Muslim culture, where men are generally dominant in the relationship and women are required to be more subservient*’. The study found that women were less likely to see a GP than men because they were often not "allowed" to do so by their male partners or family members. This reflects the traditional gender roles that are still prevalent in many cultures. The women were, therefore, less likely to seek support from and disclose their mental health issues to male GPs due to the prevailing gender power imbalances (247).

Stigma as a barrier to support. Societal stigma towards mental health difficulties and migrants was prominent in three studies (227,229,248). Self-stigma and perceived stigma of mental health stopped young females from seeking support from family or services, ‘*my friend...never tells her mom anything [about her mental health problems] and she always bottles it up and she just...thinks of her mum getting upset*’ (229). The stigma attached to being a migrant within health settings was highlighted, “the doctor, for example, is suspicious and thinks, all the asylum seekers are taking advantage of Switzerland and on top of that they fake being psychologically distressed.” (Stakeholder, Switzerland) (230). Although younger female migrants are more likely to be socially active and have greater access to mental health support, they are also more likely to experience racism. This can be a cause of mental health problems, and it can also make it more difficult for them to access the support they need (229,244,247).

Structural and Service Barriers

Female migrants reported more unmet healthcare needs compared to their male counterparts (234,246). There was reluctance to access services due to suspicion of asking for help from strangers and when they did access services, female migrants reported that they often were not sensitive to their needs, specifically mental health services, and statutory services that the female migrants felt had the power to detain or deport individuals (234,244). Similarly, one study reported that female migrants are not likely to utilise some primary care services compared to their male counterparts in an area of the UK as most of the GPs were male (247). Regarding the heterogeneity of definitions as to what constitutes a migrant, mental health support services too were considered inaccessible to certain types of migrants, for example, failed asylum seekers (234,239). Josephine, a failed asylum seeker, originally from Uganda, was pregnant and still could not register with a GP in the UK to access support for her physical and mental health, ‘*Every time they would chase me away, they told me that as*

my visa was still valid, I wasn't entitled. They told me I would have to pay something like £300' (234).

Language barriers were identified in accessing psychological and physical support for female migrants both in transit to the host nation and upon arrival in the destination nation. As one female participant from Ghana who travelled to Italy stated, *'The doctor did not speak English, did not understand, then at some point spoke in Italian....'* (227). A female Ethiopian migrant alluded to the relationship between unmet physical health needs and the impact they had on her anxiety, as she stated that it was only when her kidneys dropped to functioning below 5% that the GP who had never asked for a translator finally arranged for one (244). One female mentioned *'You don't know how to approach that person who is not in your language speaking'* (231).

Gender-Specific Barriers

Several studies highlighted how traditional gender roles may play a role in accessing support for mental health needs. For example, Kiselev and colleagues (2020) mentioned a lack of childcare opportunities for female migrants may act as a barrier to support as it is always assumed the burden of responsibility for looking after children fall upon women.

Additionally, they identified the burden female migrants experience in keeping their mental health concerns within their family rather than talking to health professionals *'One always says you can talk to your mother and with your friends. This is the way it is in Syria'*. The same burden is then placed on migrant mothers not accessing support for their mental health, *'maybe fathers are always outside having kind of fun thing or at least chatting to another person, so that is why it is not that many big issues, but when it comes to the mothers the problems are bigger larger scale'* (231). One study reported how males did not want their female members of the family's voices to be listened to by anyone else outside the family (247). There was further reluctance for some males to let females access support for their mental health due to fear of the domestic burden at home being raised in the absence of the female (247). Young Pakistani females felt they would not be able to discuss issues in a family therapy setting, *'you wouldn't want to say anything...rather have one-to-one'*. Older females tended to be socially isolated which in turn reduced access to support (228,231,247). Female migrants who were pregnant, and had previously experienced gender-based violence, including forced marriages encountered maternal health issues which impacted their mental health (234).

3.4.5 Facilitators to seeking and accessing mental health support

Although few facilitators for accessing support were identified, the role of charities was praised. One study participant remarked, '*Nowadays there are so many charities that are helping*' (231). In cases of female migrants whose immigration status meant that they were limited in support from traditional health care, doctors could also refer them to charities that were sympathetic and could meet migrant mental health needs (234). Additionally, a greater focus on awareness was seen as an essential part of enabling migrants to access support, as one female migrant asserted, '*Awareness is the first and the most, educating the community, understand that this is an illness.*' (231).

GPs as facilitators to accessing mental health support: Several studies (231,232,237,242,244) considered GPs as accessible for female migrants when dealing with their mental health needs, '*Whatever problem we have in mind, the first person to contact will always be the GP*' (231). Though traditional GP surgeries may have refused to provide support for some undocumented or refused asylum seekers, doctor-led organisations such as Doctors of the World filled the role of providing them with easier access to support (234). Moreover, one study highlighted the role of community mental health support for female migrant mental health needs, with greater satisfaction reported than their male counterparts (242).

Technology facilitating access: For younger female migrants, access to appropriate technology such as smartphones and the internet was seen as positive support, '*I know that there is ChildLine where you just speak ...*'. Culturally sensitive healthcare support, especially when delivered by female migrants, was identified as a facilitator to access and support (229,231,242). Equally as important was the provision of readily available interpretation services within some GP surgeries, '*having an interpreter stand by is always good...where you have access...9 to 5 is always a big point. Yeah, well done to the [GP surgery]*' (231).

Religiosity, Community, and religious leaders: Having access to spiritual leaders and spiritual support from friends and family was a demonstration of the intersection of religion and culture in alleviating symptoms of distress (234,235,241,244). This was the case, particularly for older migrants who looked up to imams and sheikhs to alleviate their mental health distress (245). Relatives were seen as possible facilitators to support, as Zeta explains, '*And lots of relatives...so I won't feel lonely...they visit us quite often*' (235).

Educational settings: The role of education in providing knowledge was considered an enabler for awareness of treatment and support options such as Cognitive Behavioural Therapy (CBT) for young female migrants, with subjects such as Psychology cultivating awareness in this demographic (229). Young female migrants were able to socialise with their friends and could speak to them openly about mental health, unlike most of their older female migrant colleagues.

Resilience and Adaptability: Three studies highlighted feminine resilience and adaptability (234,235,244). Females were more likely to successfully adapt and be more socially active which could lessen their chances of developing mental health conditions due to loneliness and isolation. Increased social integration ensured that they learnt English quicker than their male counterparts, and thus were more likely to start or continue in education and be employed. Where challenges were faced, female migrants persevered, as illustrated by the stories of Josephine and Miriam (234) and Aisha, who states, *'The way I see Somali woman is, is that they are really strong... Most of them are single mothers, and the way they cope is unbelievable, it's unbelievable. I mean, they try their best, yeah? And most of them don't have any families around at all, it's only them.'* (235).

3.4.6 Feminist appraisal of the included papers

Study characteristics and a quality summary, assessed using the Feminist Appraisal Tool, are presented (see Table 9).

Table 9: Feminist appraisal of included studies

Author and Year	Feminist appraisal		
	*Study Conceptual Underpinnings	Gendered Context in Discussion	Quality of feminist analysis
Ali et al. (2016)	N/A*	Researchers state gender mixing is not socially prescribed in Pakistani culture hence the reason for holding separate focus groups between boys and girls.	*Cursory
Burchet et al. (2019)	N/A	Previous research has shown that access to expensive communication devices tends to vary along age and gender lines. Older women often relied on their sons or grandsons when it came to the use of communication technologies (24).	Cursory
Carruthers & Pippa (2019)	N/A	N/A	Cursory
Fox & Hiam (2018)	N/A	N/A	Cursory
Grupp et al. (2019)	N/A	Less frequently cultural barriers in accessing healthcare were mentioned predominantly by female participants preferring female doctors and if possible	Cursory
Kiselev et al. (2020)	N/A	Other barriers such as lack of childcare opportunities for women and transport costs were mentioned once each.	Cursory
Knipscheer and Kleber (2001)	Adjusted for age and gender,	Women made relatively more use of the CMHC than men – they reported more MH problems and had greater satisfaction with CMHC services	Cursory
Kohlenberger et al. (2019)	N/A	Unmet health needs and barriers to health access are relevant concerns for recently arrived refugees. Female refugees below 40 years of age report worse health than Austrian women. In	*Thorough
Linney et al. (2020)	N/A	N/A	Cursory
Loewenthal et al. (2012)	N/A	Due to cultural considerations, the four researchers, all of whom were themselves born outside of the UK and, in terms of their languages and cultural backgrounds, members of the respective communities relevant to this study, conducted the focus groups and respondent validation	*Moderate
Markova et al. (2020)	N/A	N/A	Cursory
Mölsä et al. (2019)	Almost 48% of Somali language speakers were female in Finland.	Somali women used less preventive healthcare compared to other female migrants.	Cursory
Morgan et al. (2017)	N/A	N/A	Cursory
Papadopoulos et al. (2017)	N/A	N/A	Cursory
Pooremamali & Eklund (2017)	N/A	N/A	Cursory
Straiton et al. (2019)	Comparing migrant and descendant women's use of OPMH services with the majority of women using national-level registry data.	Overall, our results suggest that migrant and descendant women use OPMH services to a lesser extent than most women. Descendant women are less likely to use OPMH services, while female migrants are both less likely to use OPMH services and have fewer follow-up consultations for common MH disorders.	Moderate
Tabassum et al. (2009)	A secondary aim was to explore the needs of women regarding mental health services	N/A	Moderate

Author and Year	Study Conceptual Underpinnings*	Gendered Context in Discussion	Quality of feminist analysis
Van Loenen et al. (2018)	N/A	Less frequently cultural barriers in accessing healthcare were mentioned predominantly by female participants preferring female doctors and if possible, from the same geographical/cultural background.	Cursory
Whittaker et al. (2005)	Exploring individual and collective understandings of psychological well-being among young Somali asylum-seekers or refugee women.	The findings of the research highlight the tensions for the women participants when religious interpretations were used to constrain gender roles	Moderate

Definitions

*Conceptual underpinnings = definitions of gender and epistemologies study authors are influenced by the methodology.

*N/A = Not clear or not clearly stated. This has been used throughout this table to signify information lacking enough to be analysed within the scope of this review.

*Cursory = satisfying one category of the tool.

*Moderate = satisfying 2-3 categories of the tool.

*Thorough = Consideration of gender and power as measured against the tool's framework.

Only three of the included studies (187,235,246) implied a conceptual underpinning of the study concerning gender as a study outcome. For example, all three studies related their studies to women's mental health rather than generalising to whole migrant populations. Overall, there was little consideration of possible power imbalances between the researcher and participant groups of different genders. Where studies sought specific views from females, male presence in the form of a family member was justified as being normal within non-Western cultures (247). Where the views of both male and female participants were included in the data analysis, several studies chose to highlight male issues to the detriment of female issues through their use of supporting quotes. For example, one study with close to equal numbers of male and female participants included 22 quotes from male participants and only one from a female participant (241). The researchers acknowledged this as a weakness of their study and recommended that future research should place more emphasis on female voices. Further recommendations for improving access, support and producing higher quality research concerning females are suggested by some papers (187). One study included gender and sex as a category in the analysis (240).

Overall, only one paper (246) had a 'thorough' feminist analysis of the four categories of the framework. Four papers scored moderately (187,232,235,247) meaning that they had satisfied 2-3 of the above categories, whilst the rest of the papers had a score of ' cursory' meaning that they had satisfied at least one of the above categories. Qualitative papers were stronger in quality compared to mixed and quantitative methods.

Cultural sensitivities being put at the forefront of gender issues ran the risk of biased reporting; one study (241) reported the risk of response bias and social desirability within a participant focus group which was male-dominated and facilitated by a White researcher of the majority population. There are no considerations about female participants being included in a group of mostly males and the effect this group composition would have on

females' motivation to speak about their intentions and beliefs around treatments for PTSD. The inclusion of the sex and gender of the researchers may have implications on the interpretation of the studies when accounting for the sex and gender of the researchers and their interactions with the participants.

Certain studies within the review, notably, elucidated both gender disparities and commonalities in perceptions and experiences as expressed in focus groups and interviews (229,231,232,238,244,245,247). However, the participants across most of the studies shared a defining characteristic, namely, low socioeconomic status, irrespective of their migrant background. This runs the risk of not identifying the needs of the fewer female migrants who are not of low socioeconomic status. The resilience of female migrants is often not acknowledged in studies, however, for a population deemed ‘‘at-risk’’ and facing insurmountable challenges in a traditionally hostile environment for migrant populations, resilience and adaptability were key in overcoming challenges with integration. For example, in one study (244), Ethiopian women adapted better to life in the UK than their male counterparts due to what they termed as feeling liberated from positions of subjugation, thus becoming more active in public life. This can be contrasted with older Pakistani women, who felt socially isolated (247).

3.5 Discussion

The findings from this review suggest that female migrants face gender-specific barriers to help-seeking and accessing mental health support during migration, post-migration, and acculturation. In the review by DeSa and colleagues (249), which looked at the barriers refugee women face in accessing mental health services in high-income countries, stigma, language, lack of culturally appropriate support and gender roles were found to be barriers to access. Their results share some similarities with the results of the current review. However, the review by DeSa centred on refugee women, whereas the current review includes broader forms of migrancy. Our findings also underscore the poor quality of migrant research, where issues of female needs are either inadequately addressed or entirely omitted. The absence of a gender framework within the included studies affected how gender was analysed. For example, the studies did not address the challenges of defining sex and gender and what impact a lack of consideration for this would have when

reporting different sex and gender needs. To the best of our knowledge, this systematic review is the first to analyse the quality of migrant studies using a feminisms lens to examine female migrant access to mental health services in Europe. The dual effect of GPs and religious leaders being both barriers and facilitators to access for female migrants poses serious concerns as well as opportunities for female migrants who may attempt to access both for their, mental, physical, or spiritual support needs. Little is known about the impact of both being facilitators and barriers.

The study identified a preference among most female migrants for GPs as the first point and favoured support. This is reflected in some studies on preference for male healthcare providers seen as authoritative and knowledgeable (250,251). However, the dominance of male GPs in healthcare may unintentionally reinforce patriarchal dynamics and expectations around health-seeking behaviour, particularly in conservative cultural contexts where mental ill-health and interactions with male healthcare providers may be stigmatised or perceived as inappropriate (5,251). These norms can create additional barriers to accessing care, especially when female GPs are less readily available. This duality underscores a critical tension: while GPs often act as gatekeepers to care, their perceived role within patriarchal systems may create barriers for female migrants navigating complex healthcare needs.

The dynamics explored here resonate with the methodological tensions experienced in this study, particularly in the role of the PhD Candidate as a male researcher. Similar to the GP as a figure of institutional power, the positionality risked mirroring the patriarchal systems and longstanding structures of oppression that have historically marginalised female migrants. However, for the review, the EMBaRK framework was instrumental in challenging these dynamics, creating a collaborative research environment where power was redistributed, and all knowledge systems were valued equally. By embedding female migrants as co-researchers and amplifying their experiential expertise, EMBaRK dismantled traditional hierarchies in knowledge production, much like the reciprocal approach to care envisioned in healthcare reform.

This approach to research and care, grounded in mutual respect and trust, reflects the feminist commitment to dismantling systemic oppression. It reframes the male-dominated "father figure" dynamic not as a barrier, but as an opportunity to co-create equitable spaces

where both professional and experiential knowledge contribute meaningfully to shared outcomes. By addressing these structural and interpersonal dimensions, both research and healthcare systems can move toward more inclusive and just practices.

The current review confirms, as previously reported, how inequalities in gender roles may act as a barrier in addition to other socio-cultural barriers and labels associated with being a migrant. This is consistent with a plethora of studies that have reported similar results (4,252,253). The case studies of Mariam, Josephine and Deidre underscore the importance of understanding the specific needs of female migrants. For example, an individual can present with multiple intersecting experiences and labels. In Mariam's case, a Black African female, widow, mother, a victim of rape, violence, smuggling, refused asylum seeker, homeless and with poor physical and mental health states (234).

The included studies implicate a lack of information awareness as a barrier to accessing support for mental health conditions by female migrants. Furthermore, stigma was identified as a barrier to accessing support. Some migrant mothers expressed a reluctance to discuss mental health concerns for fear of deportation or their children being taken away by social services, whilst some who were pregnant were turned away from primary care services in host countries with a policy of access for all to primary healthcare. These fears are echoed in similar reviews that identify this fear as a barrier to accessing support specifically among undocumented migrant mothers and expectant mothers (180,181). This highlights the differing needs and perceived rights of different migrant populations, and therefore, the weakness of blanket information awareness policies and strategies in increasing access to support which are not tailored to or appropriate for the needs of female migrants. The results demonstrate why the rigour of migrant research should be critically examined, as it has implications for service provision and information awareness for female migrants, regardless of migrant status. The country of origin may influence perceptions regarding the access to and delivery of services for female migrants. For example, linguistic minorities in Italy have found it difficult to access support due to their lack of proficiency in Italian. Similar findings were reported in a review of refugee and asylum-seeker health in Europe (196).

Language has long been considered a barrier to finding employment and accessing health support for migrants (26,107,254,255). Language difficulties and cultural proscriptions on

socialising led to social isolation and a lack of integration within host communities for some older female migrants. Additionally, the distressing experiences of female asylum seekers being assisted by a male interpreter when accessing support for their health to circumnavigate this barrier have been reported previously in other reviews (107,254). Acculturation has been identified in a review by Lindert et al., as a factor for service utilisation for migrants (178). Curiously, women with a low educational level who had a longer residential stay sought treatment more often, alluding to presenting with mental health needs later than other populations (242). In the current review, female resilience and adaptability were shown as factors in overcoming religious, cultural, structural, and social barriers and therefore promoting post-traumatic growth. This encouraged some female migrants to seek support.

3.5.1 Research implications

One paper (241) raises serious questions for policymakers regarding population management and health, particularly as the paper is heavily influenced by 22 quotes from male migrants and only one quote is attributed to a female migrant. Our review raises questions about the impact and applicability that migrant research findings have on service design. Most migrant studies involve younger migrants, but questions are still left as to what happens to the female migrant population as it ages when considering access to support. The review has demonstrated that equal representation of female migrant participants in studies does not necessarily lead to equal reporting of findings concerning gender. To the best of our knowledge, this is the first review to establish that connection.

For the feminist appraisal, our findings are similar to results obtained in a feminist quality analysis which indicated the relative strength of qualitative studies compared to quantitative studies when scoring the feminist appraisal tool (224). Exploring the studies using a feminist lens has enabled the review to include personal facilitators of resilience and coping which are often missed when exploring barriers and facilitators to healthcare. Additionally, this review calls into question the prioritisation of migrant status over gender and sex and why intersectionality is seldom considered in migrant studies.

The Feminist Quality Appraisal Tool is rooted in many feminist perspectives, including radical, constructionist, and intersectional approaches. However, its theoretical foundation would benefit from greater specificity. Explicitly linking its criteria to established feminist

frameworks such as intersectionality (6,12), standpoint theory (256), and post-structural feminism (257) would strengthen its academic rigour and practical utility. For example, intersectionality could require reviewers to evaluate how studies address the interconnected nature of gender with race, class, and other axes of oppression (6). Standpoint theory might encourage reviewers to consider whether studies centre the voices of marginalised groups (256), while post-structural feminism could critique how research challenges taken-for-granted assumptions about gender (257).

The tool's integration into this review highlighted its dual role as a complement and a challenge to traditional frameworks. Studies that explicitly engaged with female migrant experiences, addressed systemic inequities, or prioritised participant voices were appraised more favourably, reflecting the tool's alignment with feminist principles. However, studies that focused on systemic barriers outside of a gendered lens often received lower scores, demonstrating the tool's potential to narrow the scope of appraisal unless explicitly adapted to address intersectionality.

Implications of the use of the Feminist Quality Appraisal Tool in this review

The application of the Feminist Quality Appraisal Tool in this systematic review revealed both its strengths and challenges. By exposing gender bias and inequities, the tool enriched the evaluation process and highlighted studies that prioritised inclusivity and reflexivity. Its alignment with feminist principles ensured that the review remained focused on equity while offering insights that might have been overlooked by traditional appraisal frameworks.

While the tool is still emerging within the field of health research, its use in this thesis is particularly novel, given the focus on female migrants' mental health - a population often marginalised in both research and policy. To the best of my knowledge, this study represents one of the first applications of the tool in the context of female migrants, marking a significant departure from its conventional use in addressing general gender biases in health research. This unique adaptation underscores the tool's flexibility and relevance across diverse contexts, while also emphasising the importance of further refinement to address the complex intersectional realities of female migrants' lives.

Additionally, the potential for this tool to inform research on male migrants should not be overlooked. Gendered health disparities are not limited to comparisons between women and men but extend to understanding how socially constructed masculinities affect male health behaviours, access to services, and vulnerability to systemic inequities. By incorporating a feminist lens, studies on male migrants can move beyond simplistic framings of gender as a binary conflict and instead adopt a more intersectional approach that recognises how power dynamics and structural inequalities shape health outcomes for men as well.

The Feminist Quality Appraisal Tool also provided a foundation for critical reflection that influenced the development and operationalisation of the Empowering Migrant Bridges: Active Research and Knowledge (EMBaRK) framework. The tool's emphasis on reflexivity, inclusivity, and power dynamics directly aligns with EMBaRK's core principles of participatory action, co-production, and community empowerment. For instance, the tool's criteria for evaluating whether studies prioritise participant voices and address systemic inequities informed how the EMBaRK process was designed to centre female migrants' lived experiences and ensure their active participation as co-researchers. Furthermore, the collaborative and iterative discussions necessitated by the tool mirrored the dialogic and reflexive practices integral to the EMBaRK process, reinforcing the framework's commitment to ethical and equitable research methodologies.

In this study, the tool's integration was further enhanced through collaboration with the FMCG (Female Migrant Co-Production Group) and input from supervisors and external collaborators. This reflexive and participatory approach ensured that the tool was applied rigorously and responsively, adapting its criteria to suit the specific needs of the population under study. These adaptations contributed to a deeper understanding of the systemic barriers faced by female migrants and positioned the tool as a valuable instrument for advancing equity-focused health research.

3.5.2 Implications for public health and primary care policy and practice

Currently, there are no widely known or readily accessible Europe-wide initiatives specifically aimed at changing policies to address the unique challenges faced by female migrants regarding their well-being. Evidence gathered to support policy on migrant mental health should consider the heterogeneity of migrant populations. Migration studies

should include a fully operationalisable definition of migrancy and the impact of the definition on studies and policy. Referral processes for mental health support need to be clear on the needs identified concerning gender-specific needs. Within support organisations, staff must be trained to consider the gender-specific needs of female migrants, including the impact that social and physical health inequalities have on their mental health. Commissioners of services should require potential services supporting migrants to consider gender-sensitive service delivery. There are gaps in research on failed female asylum seekers in accessing services. Given the higher risks of developing or exacerbating poor mental health, health promotion should aim to increase access to support. Failed asylum-seeking females were rarely mentioned in studies, as was the difference in access for asylum-seeking females and other forms of migrants. Studies have mostly focused on female migrant populations with low socioeconomic status, as these individuals tend to be unemployed or in low-paying jobs. However, efforts must be made to understand better the mental health needs of the minority of females migrants who do not fall into this category, with a particular focus on their resilience in often high-stress environments and male-dominated roles. The high prevalence of perinatal depression, PTSD, and anxiety in the general female migrant population warrants the development of specialised mental health services tailored to the specific needs of this group of migrants. Female migrant research, policy, and commissioning must address the individual, social, and structural factors that affect access to and support specific to female migrant mental health. The review has highlighted some of these factors which include trauma, social isolation, and stigma, which are all rooted in intersecting systems of oppression that this specific group of women and girls face. Promoting community-led feminist participatory action research may help overcome some obstacles traditional research has encountered in engaging with migrant populations.

3.5.3 Strengths and limitations of the review

To the best of our knowledge, this is the first review to employ a feminist lens to critique the quality of migrant studies by highlighting shortcomings that may be used to inform immigration policies and public opinion in Europe. A strength of the current review is the geographical breadth of the included studies, which has highlighted a need for coordinated and concerted efforts in planning and policymaking to lessen barriers to access to support for mental health by female migrants. Specific migrant laws are diverse across countries;

therefore, this could be viewed as a weakness of the review as it does not consider country-specific migratory policies. Further, it is acknowledged that no paper was rejected for review based on quality. An additional acknowledged weakness of the review is the inclusion of research that focused primarily on male migrants whilst overlooking female issues, with a sparsity of quotes representing female migrants. Though it is a strength in critiquing a male narrative, it is open to criticism for not fully raising feminist issues to access mental health support in primary care. The lack of a standard definition of "migrant" across the studies could be a limitation of the review. The definition of "migrant" may have lacked consistency across the included papers and potentially diverged from the definition employed within the review itself. This discrepancy could introduce inconsistencies in the data, thereby complicating the process of drawing definitive conclusions. Naming specific services and therapies, (e.g., CBT and psychotherapy) may have had the effect of narrowing the search, likely causing potentially relevant articles to be missed. Further weaknesses of the review include the exclusion of studies not written in English and the exclusion of grey literature due to a large amount of policy and Non-Governmental Organisations (NGOs) data on newcomer populations in Europe. This raises an issue about inclusivity in research when searches are strictly narrowed down to studies written in English and peer-reviewed articles.

This review is limited in its focus to GPs and other medical agencies, rather than encompassing the broader range of mental health primary care providers, which also includes pharmacists. Future research should examine the role of a wider range of primary care providers as both barriers and facilitators to mental health care.

The Feminist Quality Appraisal Tool (224) represents a significant advancement in addressing gender bias and inequities in health research. Its structured framework evaluates studies based on their engagement with gender constructs, equity, and inclusivity, offering a critical lens through which traditional health research methodologies can be assessed. The tool's application in this systematic review underscored its potential to enrich the appraisal process by foregrounding gendered analyses and equity considerations, while also revealing several methodological and theoretical limitations.

One of the most notable strengths of the Feminist Quality Appraisal Tool is its ability to fill a significant gap in the quality appraisal of health research. Unlike conventional

frameworks such as PRISMA (258) or the Mixed Methods Appraisal Tool (MMAT) (223), which primarily emphasise methodological rigour and replicability, the Feminist Quality Appraisal Tool critiques whether studies adequately address gendered power dynamics and systemic inequities (6,7,224,259). This unique focus ensures that research does not reinforce essentialist notions of gender but interrogates its fluid and socially constructed nature (7). The tool's emphasis on the social construction of gender is particularly relevant in health research, where societal and cultural factors often shape health outcomes in deeply gendered ways (260).

In addition, the tool's feminist perspective strengthens its value as a critical framework. By encouraging reviewers to assess how studies engage with principles of gender equity and intersectionality, the tool fosters a broader critique of systemic inequities in health research. It also aligns with feminist participatory action research principles by prioritising reflexivity, inclusivity, and equity in the research process (261), making it particularly well-suited for appraising studies on vulnerable populations such as female migrants.

Despite its strengths, the Feminist Quality Appraisal Tool presents several limitations. One significant challenge is its binary conceptualisation of gender. While the tool critiques traditional notions of masculinity and femininity, its practical application may inadvertently exclude non-binary and transgender identities, particularly in contexts where such identities are underrepresented in research (262). This limitation underscores the need for an expanded framework that better captures the complexities of gender diversity.

Additionally, the tool's reliance on subjective judgments introduces variability in its application. For example, categorising studies as demonstrating "cursory," "moderate," or "thorough" gendered analyses requires interpretive judgment, which can lead to inconsistencies between reviewers. In this review, discrepancies in scoring necessitated extensive reflexive discussions to ensure alignment, highlighting the resource-intensive nature of the appraisal process. While such talks enriched the review, they also underscored the need for greater standardisation and the inclusion of clearer guidelines and examples.

Another limitation is the tool's relatively narrow focus on gender, which, although comprehensive, may overshadow other systemic barriers such as socioeconomic inequities or immigration policies (263). While the tool acknowledges the intersection of gender

with other social identities, its criteria may not fully capture the complex interplay of these factors, particularly in studies addressing multidimensional health disparities (264).

3.6 Conclusions and recommendations

Compared to the general population and male counterparts, female migrants face a greater number of barriers to accessing support for their mental health needs in primary care. Future research should consider the impact of gender and sex on the design, recruitment, interviewing, interpretation of results, and formulation of interventions. This paper argues that these crucial factors are frequently overlooked, leading to significant gaps in evidence-based decision-making. Consequently, services often become unintentionally male-centric, failing to address the specific needs of female migrants. To remedy this, female migrant voices must be included in the design of mental health services. Access to specialist mental health support services within primary care needs to include assurances of fair treatment regardless of immigration status, for female migrants to have a greater chance of achieving better mental health outcomes. Treatment and support options should consider the diverse meanings and understandings of mental health within specific cultural contexts, as well as the significance of spirituality for some individuals. When developing inclusive services, gender appropriateness should be a paramount consideration. Additionally, incorporating definitions of terms such as 'migrant', 'asylum seeker', and 'refugee' may enhance clarity and appropriateness in research publications. Though migrant classifications are of great significance in identifying and understanding the varying needs of migrant populations, gender and sex similarities and differences and the intersectional nature of individuals and whole groups must be given similar priority to understand what the barriers and facilitators are to accessing mental health support in female migrant populations.

The Feminist Quality Appraisal Tool represents a significant contribution to addressing gender bias and inequities in health research. By prioritising inclusivity, reflexivity, and equity, it offers a critical framework for evaluating studies that extend beyond traditional appraisal methods. Its emphasis on exposing systemic biases and highlighting participant voices aligns with broader feminist methodologies and provides valuable insights for advancing gender-equitable research practices.

This study demonstrated the tool's adaptability to novel contexts, particularly its use in appraising research focused on female migrants' mental health. The tool's integration into the EMBaRK framework further illustrates its potential to influence participatory and co-productive methodologies, enhancing the capacity of researchers to address complex intersectional inequities. Additionally, its relevance for studying male migrants underscores its flexibility as a framework that can inform diverse research contexts and foster equity across all genders.

However, further refinement and validation of the tool are necessary to strengthen its utility. Expanding its criteria to incorporate a broader intersectional focus, developing guidance for quantitative and mixed-methods studies, and addressing its binary conceptualisation of gender would enhance its relevance and applicability. These advancements could help ensure that the tool remains inclusive and adaptable to the evolving demands of equity-focused research.

Future applications of the tool should also explore its potential to inform policy and practice. By translating the insights gained from its use into actionable recommendations, the tool could contribute to broader social justice initiatives and systemic change in health research and beyond. Moreover, ongoing dialogue and refinement, informed by its application in diverse contexts, will ensure that the Feminist appraisal tool continues to evolve as a robust instrument for promoting equity and inclusion.

3.7 Lived Experience commentary on the systematic review

A member of the Female Co-production Group volunteered to provide an independent commentary on her views of the review. The group had been asked to look at anything they saw as strengths of the review as well as any areas they may have felt were lacking.

Commentary of the review by a member of the Female Co-production Group

Having reviewed the Results and Discussion sections of the Systematic Review, I reflect that there are many different barriers and facilitators for female migrants accessing support for mental health and that these barriers vary greatly depending on the culture, religion, and age of the female migrants.

There are many strengths of the studies including the following: the recruitment of co-researchers with lived migrant experiences; carrying out the data collection in community-based settings; the number of different countries in which the research was carried out and the many different countries from which the female migrants had originated. I particularly thought that Table 4 was an excellent tool for summarising the results of the research. I particularly found the sub-themes of stigma very informative.

For this review, I think it would have been informative to also include information on how the barriers and facilitators varied depending on the number of years the migrant had been in the country. I also think that other ways of accessing mental health apart from through the GP could have been reviewed.

I think that for any future research, there are groups of female migrants who should be recruited to participate. I think that female migrants who are currently isolated do not have much social contact and don't currently have any community professionals involved in their lives should be recruited, as I am sure that their experience of the barriers to accessing mental health support would add useful information to the review.

JB

Chapter 4: Experiences and perceptions of mental health and access to support of female migrants living in Kent, Surrey, and Sussex: A qualitative interview study

4.1 Introduction

This qualitative study is underpinned by findings from the systematic review (1) in Chapter 3, which underscored the need for information regarding suitable mental health support, compounded by language barriers encountered when attempting to access such services. The existing literature on the inclusion of female migrant voices in research design is limited, and there is a scarcity of scholarly findings focused solely on the mental health experiences and perceptions of female migrants. There are gaps and limitations in the existing literature on female migrants' experiences and perceptions of seeking and accessing support for mental health specifically in Southeast England. Furthermore, recommendations for improving both research and service design through a feminist lens are currently scarce in the research landscape. Therefore, this study sought to build a knowledge base on the experiences and perceptions of female migrants in Southeast England and specifically related to Kent, Surrey, and Sussex.

4.1.1 Theoretical and philosophical underpinnings to data collection

Building upon a theoretical framework, as emphasised by Moorley and Cathala, research studies gain structure and direction, guiding their methods and interpretations. (265). In researching female migrant experiences and perceptions of mental health and access to support, the theoretical framework of intersectionality was adopted. Intersectionality recognises that the experiences and perceptions of female migrants are shaped by a variety of factors, including their gender, race, ethnicity, class, and migrant status, and often these result in unique experiences of mental health for female migrants (266).

For this study, the PhD Candidate and the FMCG were particularly interested in barriers relating to constructs of stigma by asking '*What are some things that you think have stopped you from seeking or accessing support?*'. The literature indicated that individual, societal, and even health professionals' stigmatising views about mental health play a role in accessing support (1,127,267–270). This study is informed by a theoretical framework that emphasises the pervasive impact of stigma on the mental health of female migrants.

Specifically, the study draws on Goffman's Stigma Theory (120) and Link and Phelan's Conceptualisation of Stigma (136) to investigate how stigma, both pre-migration, during migration, and post-migration, can contribute to an increased likelihood of developing mental health disorders. By incorporating feminist theories, the study highlights the intersectionality of gender, migration, and mental health stigma, revealing how patriarchal structures and gendered expectations exacerbate the vulnerabilities of female migrants. This includes not only the stigmatisation of migrants themselves but also the stigmatisation of mental health, which can lead to a reluctance to seek support.

Chapter 1 introduced the concept of stigma and its role in help-seeking and support; this section explored different definitions of stigma and presented several frameworks that explained the concept (120,137,149,150). A reflexive thematic analysis approach (271) was specifically selected in the present study, to explore the lived experiences of female migrants and their subjective interpretations of those experiences. Compared to other qualitative approaches that might utilise pre-defined categories, reflexive thematic analysis, as employed in this study, uniquely allows the research to be shaped by the participants' narratives. It actively prioritises participants' words while involving the researcher in the interpretation process. Furthermore, it fosters a deeper exploration and detailed understanding of how female migrants articulate and make sense of their experiences. Thematic analysis, as applied in this study, allowed for identifying overarching themes, including interpersonal, structural, and systemic factors, that were derived from the participants' narratives and shaped their experiences.

This research is distinctive in that every step has been guided by feminist theories and the insights of the FMCG, amplifying the often unheard voices of women. This approach ensures that the study not only captures but also respects and elevates the diverse perspectives of female migrants, which are frequently marginalised in conventional discourse.

This qualitative study builds on the overarching research question by exploring the lived experiences of female migrants in navigating mental health challenges and accessing services. Through in-depth interviews, the study aims to uncover the nuanced, context-specific barriers and coping mechanisms of female migrants.

The quantitative study contributes to answering the overarching research question by examining referral pathways, diagnostic patterns, and severity levels among female migrants. By leveraging large-scale clinical data, this analysis provides a population-level perspective on the systemic inequities and mental health needs of female migrants.

Aim: To explore the experiences, perceptions, and understanding of mental health among female migrants, and their experiences of seeking and/or accessing support in primary or community care settings across Kent, Surrey, & Sussex, Southeast England.

Objective: To conduct semi-structured interviews with female migrants who may have considered or may have sought and/or accessed support for their mental health in primary or community care settings in Southeast England. The interviews will examine participants' understanding of mental health within their cultural, social, and personal contexts, their experiences of seeking help, and the barriers and facilitators they encountered. The data will be analysed using reflexive thematic analysis.

4.2 Methods

The study sought to understand the perceptions, experiences, and cultural, social, and personal contexts of help-seeking for mental health services among female migrants in Southeast England, utilising semi-structured interviews.

4.2.1 Philosophical underpinnings of individual interviews

Adopting a feminist perspective, individual interviews with female migrants were deemed the most appropriate data collection method. This decision was informed by the intricate, personal, and multi-layered nature of mental health, which may not lend itself to open discussion within a group setting, particularly among potentially vulnerable individuals. Furthermore, the stigmatisation often associated with mental health issues, as previously discussed in Chapter 1, could further inhibit candid conversation in a group context.

In alignment with Feminist Standpoint Theory, individual interviews are privileged as they facilitate a deeper understanding of individual experiences and perspectives, emphasising the value of the marginalised knowledge of female migrants (11). This method allows researchers to access "situated knowledge" that is pivotal in highlighting the unique mental health challenges faced by this group, thus addressing the power dynamics often ignored by more traditional research methodologies.

Further, adopting a Feminist Participatory Action Research (FPAR) approach underscores the participatory nature of the research, where female migrants are not merely subjects of study but active collaborators in shaping the research process (14). This approach is integral in ensuring that the research environment is safe, supportive, and empowering, thereby reducing the potential for responses influenced by social desirability bias. It also helps in amplifying the voices of female migrants, who are often marginalised and underrepresented in research, thereby transforming the research process into an act of empowerment and advocacy.

Intersectional Feminism further enriches this framework by acknowledging that female migrants may face layered and intersecting forms of discrimination and barriers to accessing support for mental health (12). This theory demands an intertwined exploration of how various factors such as race, class, gender, and legal status intersect to impact the mental health of female migrants. By integrating this perspective, the study becomes more

attuned to the complexity of experiences within this group, avoiding the homogenisation that can obscure significant differences in experiences and needs.

Ontological and Epistemological Positions

The study adopted a constructivist ontological position, acknowledging that reality is constructed through individual interpretation. This aligns with Feminist Standpoint Theory, which posits that marginalised experiences offer valuable insights. The PhD Candidate would gain knowledge through discourse with co-production group members and participants, reflecting an interpretivist epistemological stance (272,273).

The selection of reflexive thematic analysis as the data analysis method aligns with the constructivist and interpretivist positions. It allows for the identification and exploration of patterns in the data about female migrants, responsive to the context of their experiences, perceptions, and data collection methods (271). This method also encourages ongoing reflection by the PhD Candidate, a male researcher seeking to understand the experiences and perceptions of 'the Other,' without reducing the Other to a mere footnote in the research process due to his maleness (274,275). Therefore, reflexive thematic analysis is crucial for ensuring that interpretations of the data are equitable and precise concerning the female migrant experiences and perceptions.

The study investigated the protective factors that contribute to resilience in female migrants, such as strong social networks, effective coping mechanisms, and a positive outlook on life when faced with challenges such as discrimination, poverty, and isolation. Integration of the Unmitigated Communion Theory (175) is explored posteriori.

4.2.2 Ethical considerations of the research

Ethical approval was provided by the Brighton & Sussex Medical School Research Governance & Ethics Committee (Project ID: ER/BSMS9K87/1). This section outlines the general ethical considerations of the research and details how the study was conducted with the involvement of female migrants, who, due to intersecting characteristics, were regarded as a vulnerable population. The qualitative study also involved collaborating with female community researchers, who were acknowledged as co-researchers and actively participated in data collection through interviewing and analysis.

The British Psychological Society (BPS), ethical code of conduct was adhered to, as its four ethical principles of Respect, Competence, Responsibility, and Integrity (276) were especially pertinent to this study. The PhD Candidate also used the University of Brighton guidelines including filling out risk assessment forms (An example is attached in Appendix F: Example Risk Assessment Form).

4.2.3 The British Psychological Society (BPS) Code of Ethics and Conduct

The PhD candidate is a registered Graduate Member of the BPS. As a member of the BPS, the PhD Candidate is bound by the BPS Code of Ethics and Conduct (277). Below is a brief outline illustrating how the PhD Candidate conducted the qualitative project, as well as the entire PhD project, in adherence to the principles of the BPS.

4.2.3.1 Respect

The first principle centres around respecting the autonomy and dignity of the people with whom the PhD Candidate conducted the research. This principle was fundamental to the research as the PhD Candidate needed to respect the difference in gender between himself and the participants and how it might impact their sharing and his comprehension of their experiences. By applying the values within the principle, the PhD Candidate considered the issue of power as a male and a researcher. Consent forms and information sheets which had been co-produced with female migrant members of the study co-production group were given to all prospective participants in the study. Due to the sensitivity of participants sharing their experiences, confidentiality was a central theme in the information sheets, consent forms and debrief sheets. As a researcher, the PhD Candidate is ethically bound to maintain the confidentiality of the participants. Breach of confidentiality in studies has led to strained relationships in communities, feelings of betrayal, humiliation, psychological distress for research subjects, and mistrust of researchers (278). As far as possible, maintaining the trust and safety of the participants was paramount to the successful conclusion of the study. To maintain the privacy of participants, all names were anonymised, however, the PhD Candidate ensured control was maintained by the participants on what names were used in the study. To do so, each participant was asked to provide a name they would like to be called in the interview rather than an interview number, hence the aspect of self-determination was applied. This

simple aspect of letting participants choose a name they would like to be called in the interview has a psychological impact and not only enhances the quality of the interview through building trust and maintaining anonymity but also empowers the participant (279).

4.2.3.2 Competence

The BPS principle of competence relates to members of the BPS working within their qualifications, skills, and knowledge. Therefore, the PhD Candidate undertook training on qualitative interviews with the female migrants. Where the PhD Candidate had to provide support resources for suitably qualified professionals and services, this was done through the co-production of a resources sheet for the female migrants so they could access support and information relating to finance, work, domestic abuse, housing, and physical and mental health amongst other resources (*See Appendices F, G and H: Resources for Participants*). Other tasks which were to be prioritised were the use of various forms of interviewing including in-person, telephone and online skills and facilitation to ensure competency in undertaking the interviews and interactions with the female migrants in a manner that minimised distress and inconvenience.

4.2.3.3 Responsibility

The principle of responsibility underpinning this study encompassed two key aspects, which the PhD Candidate considered fundamental to any engagement with community researchers, the co-production group, and the female migrants who would be interviewed. As a male researcher occupying a position of influence and power, the PhD Candidate had an ethical imperative to prioritise the well-being and interests of both the female migrants and the community researchers. Research documentation, including information sheets and post-interview check-in calls, was meticulously designed to mitigate harm and prevent any misuse or abuse of this inherent power dynamic and the trust it engendered. This included careful consideration of interview locations, which were to be conducted in university settings or public places as per the convenience of the female migrants.

Any potential conflicts of interest were to be transparently reported. In this instance, the PhD Candidate declared that he had assumed a non-executive directorship role at the community partner organisation, Diversity Resource International (DRI), on September 8th, 2021, after the commencement of his PhD studies. To further safeguard against any

perceived or actual conflicts of interest, all correspondence between the PhD Candidate and DRI on the study was to be copied to the primary supervisor, who would be in a position to identify and address any such concerns.

4.2.3.4 Integrity

For the fourth principle concerning the qualitative study, the PhD Candidate had to demonstrate honesty, truthfulness, accuracy and consistency in words, actions, methodologies, and outcomes. Time was factored in for a debrief for each interview involving the community researchers. Every potential interviewee would be informed of the reasons for the research and allowed before and after each interview to ask any clarifying questions. Building trust with the female migrants was set as a priority and consistency in messaging was seen as one way of maintaining the trust. To do so, the same information was shared throughout the study.

After submission and several reviews addressing the BSMS ethics committee's concerns, ethical approval was given to conduct the qualitative study. The BSMS RGEC Research Ethics and Governance Approval letter and the certificate of approval (Certificate number ER/BSMS9K87/1) are included in the appendices (Appendix J: Research Governance Approval Letter and Appendix K: Research Governance Certificate).

4.2.4 Justification of sample size and sampling strategies

4.2.4.1 Justifying sample size

The sample size of 18 participants for a qualitative study looking at female migrant experiences of mental health is justified by, firstly, the principle of saturation. Data saturation is the point at which no new information is being obtained from the data, and the researcher has reached a point of redundancy, rather than being guided by predetermined numbers of participants (280,281). When data saturation has been achieved, this indicates sufficient data has been collected to comprehensively explore the phenomenon. Further data collection would be unlikely to yield novel insights. The initial sample size was set at six interviews within the Southeast, followed by iterative data collection of three additional interviews per counties of Kent, Surrey, and Sussex until theoretical saturation was achieved. This methodology was informed by a modified version of the guidelines proposed by Francis et al. (2010) (280).

Secondly, qualitative studies prioritise gaining a deep understanding of the experiences of a smaller participant group compared to the typically larger samples employed in quantitative research (282). Consequently, a sample size of eighteen participants was deemed sufficient for this study.

The sample size selection was informed by several factors aligned with the concept of "Information Power" (282). Firstly, the study possessed a narrow focus, investigating the experiences of female migrants residing within a specific geographical area (KSS). Secondly, the sample itself exhibited specificity, as it exclusively comprised female migrants living in this area.

Furthermore, the theoretical background, established through a review conducted by the PhD Candidate on barriers and facilitators to accessing mental health support, contributed to this decision. Additionally, the anticipated quality of dialogue, stemming from shared experiences of gender and migration status among participants, and the chosen analysis strategy, utilising Reflexive Thematic Analysis which is well-suited for smaller samples, were also crucial considerations.

Malterud et al. (282) describe this concept as "Information Power," suggesting that the adequacy of sample size in qualitative research is determined by the study's aim, sample specificity, the application of established theory, the quality of dialogue anticipated, and the chosen analysis strategy. The broader study aims and less specific samples necessitate larger sample sizes. Conversely, a narrow aim and a specific sample can justify a smaller size, as these factors enhance the informational contribution of each participant.

Unlike statistical sampling strategies, which rely on power calculations to determine the minimum number of participants required for generalisability, qualitative research prioritises depth over breadth (282). The term underscores the qualitative emphasis on capturing a range of perspectives to answer the research question effectively.

In this study, information power was a guiding principle for determining the sample size in the qualitative phase. By focusing on female migrants with varied experiences of mental health services, the study ensured that the data provided sufficient depth and variation to generate meaningful insights. This approach reflects a deliberate shift from quantitative notions of statistical power, aligning instead with qualitative goals of achieving data

saturation and conceptual richness. Employing this concept highlights the methodological rigour of qualitative research while affirming its unique epistemological priorities

The strategic decision to recruit participants across various locations within KSS aimed to achieve a balance between obtaining a diversity of viewpoints and conducting in-depth explorations of individual experiences. This approach effectively leveraged the Information Power of the chosen sample, particularly considering the limited resources available for this PhD project, including a restricted budget for participant remuneration. Overall, the sample size of eighteen participants was considered sufficient to answer the research aims.

4.2.4.2 Overview of sampling strategies considered for the study

For the current qualitative study, sampling was defined as the process undertaken in selecting a subset of adult female individuals from a defined migrant population for inclusion in the study. Purposive sampling was the most practical and effective sampling strategy for the study for the following reasons:

Purposive sampling, also known as judgement sampling, is a simple non-probability strategy widely used in qualitative research (283). It involves recruiting individuals with characteristics suited to answering the phenomenon of interest. Categories of purposive sampling include:

Heterogeneous (or maximum variation), involves the researcher's judgement on the selection of different characteristics to gain a deeper understanding of a phenomenon through diverse views (284). The umbrella term "female migrant" encompasses a diverse range of experiences, encompassing those who arrive seeking employment, education, or family reunification, alongside refugees, asylum seekers, and undocumented individuals. This heterogeneity extends to their rights and restrictions in accessing essential services. While the United Nations acknowledges significant differences in legal definitions between refugees and migrants (285). However, both groups often face similar challenges due to their foreign-born status, including language barriers, inadequate housing, and poorer health outcomes compared to the host population nations (178,286–290). This scarcity of research encompassing the collective experiences of female migrants,

regardless of their specific migration category, underscores the importance of focusing on their shared experiences and perceptions.

Given the study's focus on female migrants, a heterogeneous sample was chosen to capture the diverse experiences within this population. This approach ensured participants with various migration statuses could contribute their perspectives on mental health, including their own experiences and those related to seeking or accessing mental health support.

4.2.5 Design

A qualitative study utilising interviews.

Participants

Individuals over the age of 18 years who self-identified as female migrants and were either currently residing in, or had previously resided in the Kent, Surrey, and Sussex regions.

Inclusion and exclusion criteria

The study aimed to interview individuals who self-identified as female migrants. This study aimed to look at the experiences of females in all migrant categories. Therefore, asylum seekers, refugees, undocumented individuals, and those females who had moved to the UK because of family, economic, climate or educational reasons were eligible to take part in the study. They were asked to self-identify as experiencing psychological difficulties for which they required support regardless of having received the support or not. Within this cohort, not all people identified as having been diagnosed with a mental health illness. Rather, individuals were encouraged to take part in interviews if they expressed feelings that may have led them or others on their behalf, to consider seeking help.

Inclusion

To be eligible for participation in the interview phase of the study, individuals were required to meet specific inclusion criteria. Participants needed to self-identify as female migrants, ensuring that their experiences aligned with the study's focus on this demographic. Additionally, they were required to be at least 18 years of age at the time of the interview, guaranteeing that all participants were legally recognised as adults. Finally, eligibility extended to those who were either current residents of Kent, Surrey, or Sussex

(KSS) or had lived in one of these regions within the preceding five years, ensuring a connection to the geographical area of interest.

Exclusion

Individuals were excluded from participation in the study if they did not provide informed consent to take part. Additionally, those whose primary and sole diagnosis was identified as either a learning difficulty or dementia were not eligible, as these conditions may have affected their ability to engage with the interview process or align with the study's objectives.

4.2.6 Recruitment

The recruitment strategy involved two phases: 1) promotion of the study and 2) purposive sampling. In the first phase, the study was promoted via organisations including Diversity Resource International (DRI), Ethnic Minorities in Canterbury (EMIC), The Refugee Buddy Project (TRBP), social media, and in-person events which included conferences. In the second phase, 4 recruits were asked to encourage female migrants who fit the inclusion criteria to contact the PhD Candidate.

Organisations supporting female migrants working across Kent, Surrey, and Sussex were emailed a letter of invitation. The letter contained a brief introduction about the researcher, and why the research was being conducted. It then went on to list the requests as to why they had been contacted, mainly to assist with recruitment through advertising the research in their organisation and networks. Similar to the information sheet, the letter contained brief information on what taking part in the research would entail and the ethics behind data collection and storage. A copy of the gatekeeper's letter can be found in Appendix L: Gatekeeper's Letter. The study advert, participant information sheet, consent form, and demographics sheet, which was titled "About You" as suggested by the co-production group members, were included in the correspondence (see Appendices M, N, O & P).

Secondly, to expand the reach of recruitment, the PhD Candidate used a personal Twitter account to advertise for participants in the study. X (Formerly Twitter), a popular social media platform, has the potential to expand the reach of study recruitment (291). To maximize participant reach, a multifaceted recruitment strategy was implemented. The

research advertisement was disseminated via the PhD Candidate's social media profile, encouraging user engagement (e.g., "likes" and retweets) to amplify its reach through participant networks. This approach successfully yielded two female migrant participants.

Furthermore, the PhD Candidate actively participated in relevant community events to enhance recruitment efforts. This included serving as a guest speaker at a mental health awareness workshop in Brighton specifically designed for newly arrived British passport holders from Hong Kong. Additionally, participation as a panel member and guest speaker at the closing ceremony for Black History Month held at Lewes Town Hall, East Sussex, further diversified the participant pool.

Snowballing was used as a strategy for recruiting participants. Snowballing can be described as when a researcher asks '*a limited number of relatively easily accessible participants to recruit informants to whom the researcher has no personal access*' (292). Potential recruits, who had expressed interest in being interviewed, were asked to approach any female migrants residing in KSS if they would be interested in being interviewed for the study. Once an individual had expressed interest in being interviewed, they would then be emailed the participant information sheet, consent form, an advert for the study and a demographics sheet titled "About You".

4.2.7 Procedure

Developing the topic guide

The topic guide is an integral part of qualitative research that helps the interviewer focus on the topics and issues which are part of the aims of answering the research questions (293). As mentioned in the previous section, the topic guide was co-produced with female migrants, academics and professionals supporting female migrants. The supervisory team contributed to the topics to be covered, including suggesting possible questions and had oversight throughout the development of the topic guide by providing constant feedback.

The preliminary headings for the research questions were derived from the systematic literature review concerning the mental healthcare experiences of female migrants (*Chapter 3*) (294). Barriers and facilitators identified within the systematic review were tallied, and subsequently, a meeting was convened with four members of the Female

Migrant Mental Health Co-production Group (henceforth, FMCG; for further information regarding the co-production group, *See Chapter 2, Section 2.5.2*). However, only two members were in attendance at the initial meeting.

To avoid replicating previous studies that often focus on broad categories of "migrant experiences," this research adopts a localised feminist lens, centring on the specific experiences and perceptions of female migrants in Kent, Surrey, and Sussex. This approach prioritises the voices and perspectives of these women, not as monolithic "migrants," but as individuals navigating the complexities of stigma and resilience within their specific regional contexts. For instance, interviews explored the unique challenges female migrants face in accessing local healthcare services, negotiating cultural norms within specific communities, and building social support networks in the distinct socio-political landscapes of each region.

Piloting the topic guide

A pilot study is the *pre-testing of a particular research instrument such as a questionnaire or interview schedule* (295). Piloting may decrease mistakes and enhance the quality of the study by increasing the validity and reliability of the research (296,297). The piloting offered the opportunity to refine questions, change questions and check the appropriateness of the questions. Piloting has been suggested as offering practice in interviewing techniques (298). Based on guidance (299,300) on researching vulnerable populations such as migrants, consideration of the high risk of exploitation towards the participants and the need for anonymity was at the forefront of the piloting of the data gathering process. Furthermore, time constraints of the participants due to childcare issues and work or study commitments may restrict interview time, hence the need to trial the timings and make the most of the time that was given to the researcher.

The pilot interviews, conducted with two volunteer female migrants and two colleagues, proved invaluable in refining the research instrument. None of their responses were included in the final analysis. One key improvement involved standardising the terminology used to refer to the study's target population, choosing "*female migrants*" consistently over the previously interchangeable "*migrant females*." This change, suggested during a practice session, enhanced the topic guide's clarity and precision.

Notably, this inconsistency had not been previously identified despite the guide being reviewed by numerous individuals—including the supervision team, co-researchers, and a mentor.

The pilot interviews, including rehearsals with a co-researcher who also contributed to data collection, provided a critical opportunity for final refinement before the formal study commenced. The terms "*female migrant*" and "*migrant female*" are not interchangeable, as their distinction lies in the emphasis placed on gender or migration status as the primary lens of analysis. "*Female migrant*" foregrounds the gendered experiences of migration, recognising how migration interacts with systemic inequalities based on gender (1). This term is particularly relevant in feminist frameworks, where the focus is on the unique challenges and barriers faced by women within patriarchal and often exclusionary systems (209,275).

In contrast, "*Migrant female*" primarily identifies the individual as a migrant, with gender as a secondary characteristic. While this term may still capture relevant experiences, it risks minimising the intersectionality of migration and gender, overlooking how these intersecting identities shape lived realities. In this thesis, "*Female migrant*" is used intentionally to align with feminist theoretical frameworks and to centre gendered experiences as a critical component of the analysis. This choice reflects the overarching aim to prioritise equity and inclusivity, addressing the specific vulnerabilities and strengths of female migrants within healthcare systems.

Pre-interview contact

The FMCG emphasised the importance of establishing rapport and trust with female migrant participants as a prerequisite for the study's success. They recommended offering all potential participants an opportunity for an informal discussion about the study, either via telephone or through the online communication platforms intended for the interviews (Zoom and Microsoft Teams).

Upon expressing interest in participating in the interview study, female migrants were offered an informal discussion about the research at least one week before the scheduled interview. Eight potential participants opted for these brief chats, allowing them to ask

questions and be fully informed before providing consent. Of these eight, four requested video conference calls, two preferred telephone conversations, and two chose email exchanges to have their questions answered.

Seeking informed consent

Research participants were provided with information on what would happen to them during the research and any potential risks and benefits they may incur resulting in their participation in the research (301). Consideration was given to providing a Participant Information Sheet (PIS) written in simple English to all potential participants (*see* appendix N: Participant Information Sheet). A consent form (CF) was included in the information pack. All potential participants who expressed an interest in participating in the study had to fill out the CF (*see* Appendix N: Consent Form). It was indicated they could get support in filling out the form or if they wanted to discuss aspects of the form before making an informed decision to fill the form.

On the day of the interview, it was explained to the participants that the researcher was required to check with the participants if they were happy to give their consent to their participation in the research study. Firstly, a brief statement was read explaining the reasons for conducting the research and why they had been invited to interview. The next step was to read statements for which they were asked to agree or disagree to. The statements included the provision of information that the interview process and the use of information provided during the interview would be confidential and their identity and those of others mentioned would be anonymised unless in exceptional circumstances where it was deemed necessary to disclose to the supervision team or relevant authorities. These exceptional circumstances included if they or someone else was at risk of significant harm. Additionally, they were informed their participation was voluntary and that they could withdraw at any time during or after the interview. All participants were reminded of the voluntary nature of participation during the interview and at the end of the interview.

An awareness of potential harm by the researcher to research subjects has been recommended as good practice when conducting interviews with vulnerable populations (302). The potential construed positions of power the PhD candidate may have occupied as a male and a researcher are detailed in the reflexivity section. This awareness was

important to the study as most females are disadvantaged across their lifespan biologically and socially (303) and as a male researcher, the PhD Candidate had to limit the perceived and real inequalities in the power distribution. As it was female migrants potentially being interviewed by a male researcher, steps were taken to ensure the participants were happy to be interviewed by a male researcher, so a statement was included in the consent form for their preference for the gender of the researcher on the day of the interview. On the day of the interview, a check-in statement was read out (*I am happy for the Primary Researcher (male) to be present during my interview*). The participants were free to indicate that they were still happy, or otherwise, to be interviewed by a male researcher. If they were not happy to be interviewed by the male researcher on the day, then the interview would be cancelled, and adequate arrangements would be made to reschedule with a female interviewer. For the study, none of the respondents requested being interviewed by anyone else other than the PhD Candidate before agreeing to interviews being arranged, nor was it the case that on the day someone changed their mind.

4.2.8 Data collection

All the interviews were initially expected to take place online due to previous public health COVID-19 guidelines limiting face-to-face contact (36,304). Subsequently, online, and in-person interviews were conducted for the project between August and November 2022. Most interviews were conducted online, although consideration was given that not all interviews may take place online due to *digital poverty*, a term that refers to a lack of skills, resources, or access to digital technologies (305). The report by Holmes and colleagues (305) summarises several factors that may influence digital poverty, including, internet or device access, skills, and motivation. Additionally, they highlight some of the characteristics of gender, ethnicity, levels of education, income, and disability as being those of individuals likely to be affected by digital poverty. As previously reported, female migrants face some of the worst health and societal inequalities, hence the reason to consider other forms of interviewing, including face-to-face to give them the right platform for them to have their voices heard.

Six of the participants indicated they would require an interpreter for the interview. The potential for data to be lost or misinterpreted in translation, both linguistically and culturally, was a critical consideration in the study design and implementation. Several

measures were taken to mitigate these risks. First, interpretation support was organised through bilingual co-researchers who were certified interpreters and advocates, ensuring that both linguistic and cultural nuances were respected. Additionally, Vandu Languages, an established interpretation service, was engaged to provide professional support for over 135 languages (306). Approval for Vandu Languages to provide linguistic support had been granted by the ethics committee.

For face-to-face interviews, arrangements were made to conduct the sessions in convenient, well-ventilated spaces that were suitable for both the interviewer and the interviewee. The interview spaces were arranged through the universities of Brighton and Sussex in Sussex and the University of Surrey in Surrey. In Kent, interview facilities were pre-agreed through the local National Institute for Health and Care Research (NIHR) facilities where it was deemed convenient and agreed by all parties that they are adequately mitigated against the risks of COVID-19 by providing ventilation and safe distancing space. Private rooms were required to ensure confidentiality for the interviews.

Subsequent interviews were conducted at the Diversity Resource International (DRI) facilities in Lewes. Before any fieldwork, a risk assessment was conducted using AssessNET, the University of Brighton's online risk assessment tool. An example is attached as Appendix F: Example Risk Assessment.

Interviewing participants

In the context of research, the National Bioethics Advisory Commission (NBAC) defines vulnerability as *“a condition, either intrinsic or situational, of some individuals that puts them at greater risk of being used in ethically inappropriate ways in research”* (307).

Female migrants are identified as a vulnerable population (308). Although not all female migrants are considered vulnerable, the contextual situations make it likely that such individuals are considered at high risk of being vulnerable. The role of the researcher was to minimise distress during and after the research participation. This was undertaken through several steps:

4.2.9 Acknowledging the power dynamics between the male PhD Candidate and female participants

As a male researcher who is in a position of perceived power in the context of being seen through the lens of someone who is a researcher exploring the vulnerabilities of female migrants, there were strategies employed in mitigating the power dynamics with participants:

- **Removing pressure.** Before the interview and during the interview process, participants were reminded that they were under no obligation to answer any questions. It was always stated, *'you are free to not answer any question or to share as little or as much as you feel comfortable'*. At the start of the interview participants were again reminded that they had the right to withdraw from the interview at any time, even after the interview had begun. Similar interview studies reporting on methodology have stressed the importance of checking in with participants that they are aware of the right to withdraw at any time (302). The experience of “empathic moments”, or rapport during an interview has been reported to have a positive outcome on the interview process. Within these empathic moments are constructs of consent, respect, mutual trust, and sensitivity to power imbalances (309). Building rapport was prioritised by making the interview as informal as possible, through a conversational style with time assigned for the participants to ask questions and give their observations relating to the research throughout the interview.
- **Asking about preferences in recording the interview.** Participants were asked which format of the interview recording they felt most comfortable with, including whether they wanted to have just audio or full video recording or if they preferred, the interviewer take notes only. These options of data collection had been approved by the ethics committee. All the participants indicated they did not mind which format of recording for the interview and expressed appreciation for being asked first about their preferences. Before starting the interviews, a clarifying question was asked to check if the participants still had the same preferences for recording.
- **Protecting privacy.** Statements were read on the steps that would be taken to protect the privacy of the participants, including the storage of information, how the information would be used, and maintaining privacy and confidentiality throughout

and beyond the research. All participants were asked which unidentifiable name they preferred to be called during the interview and if those were the same names they wished to be used in the reporting. Some participants preferred to be called by their name during the interview, but it was always stated that the names would be changed to a name they preferred before analysis. Time was set aside after the interview to check if they were happy with the name that was going to be ascribed to their quotes during the analysis and write-up stages.

- **Highlighting the co-produced nature of the interview schedule.** After reading a brief description stating who the researcher was and that the researcher was seeking to hear participants' views and experiences. At the start of the interview, it was always mentioned that the interview schedule was co-produced with female migrants and professionals who support or research female migrant mental health. An attempt to make the interview process as informal as possible was used in each interview through the line *'I hope we can have more of a discussion, rather than me interviewing you today.'*

The interview processes

During the interview, the interviewer kept a lookout for any signs of distress or discomfort, specifically when asking the participants questions that may appear difficult to respond to, for example, when asking participants about times in their lives when they felt they had experienced poor mental health - one of the questions related directly to these experiences as it asked them to *'Describe a time in the past 12 months you have experienced poor mental health'*. If a participant appeared distressed, they were asked if they would like the interview to be paused or terminated completely. This occurred with one participant who started to appear upset, for a few seconds when she recalled a time when she felt mentally ill. After checking in with her if she would like to stop the interview, she stated she only needed a moment to get *'myself together'* and then she asked for the interview to continue. The researcher checked in on her throughout the interview if she was still okay to continue and she stated she was fine. All the participants continued the interviews, for which the interviewer told them he was grateful and in turn, they mentioned that empathising with them was meaningful as well appreciated.

Debriefing process

After each interview, participants were thanked for their involvement and asked to remain on the line while the recording was stopped. This provided an opportunity to check on their well-being, particularly if they had found any questions challenging or emotionally taxing. Participants were reminded of the support resources sheet (Appendices G, H, and I) included in the interview pack, and the interviewer offered to resend it if needed. Additionally, participants were offered a follow-up call or email 2–3 days after the interview to check on their well-being. Two participants requested brief check-in calls, and one preferred an email. All participants expressed a willingness to be involved in future research related to the qualitative study.

Reflection on the debriefing process and research engagement

As a male researcher conducting interviews with female migrants, I was acutely aware of the power dynamics and sensitivities inherent in our interactions. This awareness often shaped my approach, particularly during the debriefing process. At times, I found myself overthinking how participants might perceive my responses to their deeply personal disclosures. In trying to ensure they felt reassured, I occasionally overcompensated, which may not always have felt entirely authentic.

Despite these moments of self-consciousness, the relationships fostered throughout the research process often transcended these uncertainties. Participants placed considerable trust in me, sharing intimate and vulnerable aspects of their lives. I believe this trust stemmed from the collaborative and co-productive engagement that underpinned the study, where participants felt their voices were valued and respected. On several occasions, participants mentioned that the interview provided a safe and supportive space, which underscored the relational nature of the research.

Reflecting on these experiences, I recognise how the research process, particularly moments like the debriefing, illuminated the importance of balancing professionalism with genuine care. The trust participants placed in me not only enriched the research but also reinforced the significance of building respectful and empathetic relationships in qualitative work

4.9.8 Reimbursement

The participants were expected to provide recommendations based on their lived experience expertise, which was recognised as valuable and deserving of acknowledgement and compensation. This awareness was extended to acknowledge that the participants were giving their time and often using data, and electricity when being interviewed, therefore, they were to be reimbursed accordingly.

All participants were offered a £25 high street voucher. This was calculated as £20 for the interview and £5 for the expenses (e.g., data and electricity). The £5 was adopted from

guidelines by the NIHR concerning expenses incurred by members of the public contributing to the research from home (310). For 17 of the participants, this involved emailing a voucher code of their choosing if it was readily available for purchase. In the case of one participant, she requested a physical copy of the voucher to be posted to her home address.

One point to note is that some of the participants expressed a desire for their vouchers to be sent to other female migrants who may need the vouchers more than they did, and in the words of one *'just knowing you are conducting this research is reward enough for me and it makes me happy so please send it to someone else who may need it. Or you can have it because you are doing a great job'*. The offer to use the vouchers personally by the PhD Candidate was kindly declined, instead, the PhD Candidate suggested sending the vouchers to the participants so they would use them as they felt fit, including donating to people and charities supporting vulnerable individuals. The selflessness of the participants interviewed is a point of reflection both across the study and in the reflexive statement, as some of the participants had financial difficulties in buying essentials, yet they offered to have vouchers given to others. (*See* section 6.3 Personal reflexivity).

There has been debate on the payments, incentives and reimbursements ranging from exploitation and the ethics of offering payments to participants and its effects on research outcomes (311–313). Draper and colleagues (311) suggest, despite the challenges associated with reimbursing participants in studies, it is still considered the ethical course of action. The NIHR has produced guidelines for researchers, professionals, and public members on the payments of public contributors to research studies (170,310).

Involvement opportunities include one-off activities and longer-term involvement. Using this guidance, it was considered best practice to follow these guidelines in ensuring all possible information was given to potential participants on the impact of receiving a one-off voucher when participating in the research as interviewees on any financial arrangements they may have had in place.

A letter based on the NIHR template letter to the Jobcentre (314) was offered to all interview participants, should they have had concerns about the impact of receiving vouchers for being interviewed and if it impacted any financial arrangements, for example, benefits (*See* Appendix P for the letter to the Jobcentre).

4.2.10 Data preparation

This section briefly describes the process of transcribing and anonymising data.

Transcription process

Transcription can be understood as a *process that is theoretical, selective, interpretive, and representational* (315). As the PhD Candidate had undertaken all but one of the interviews, the process of transcribing was conducted to compare the recordings against the notes written during the interview and a recollection of the moments when there were pauses, sighs and changes in tone. The interviews were transcribed verbatim. The primary source of notes was the in-built transcription feature of Zoom then adding information to the transcript. This involved listening several times to the recordings and typing up the interviewer and interviewee exchanges. To ensure the fidelity of the interviews that involved an interpreter, three snippets from each interview were shared with other female members of the co-production group who were fluent in Portuguese and Arabic. These members were asked to compare the translated transcripts to the original recordings to identify any discrepancies. Additionally, they were given a snippet to back translate. Back-translation is a quality assurance method to assess the accuracy and equivalence of a translation. In back-translation, the translated text is translated back into the original language by a blinded researcher. Comparison of the back-translated text and the original helps in identifying errors or inconsistencies (316).

Using these techniques, the feedback was that the interpretation was correct, save for one interview where the interpreter mainly spoke in the 3rd person. All final transcripts were saved to the secure University of Brighton OneDrive server within a password-protected folder only accessible by the PhD Candidate and the lead supervisor on the project.

Anonymising data

All interviewees were asked to provide a pseudonym, a name which is not their real name, which they would like the interviewer to call them by during the interview, and for the analysis and write-up to ascribe their quotes without identifying them within the words and context. Two interviewees had rare medical conditions, one whose condition was currently being named, which may have led to possibly identifying them, especially since they lived in smaller towns or cities, so it was deemed safe to not include specifics of the

medical conditions in the transcript as well as in the analysis and write-up. Therefore, for the medical conditions of both interviewees, it was stated “*I have a medical condition*” without identifying the specific medical condition.

All demographic data was kept in separate password-protected folders only accessible by the PhD Candidate and the lead supervisor for the PhD project.

4.2.11 Thematic Analysis Process

Reflexive Thematic Analysis is the process of finding, evaluating, and reporting themes within data. It has been widely used in interviews, focus groups, and observations in exploring meanings and interpretations of qualitative data (226,317).

Thematic analysis is not without its detractors, with some criticising it for being too ill-defined, inconsistent, incoherent, and often leaving the reader confused as to what thematic analysis is and how it was undertaken (318–320). However, thematic analysis is popular within qualitative research as a methodological approach which may be easy to undertake and report on, largely through the accessibility of a growing catalogue of resources by Braun and Clarke in promoting the approach (321).

The thematic analysis in this study was conducted following the systematic guidelines proposed by Braun and Clarke. The process unfolded through the following six key steps:

Step 1: Familiarisation with the Dataset

The initial phase involved immersing oneself in the data to deeply understand its content. Interview transcripts were imported into QSR International’s NVivo 12 qualitative data analysis software (225). Each transcript was read multiple times to facilitate familiarity, while notes were taken, and significant points of interest were highlighted for further exploration.

Step 2: Identification of Themes

Subsequent readings of the transcripts and associated notes enabled the identification of recurring patterns, topics, or ideas across the dataset. These elements were systematically grouped and labelled using descriptive and interpretive codes, reflecting both the explicit content and underlying meanings within the data.

Step 3: Analysing the Themes

The coded data were then examined and organised into broader themes, capturing significant patterns within the dataset. This process involved collating related codes and discerning how they collectively contributed to addressing the research question.

Step 4: Reviewing the Themes

To ensure coherence, relevance, and consistency, the emerging themes were carefully reviewed. This iterative phase involved refining, merging, adding, or discarding themes where necessary to ensure they accurately reflected the data and meaningfully contributed to answering the research question.

Step 5: Defining and Naming Themes

In this stage, each theme was clearly defined and given a name that encapsulated its core essence. The naming process ensured that each theme was distinct and directly relevant to the research objectives. Furthermore, example quotes and concise descriptions were provided to contextualise and illustrate each theme. A detailed framework, including example quotes, is presented in Appendix Q for reference.

Step 6: Presentation of the Findings

The final phase involved synthesising the findings into a coherent narrative. The presentation included the interpretation of the meanings underpinning key quotes, supported by relevant literature and theoretical references to substantiate the analysis and reporting of the findings.

This systematic approach ensured that the thematic analysis was rigorous, transparent, and reflective of the data's richness while remaining firmly grounded in the research objectives

4.11.1 Validation

To enhance the study's rigour and trustworthiness, two members of the co-production team independently reviewed interview transcripts to identify codes and themes. This approach promoted transparency and minimised the potential for subjective interpretation or researcher bias. An inductive approach was encouraged to ensure that the emerging codes and themes were grounded in the data, rather than preconceived notions.

This member-checking process, while not strictly aligned with the traditional tenets of Reflexive Thematic Analysis (RTA) (322,323), nonetheless served several important functions. It provided a form of multivocality, incorporating diverse perspectives into the analysis and interpretation of the findings. Additionally, the feedback from the FMCG team members offered a valuable "reality check" against the male researcher's interpretations, mitigating potential biases stemming from academic and gendered perspectives. This collaborative approach ultimately strengthened the study's credibility and contributed to a more nuanced understanding of the data study (322,323).

Two members of the FMCG were asked to consider:

1. *What are the causes of poor mental health for female migrants?*
2. *What are the barriers to accessing support for mental health?*
3. *What helps in maintaining the mental health of female migrants?*
4. *Anything else you think stands out for you – maybe experiences or perceptions?*

These questions were based on the research question. The responses were subsequently juxtaposed with the preliminary thematic table, enabling further refinement through guidance from the FMCG members' insights. Table 10 exemplifies the initial coding conducted by the PhD candidate concerning the themes delineated by the two co-researchers. Quotations corresponding to each theme were collated and assessed for their alignment with the co-researchers thematic ascriptions. Discrepancies prompted the PhD Candidate to re-examine the transcript and undertake a comparative analysis with other transcripts.

Table 10: Example comparative coding framework of FMCGs' and PhD Candidate's thematic ascriptions.

Original coding	Theme as identified by co-researcher	Quote
The interface between mental health and physical health	Pain is caused by a physical health problem.	<i>'during the evenings the pain is getting worse, and I can't sleep properly. When you can't sleep and you are in the bed awake, you start thinking many things coming in your mind.'</i>
Work-related issues	Being unable to work	<i>'I see all my neighbours going out to work. See my son go to school and I be at home. Is like I feel lazy girl.'</i> <i>"You feel, useless, useless, useless.'</i>
Support from friends and family	Talking to friends and family	<i>'I'm always talking to her, even especially evenings, when we are awake, we talk to each other.'</i>
Stigmatising attitudes	Fear of stigma	<i>'Before that, I never sought help Because I was kind of scared to open up myself because yeah, fear of stigma basically.'</i> <i>'I feel like those like health, mental healthcare, healthcare professionals will be biased'</i>

The EMBaRK framework played a central role in the collection and preparation of data, facilitating the integration of co-researchers and lived experience voices into the analysis. This ensured that participants' narratives shaped the thematic findings, amplifying the voices of female migrants.

4.3 Results

To ensure the robustness of the findings, careful attention was paid to minimising both linguistic and cultural misinterpretation. Cultural interpretation challenges - such as differing norms around disclosure, gender dynamics, and healthcare expectations - were mitigated through the reflexive engagement of co-researchers from similar cultural backgrounds. These co-researchers provided invaluable feedback, contextualising participants' responses and refining the data collection and preparation processes.

During the analysis phase, lived experience commentaries played a pivotal role in ensuring that cultural subtleties were not overlooked or misunderstood. This collaborative approach, combining co-researcher input and professional interpretation, established a robust framework for navigating linguistic and cultural complexities, ultimately enriching the study's insights and depth.

4.3.1 Participant characteristics

A total of 18 non-British-born females participated in the interview study. The age range was 24 to 59 years, with a mean age of 38.8 years and a standard deviation of 10.28. The most represented age group within the study population was 35-44 years, comprising 44% of participants.

The majority of participants identified as Black African (39%), followed by Arabic (17%) in terms of ethnicity. Brazil was the most common country of origin (17%), followed by Ghana, Uganda, and Zimbabwe (11% each). Portuguese was the most frequently reported first language (28%), followed by Arabic and English (16% each). Most participants identified as generalised Christian (40%), Christian-Catholic (22%), Muslim (11%), or having no religion (11%). All participants identified as heterosexual.

Sussex was the most represented county in terms of participants' residence (61%), followed by Kent (22%) and Surrey (17%). Over half of the participants (56%) reported needing support for mood disorders, including depression, anxiety, and post-traumatic stress disorder (PTSD). Other reported issues included stress-related illnesses, both physical and mental, as well as feelings of loneliness and isolation (28%). Full participant details are presented in Table 11.

Table 11: Demographic overview of female migrants in the study sample (N = 18)

Characteristics	Category	Number
Gender and sex	Self-identify as female/woman	18
Age	18-24	2
	25-34	4
	35-44	8
	45-50	1
	50+	3
	Ethnicity	White European
White Brazilian		2
Asian - Hong Kong Chinese		1
African Other		1
Turkish		1
Black European		1
White - Other		1
Arabic		3
Black - African		7
First Language		Twi
	English	3
	French	1
	Turkish	1
	Luganda	2
	Ndebele	1
	Arabic	3
	Portuguese	5
	Cantonese	1
	Religion	Christian
Christian - Anglican		1
Christian - Catholic		4
Muslim		2
Atheist		1
No religion		1
No recorded religion		1
Sexual Orientation	Heterosexual	18
Country of Origin	Turkey	1
	Hong Kong	1
	São Tomé and Príncipe	1
	Palestine	1
	Lebanon	1
	Brazil	3
	Ghana	2
	Zimbabwe	2
	Iraq	1
	Ivory Coast	1
	Uganda	2
	Nigeria	1
	Portugal	1
	Interpreter required	Yes
No		12
KSS County	Kent	4
	Surrey	3
	Sussex	11

Characteristics	Category	Number
Length of stay	<1 year	3
	1-5 years	7
	6-10 years	5
	>10 years	3
Difficulties with mental health	Mood Disorders (depression, anxiety, PTSD)	10
	Other (Including stress-related illnesses)	5
	Not stated	2

4.3.2 Themes

The findings are presented according to the following themes – Barriers and Facilitators to mental health support relating to stigma. The quotes are presented with a pseudonym and the participant's country of origin. This is done to protect the identity of the participants and to ensure that their words are not taken out of context. In academic research, it is a prevalent practice to attribute pseudonyms to participants when the research involves sensitive topics or when the identity of the participants is at risk (324). Some participants demonstrated awareness of the barriers and facilitators to accessing support by their fellow female migrants, and they were able to describe these in detail. These are included in the analysis.

4.3.2.1 Barriers to Support

All female migrants participating in the study were questioned regarding the barriers they encountered, or anticipated other female migrants would encounter when seeking or accessing mental health support. The barriers identified can be categorised at two main levels: individual and societal/structural. Table 12 details these barriers to accessing mental health services, along with how stigma intersects with and intensifies them.

Table 12: Perceived barriers to good mental health and service access concerning stigma

Level	Barrier	Role of stigma
Individual	Difficulties in communication	Stigma may hinder a female migrant's ability to express her needs effectively and feel understood by others.
	Misinterpretation of needs	Misunderstandings may arise due to cultural or language differences, potentially leading to misdiagnosis or inappropriate care. Stigma can contribute to these misunderstandings.
	Fear of judgment	Stigma may lead to shame and embarrassment about mental health conditions, hindering support-seeking.
	Internal conflict	Stigma can make individuals feel unworthy of support, leading to hesitation in seeking help.
Interpersonal	Lack of social support	A lack of a supportive network of family and friends can make individuals feel isolated and less likely to discuss their mental health.
	Discrimination	Racism or hostility from others can exacerbate feelings of isolation and fear, discouraging support-seeking.
Systems	Lengthy wait times	Long wait times for mental health care can be discouraging and reinforce the idea that mental health is less important than other health issues.
	Institutional stigma barriers	Stigma can result in institutional discrimination, leading to denial of support or inadequate care for physical and mental health needs.
Societal (including interpersonal and systems barriers)	Stigmatising attitudes	Societal stigma and negative labels associated with mental health and migrant status can discourage individuals from seeking help due to shame or embarrassment.

Difficulties in communication

Many of the participants mentioned language problems as a main barrier to their willingness to access support for their mental health. To be able to communicate their mental health needs comfortably and confidently needed a perceived grasp of the English language. For Gugu, it was not just the ability to speak the language but also the confidence in being able to fully express her needs which made her hesitant to seek support.

'I speak a different language or the words that I use which make me not seem as urgent as the next person' [Gugu, Zimbabwe}.

This is something that was reflected by Alison who categorically stated that was her inability to express herself in the language that was a barrier to seeking and accessing support:

For Alison, '*language does affect how I access services*' [Alison, Brazil]. Elaborating on her reluctance to seek support, she explained that her perceived inability to articulate her mental health concerns stemmed primarily from a lack of proficiency in English. She expressed apprehension about not being understood by others, as well as potentially misunderstanding medical terminology herself.

These experiences of language acting as a barrier to accessing support were not limited to the personal experiences of these female migrants. They also reported being aware of other female migrants facing similar linguistic challenges in accessing healthcare. For some, this lack of proficiency in English extended beyond the need for mental health support, impacting their ability to articulate their daily needs. Alison, for example, described frustration stemming not only from difficulties with her English teacher but also from the adverse effects of medication on her concentration and ability to learn the language, which would have facilitated improved communication:

It is very frustrating. I tried to learn English and I really want to speak English fluently, but because I take so many medicines that it's hard for me to actually remember it all [Alison, Brazil].

This frustration can be a source of concern in individuals. In the case of Alison, the feeling of not being taken seriously and being accused of not wanting to learn the language appeared to add to her feelings of anxiety. Some studies have reported expectations that migrants have a moral obligation to learn their native language (325). When they do not learn the language, they are met with hostility and viewed, as in the case of Francesca, as being lazy and not trying hard enough to integrate into society, as well as other factors of health that have an impact being ignored, as noted:

The teacher told me I should give up studying English and come back next year when my health is better. However, I don't want to give up and I don't have any hope that my health will get better. This makes me very anxious [Francesca, Brazil].

Several of the participants mentioned that it was difficult to express the concept of what it was they were feeling from their understanding of their language and relating it to the English language. This is supported by literature that has reported some cultures have no definition nor recognition of mental health, therefore, explaining a concept not existent in one's native tongue to a language that one is not well-versed with may have its challenges (326).

[...] coming to the UK, having English as my like additional language. I don't think I can like all the time express what is my fault really clearly. That is also perhaps one of the factors that stopped me from seeking help. Maybe I can't really tell how I feel maybe.
[Liberty, Hong Kong].

These sentiments are echoed by most female migrants interviewed for the study. For Nadia, the concept of knowing what is wrong with you but not being able to express it in the language understood by the health professional was seen as a barrier that needed to be addressed for many other female migrants.

For Nakabiri, it was the literal translation of what was meant to express a feeling or mental health condition which was an issue when it came to willingness, access support and expressing oneself as to what the mental health need was:

It's a societal thing... I don't think we have a word for stress in my language. We have a word for madness. Somebody's mad, but I don't think we have a word for stress, and usually, that is something that tells you about that culture, because [they don't] have that word in their vocabulary. There's a word that we use for people who are kind of not well mentally. But it describes a more extreme side of mental health, so anything in between has no name. So, it's either you are or you're not. [Nakabiri, Uganda].

Madness, as was described by Nakabiri, may therefore have encompassed spiritual and societal disconnection or dissonance. Indeed, the concept of madness has previously been used to describe what is now termed mental health illness (327). Connotations remain stigmatising in spiritual and cultural settings as something that is considered in the context of disruptive social behaviour, violence, and negative spiritual states (328–330). This then has an impact on help-seeking behaviours, with stigma attached to the negative views of

society and preference for traditional support and understanding from traditional and faith leaders and healers.

Nadia recognised that this was a barrier that many female migrants faced. The barrier was not only due to the way that they expressed their concerns but also because professionals sometimes struggled to understand what the female migrants were trying to express. This was not always a one-sided issue, as the professionals may also have had difficulty understanding the female migrants' needs due to cultural differences.

I think if there is a language barrier that needs to not be there. The danger is that because whether you go to the GP and say that you know [what's wrong with you], the GP needs to understand why you're there. Trying to express mental health is very difficult when you use the same language, let alone those language barriers [Nadia, Iran].

To circumvent the issues of communication, some of the female migrants relied on their friends and family to interpret their needs for them. Though not always successful, for example, in the case of Jawaria, communicating her mental health needs was almost successful with the help of her children. However, when the children were not around, she barely got through to expressing her support needs:

I did come across some problems when my kids were not around, but it wasn't as big for me. Maybe it will be for someone else who doesn't have someone to help them with the language [Jawaria, Syria].

The challenges of relying on children as brokers for communicating health and social care needs have been widely documented (331,332). Although Jawaria indicated her need for her children to act as brokers in communicating was not as serious as others' needs, she did however, allude to her heavy reliance on her children, at which times when they were not around, she could not access the support that she needed. Having the convenience of knowing her children would return at some stage during the day to translate letters or speak on her behalf with healthcare providers may have been comforting as opposed to not knowing how to access support completely. These challenges of relying on children as brokers may be highlighted against a backdrop of research stating female migrants are more likely to seek support for their mental health through formal mental health professionals compared to their male counterparts who prefer traditional means of support

which may include spiritual practices (238). For Jawaria and many other female migrants, if their children are not available to act as brokers of support, it is not for lack of wanting, but more for lack of availability of secondary support.

In line with other studies (287), the unavailability of professional interpreters in an emergency, for example, during a mental health crisis, meant that there was an overreliance on family members acting as interpreters. *[but now it is my children]. If there is any appointment or if I need to call someone or leave a message to someone, it's [my children I ask] ... They've been a great help to me [Jawaria, Palestine].*

A reluctance amongst migrants to discuss sensitive health concerns, particularly in face-to-face consultations even with a professionally trained interpreter, raises ethical concerns regarding the practice of relying on family members, especially minors, as interpreters for such discussions, particularly when sensitive topics such as suicide are involved.

Furthermore, barriers to seeking and accessing support were strongly felt by Ndri as coming from the migrant population and the attitudes and way they treated each other:

I started engaging with English people, I couldn't speak properly, but one thing I found was that our own people, migrant people, made it more difficult than English people to understand me so, that can take a big toll on your mental health [Ndri, Ivory Coast].

The push for culturally appropriate services aims to increase access to mental healthcare for migrant communities. However, Ndri's experience highlights a critical paradox: services intended to be culturally sensitive can, in some cases, become a direct source of mental distress due to the attitudes and behaviours of migrant professionals themselves.

Misinterpretation of needs

Due to issues with expressing and understanding what was being said by a mental health professional, most of the female migrants who were interviewed for the study mentioned they had support through formal and informal interpretation. This was either paid, offered by the service, or through the support of friends and family having to act as interpreters. The experiences were varied, from feeling supported to inadequacies of services or limitations in the form of interpretation friends and family could provide.

A female migrant friend of Amy's who was experiencing homelessness and severe mental health issues was reliant on the interpretation of her friend, who had been offering her accommodation and emotional support but was becoming exhausted with the burden of care. This exacerbated the stress of her unmet needs. Eventually when she was offered support and formal interpretation had been arranged, her friend did not benefit as much from it:

Her friend would probably say what she wanted ...because she couldn't explain the circumstances very well, she found that it was very difficult. Even [when she was offered CBT] there was a communication/ language barrier ... arrangements had to be made all the time to get an interpreter, ... she found it complicated [Amy, Zimbabwe].

Not having consistent interpretation was a common source of concern and a reason why some female migrants found it difficult to access support. It was not only cancellations but the lack of professionalism and cultural sensitivity by some interpreters that led to negative experiences of asking for help, which then hindered future support.

I got trouble with the interpretation. They keep cancelling the interpreter. The last time I had an interpreter at an appointment, and I described what my health problem was, the interpreter said "oh, don't come near me, don't touch me...". I left crying and that left me so sad and worked up [Alison, Brazil].

Having a shared language or culture increases an affinity towards the interpreter in times when a migrant needs support to communicate a health concern (333). Though having access to an interpreter may bring relief, being rejected by the interpreter may increase mistrust and a less likelihood to express oneself freely. Using an interpreter is already viewed as a disability due to the implicit dependency (287). The participants interviewed for the study seemed to face a dilemma: either rely on an interpreter who may be disrespectful or forego an interpreter and risk having their health needs unmet. Neither option appeared likely to alleviate the emotional and mental burden already experienced by the female migrants.

Although some interpretation services had moved online due to the convenience of remote interpretation and greater accessibility to interpretation, most of the female migrants interviewed preferred in-person translation support and familiarity with the person who is

translating their support needs. Without these, female migrants found it difficult to seek and access support for their mental health. It was not only a matter of convenience but also of the perception of feeling safe and, equally importantly, of building rapport with the interpreter, not just the healthcare professional:

I still prefer the face-to-face interpreter because I feel safe, and the person understands what I am talking about. I know one interpreter who has helped me several times, whenever I have an appointment, I ask for her because she knows my story and my problems. So, in that way language does affect how I access services [Alison, Brazil].

Psychological safety in an insecure world

Unsurprisingly, given the vulnerability of many female migrants, the concept of safety was one of great importance to them. Most of the participants spoke of related terms to feeling safe including ‘*security*’, ‘*safety*’, and ‘*trust*’, which acted as barriers to seeking and accessing support. For example, Amy spoke of familiarity as a factor in feeling safe and accepting or accessing support as a facilitator:

Personally, you know because I think I'd rather talk to someone I know, because then I feel I can trust them [Amy, Zimbabwe].

The sense of safety moved beyond familiarity towards feeling understood. Where earlier participants had frustrations of not being understood due to language issues, adding a layer of a lack of safety due to not being understood whilst expressing the need for support for their mental health appears to be a cause of mental health distress and may impact confidence in self and others when seeking support.

Where a sense of not feeling physically and mentally secure and safe was missing, it stopped some participants, for example in the case of Alison, from seeking or accessing support for their mental health problems:

I ended up staying at home most of the time because I don't feel safe going out [Alison, Brazil].

Safety extended to the preference of support through gender-specific support and determined reluctance or motivation for seeking support:

if someone has been abused...especially if [the] perpetrator, was a male... There's a level of sensitivity, not always saying that's correct... [Esther, Nigeria].

There was, according to some of the participants like Esther, a need to accommodate preferences of who, according to gender, would support female migrants. Reflecting on the interviews, some of the participants mentioned they had no preferences for discussing their experiences or preferences of support with a member of the opposite gender. This was also demonstrated through a willingness to be interviewed by a male researcher.

Most female migrants interviewed for the study preferred face-to-face mental health support and interpretation. This is keeping in line with other studies which report the preference for face-to-face interpretation over remote interpretation for health needs (287). However, due to recent cuts in funding by the local councils, it was not always possible to get face-to-face appointments in the company of an interpreter. This led to frustration and a lack of engagement with formal support leading to reliance on family members and, in some instances, one's young children to discuss mental health and practical concerns. For Jawaria she depended on her children in providing interpretation in alleviating the stressors of no longer having formal interpretation services when accessing health and social care support.

We used to have, like interpreters, well through the last year since I came to England. But then the Council can't provide interpreters anymore or not all the time... [Jawaria, Palestine].

This, it seems is not only a matter of availability but security (or insecurity of availability) of options to accessing support caused by structural barriers beyond the individual means.

Lengthy wait times

Many of the interviewees stated that a barrier to them seeking support was the long waiting time to get the support. This was mainly when individuals tried accessing support for their mental health through the GP or if they had been referred to additional support, specifically to psychological therapies.

There is a long waiting list, so even when I was referred you know you, you do get stuck on a waiting list for a long time and you know, I just believe there's an awful lot of women

who have problems with their mental health who are not getting any support at the moment [Alison, Brazil].

For Francesca, it was a matter of having to ‘*wait 2 months for an appointment with my GP.*’ Though she had been identified as having been going through a crisis. She was tearful, eventually feeling suicidal and still not receiving support for her mental health. Francesca’s experiences are reflective of some inequalities experienced by female migrants (334,335), however, other research suggests the effect of the “healthy migrant” where migrants are perceived as healthier than the local population, as not increasing waiting times for healthcare in some areas of the healthcare system, such as A&E (336).

Other female migrants like Nadia were explicitly told that they were not a priority for mental health support due to long waiting times. This hindered Nadia’s willingness and ability to access mental health support:

My GP and my local mental health support [service] both said no at both times when I needed help because they had big waiting lists, and I wasn't a priority [Nadia, Iran].

Similarly for Sarah, though there were concerns for her mental health from her GP, and a referral had been made, she was still awaiting an acknowledgement of when and whether she would get the support she said she desperately needed, which had been identified as a priority by her GP. The wait for anyone to contact her to book an appointment for an assessment was over two months.

No one has contacted me yet [Sarah, São Tomé, and Príncipe]. The lack of information on the waiting times and any updates after a referral added to the anxiety some of the participants had. Most mentioned how there were shorter waiting times in their countries of origin and how their expectations of getting immediate support for their mental health in the UK were dashed after multiple times of waiting for support for different mental and physical health needs.

Additionally, though therapy was often seen as helpful by most participants, not everyone agreed on the suitability or accessibility of talking therapies.

I live with my sister who is too busy to talk to me. I've been asking for mental health therapy for many years, but they refused and referred me to another service. I know I'm

not normal and my mental health is not good. I need therapy so that I can get better. If I don't have therapy, I can never work again [Francesca, Portugal].

Francesca's experience of feeling unsupported by her sister and professional services, coupled with her desperation to seek support for her longstanding mental health struggles, demonstrates the complex and challenging nature of accessing mental health care. Despite these challenges, Francesca demonstrates resilience and hope in her belief that talking therapies will help her improve her mental health to the point where she can return to employment.

Unlike Francesca, Sarah was offered therapy, however, hers was not much of a positive experience either:

I went once to the therapy, but I was talking, talking...when I came out, I felt worse than I came in and I don't know why. I don't know what I can expect it from the next. Yes, I don't know what to expect [Sarah, São Tomé, and Príncipe].

Sarah felt the therapy was a challenging process as it was not always easy to talk about her difficult experiences.

Stigma as an intersecting theme

Stigma, on an individual, the societal, and structural levels has widely been reported as a barrier to seeking, accessing, or delivering support for mental health concerns. All the participants mentioned different aspects of feeling discriminated against and feeling othered due to their characteristics and the impact it had on their willingness to seek and access support.

Silent Suffering: Mothers' fears of losing their children

Individuals with a diagnosed mental health illness are as likely to have children as those without a diagnosis of mental illness (337,338). The stigma associated with mental health illnesses may be a factor in the choice to disclose a mental health concern. Moreso, the fear that disclosure may lead to negative consequences such as having one's children taken away. Even though most participants had disclosed in the interviews the presence of a mental health condition which required professional support, some with children feared

that they could have their children taken away from them by authorities if they sought support.

A friend who was struggling with her mental health, but she didn't want to talk or seek help...because of the fear of having her kids taken away. Because she thought if she talks to someone then social services are gonna come and start questioning her. So, she thought she won't talk to anybody. She decided to just march on [Amy, Zimbabwe].

This fear of having children taken away extended to a bigger female migrant group whom Amy had come across. Most of the female migrants stated they would never disclose issues about their mental health as it meant that it may be a catalyst for the authorities, mainly social services, to take their children away from their care and may have consequences on other areas of their lives. This disclosure was not only limited to disclosing within mental health support circles but also within their children's schools:

If the school is aware that the mom is having a breakdown. The last thing I need to come and say is you are worse and for social services when you try to contact them, there is a reason why they are going to be placed into your family, they don't just come like that because you called them thinking they will help...This is speaking from experience [Ndri, Ivory Coast].

Ndri identified as a migrant who comes across many female migrants in similar positions where they feared disclosure would lead to consequences greater than if they withheld the information. Consequently, she came across these females at the stage where they required support and may have been supported earlier had they disclosed. Additionally, for Ndri, there had been a direct consequence of her disclosing, with colleagues finding out she was struggling with her mental health and subsequently being treated negatively. She would hesitate in future to do so. Many health professionals have negative attitudes towards mental ill-health (339). Negative experiences with interpreters coupled with any negative attitudes towards mental illnesses by health professionals and the fear of losing children may stop female migrants from seeking support for their mental health. This fear of disclosure is not unfounded as individuals with a mental health illness are up to 8 times more likely to have contact with social services than those without a diagnosis and up to 26 times more likely to have their children taken away by social services (337). Ironically,

having a child taken away led to greater use of healthcare services and reporting of depressive symptoms (340).

The power of prejudice: institutional sanctioning of stigma

Stigma has a direct impact on the stigmatised through discrimination, expectancy confirmation, and automatic stereotype activation. This can lead to indirect impact through threats to personal and social identity (143). Negative views by health professionals about people with mental health problems may lead to less help-seeking for both psychological and physical health problems (137,341). The professionals to whom Alison disclosed her condition appeared to hold, in Alison's perception, highly stigmatising attitudes towards both physical and mental health conditions. Alison's interpreter, for instance, seemed to be dismissive of the consequences of Alison's attempts to articulate her needs, stating, '*I don't want to catch whatever you got*' when Alison spoke of the anxiety arising from her physical and psychological issues.

In the case of Alison's interpreter, their dismissive remark, made without regard for the consequences, reveals a deeper-seated attitudinal issue towards individuals who are othered due to circumstances and conditions beyond their control. This experience resonates with Elizabeth's reflections on the stigmatising attitudes she and her mother encountered as female migrants with physical and mental health concerns.

When I say that the physical health condition that I have, the way the people react to it, it's that they seem to be discriminating against me [Alison, Brazil].

Alison has a rare physical condition that, when disclosed, often elicits disgust, disbelief, and adverse physical reactions from others. These reactions include individuals stepping away from her or expressing visible shock or fear of contagion. Alison's experience of having a stigmatised physical health condition has heightened her sensitivity to similar stigmatising encounters related to her mental health. This discrimination has deterred her from seeking support for both her physical and psychological well-being in the past. On occasions when she did access support, the individuals providing it were discriminatory, sometimes refusing to be physically near her, which further exacerbated her mental state.

Societal attitudes as a hidden epidemic: For many of the participants who were interviewed, the lack of a desire to seek support for their mental health stemmed from

attitudes and beliefs that were embedded in their society, through cultural and religious beliefs about the causes and meaning of poor mental health. For example, the origins of mental ill-health vary by society from the supernatural to environmental factors (328). Similarly, other studies highlight societal attitudes, perpetuated by negative reporting of individuals with mental health disorders as individuals who should be considered dangerous (342,343).

Participants indicated societal stigma towards mental health was due to a poor understanding of the epidemiology of mental health disorders and the attitude towards having a mental health concern in the context of a society that does not have the language to fully describe what the individual is going through and what support may be available to that individual. There was a widespread belief that mental ill health was not something that existed when they were growing up.

In my country, in Ghana, everybody's literally born frustrated like ...the economy... everybody's going through a lot...we just grow up thinking OK, this is normal and then you brush it under the rug and go about your day...we usually just suffer in silence, and it was an African thing [Eelin, Ghana].

These beliefs were further supported by a fellow countrywoman:

I think one of the main reasons why I haven't gone to seek any support is because from where I come from in Ghana, we don't talk about mental health. It's almost like a taboo...You can't have a mental health issue. It's not allowed [Obenewaa, Ghana].

Across Africa, there was agreement that there was a taboo in speaking about and accessing support for mental health:

for a long time, mental health meant somebody was really disturbed. [Nakabiri, Uganda].

Similarly, the experiences and perceptions are shared by Gugu who elaborates on the hesitancy to seek support as something that is termed “weird”.

You know you stress who talks about stress and about feeling low? You know people are just like get on with it, you know, just you're being weird. You're being silly. I mean, it was even what led to the divorce. It was more so much pressure because nobody understood [Gugu, Zimbabwe].

The African community doesn't really believe in those issues so that can be quite difficult for someone to come out and say I am suffering from poor mental health and oh... There's no such thing, or they will just put you in an asylum [Ndri, Ivory Coast].

In Uganda, mental health is the least that is one thing we don't talk about how, how dare you, how dare you just lose it? You can't [Masiko, Uganda].

It appeared that mental health from an African perspective was not something that was easily understood and accepting that someone had a mental health condition indicated weakness or madness, which is not related to the modern-day psychiatric understanding of mental illness, rather, conjuring up images of the madhouses of the mid to late eighteenth century. Such views were not limited to female migrants from Africa.

Internal conflict: On an individual level, some of the participants spoke of the anticipated negative perceptions of speaking about mental health or accessing support:

Arabic ladies feel... bit embarrassed, a bit embarrassed to mention their problems... some people are scared of the publicity or if some relatives or friends know, for example, this lady has a mental health problem [Ms Din, Palestine].

There was the stigma of oh, no, we'll just keep this quiet. Because no one's gonna marry anyone in this family. And you know, it's like. All bad taboo and really, it's not. It was making a dark situation at home where it didn't need [Nadia, Iraq].

A plethora of literature supports the narrated experience and fear by Ms Din as individuals with mental health illnesses are widely viewed negatively, in turn making them ashamed of their conditions and less likely to access mental health support (248,344).

Internalised stigma emanated from feelings that the individual was the cause of their mental ill-health and any failure to deal with their mental illness meant they were weak and not worthy of support, of love and of being capable of achieving anything. This led to self-blaming for having the mental health illness, blame for the need to have support and self-blame for not then seeking or accessing the support.

I don't think it's your religious system. You sometimes judge like me yourself that is the big problem. When you judge too much of you put too many questions about yourself. And this

one keeps you going down. [Sarah, São Tomé, and Príncipe]. The barrier is me. I haven't got the strength to keep chasing after my support [Elizabeth, Portugal].

Having a non-English name contributed to the anticipated stigma amongst the participants that they would be treated differently because of their non-English names.

Just some of the difficulties you face trying to get support can be your own issues, or maybe my name [Gugu, Zimbabwe].

For Gugu, the anticipated stigma of how she would be treated if the health providers saw her name proved to be a self-fulfilling prophecy as she was treated differently partly due to her name and being a migrant. Such validation of one's concerns may lead to reluctance to engage with health support if history has already proved that their fears are well founded. Many of the participants had non-English names and some asked the interviewer to call them by a hypocorism of their name. The interview response Gugu indicates that she was now expecting people to misspell or mispronounce her name even before they had attempted, which for some may cause anxiety.

Hesitancy to get support was indicated even when there were information awareness sessions for migrant workers. Nakabiri is a female migrant who supports other migrants to access support in health and social care. However, even she felt that it was not enough to provide information sessions on what is available for support when individuals would not even go and access the services.

As part of a project, [we] told them that we have somebody they can go and talk to when they feel you know things are too much. Nobody used that service [Nakabiri, Uganda].

Interestingly, it was not because of a lack of information or the realisation of the need to access support but more as a consequence of the self-stigma: *Maybe there is something about me as well that my willingness to seek help, but it doesn't help me to pick up the phone and talk to those professionals [Rachel, Zimbabwe].*

As previously mentioned, hesitancy may be due to individual, societal, or structural factors and they cannot be viewed as a single entity if it means that at any given time individuals are more likely to not access services due to the stigma surrounding being a migrant and having a mental health illness. But it was not all negativity:

Stigma plays a lot which is a shame really because the help is there if only you ask for it.
[Amy, Zimbabwe].

Participants appeared to know that there was support. What needed to be done was to break down the structural, societal, and individual walls of stigma to access that support.

Stigmatising attitudes

Many of the participants felt that discriminatory attitudes towards them were based on markers of migrancy, including accents, names, and race and that these acted as barriers to accessing support and were linked to ongoing mental health issues which they hesitated to seek support for.

For Gugu [Zimbabwe], she felt that she was discriminated against due to her name. Most non-English names require a concerted effort to pronounce if you are not familiar with other forms of grammar.

Francesca had experienced discrimination against her in support of her mental health. This was reminiscent of when the medical professionals were negligent to her mother, which eventually cost her mother's life.

I think the doctor didn't bother about her as she was a migrant, and he should have sent her to the hospital [Francesca, Brazil].

This traumatic experience of losing a mother due to the negligence of health professionals has stayed with her. She felt she did not trust emergency services including first responders such as ambulances and the police.

Experiences of racism were common and were a barrier to seeking and accessing support as individuals felt that they had to put in more effort than the local population to get support.

I still feel several incidents of racism toward me ...I don't know if it's about Asian or like maybe just how we look...I feel like for me, I have to like I don't know, just do more to get the same [Liberty, Hong Kong].

The COVID-19 pandemic coupled with the hostile environment has seen a big rise in negative attitudes, violence, and discrimination towards Asian migrants from a Chinese background (345–347). Many migrants come to the United Kingdom for safety, for better

opportunities and the freedoms associated with a Western lifestyle. The reality, sadly, for many migrants is the exact opposite. The participants spoke of a lack of availability in services, and delays in accessing support but an even greater disappointment in the way they are treated not only as individuals with mental health needs but as migrants judged by where they come from, their skin colour, appearance, and their accents.

I feel like fear of stigma and since I'm Middle Eastern and Turkish, I feel like those like health, mental healthcare, and healthcare professionals will be biased because they might automatically think that I follow those Middle Eastern cultural norms, but in reality, it's not true. So, they don't know what I'm going through basically [Rachel, Turkey].

Healthcare professionals have been reported as holding stereotypical views of people from ethnic minorities (348,349). There is a growing body of evidence of the impact of these negative views from individual accounts like what Rachel encountered during her short stay in the UK whilst trying to navigate support for her mental health (349,350).

There was tension being a young immigrant woman who felt unwelcome in their host country, not understood, yet not following the customs of their place of origin. This tension, compounded by deeply ingrained racism and sexism, extended to expectations about behaviour, access to support, and experiences within the healthcare system. As Gugu's experience demonstrates negative stereotypes and discriminatory treatment have deep mental health consequences.:

being called that angry black woman, or you know, being called militant...and the perception that black people don't feel pain as much.... I think sometimes, you shouldn't be feeling this pain, this is not your portion. Being female already, you know you don't have as much authority as the males, right? [Gugu, Zimbabwe].

The feeling of being devalued and dismissed can lead to internalised stigma, distrust of healthcare providers, and ultimately, a reluctance to seek help.

For Amy, it was the culmination of negative stereotyping of Black people in the media, and negative experiences with the police that led to her, and she felt, a lot of Black people not seeking support due to fear, anger, and resentment.

Negative reports in the media or negative things that have happened to Black people in this country. I think there are a few Black people that have been killed that were mentally

unwell... they have been killed by people in authority, the police...the impact of the interactions between the police and Blacks have been negative [Amy, Zimbabwe].

It was also the case of being othered and the attitudes of being the othered characteristics which became reality in the stereotyping and hesitancy.

I've not gotten any help whatsoever because it feels like being a Black being, the black in me, the African religion in me, you don't go for help in those terms [Masiko, Uganda].

there's already that sense of being othered by an effect of being [an outsider] [Gugu, Zimbabwe].

The Double Burden: Work and family limitations

Many of the individuals who were interviewed were in employment, or education or had families here in the UK or in their countries of origin who depended on them. This had implications for seeking support. The female migrants were more likely to be in precarious employment due to gender and migrant status.

I have to study. I have to work and now I have to spend hours talking to somebody, which I felt wasn't so necessary to some extent. I don't have the time because it's not seen as a convenience [Eelin, Nigeria].

Eelin saw no possibility of having enough time to seek support for her mental health. She, like most of the participants, hardly had time for self-care and prioritised other commitments such as work and looking after family.

Work was one of the biggest factors identified by many of the participants as being a barrier to supporting or maintaining well-being. Some participants who were both migrants and supporting other female migrants reflected on this:

Because of the lifestyles that migrants live, they're working day and night... and if you don't have children, chances are you won't meet many people. [If you are single, it is] work and home. That is the working year [Nakabiri, Uganda].

Nakabiri saw this with the female migrants she was supporting and alluded to having experienced similar challenges in her first years in the UK.

A lot of migrant women, they have families back home that they are supporting so they need to be working – they can't take time off work to say "my mental health this my mental health that... they have to be earning money because they have kids back home or kids here, so they have to be working [Amy, Zimbabwe].

Spending most of their lives at work the interviews of the participants highlight a poignant reality: for many female migrants, mental health becomes a low priority amidst the relentless pressure to provide and care for others. The quotes shared illustrate a clash between deeply ingrained societal and cultural expectations about womanhood and a genuine need for self-care. Pressure and prioritisation exist to some degree across cultures, but female migrants face additional layers. Family separation, isolation, financial strain, or uncertainty about their future can amplify these pressures. All the participants interviewed alluded to not having enough time to seek support because of these:

Everything is about the kids, so sometimes I ask myself where is the time for me? [Ndri, Ivory Coast].

I've got so many other things I do during the day. Sort of looking after other people or things I need to do, but I don't have any time to look after my own needs [Elizabeth, Portugal].

And on days off work, house chores, and anything other than resting:

I think it's really the housework. It takes up like quite an amount of my time after work, so I don't really have the energy or like the clear mind states to relax or to think about my future and everything. It's too much. I don't know where to start honestly [Liberty, Hong Kong].

Work-related stressors and barriers play significant roles in impacting the mental health of female migrants. Masiko's experience demonstrates direct workplace exploitation where threats and restrictions prevented her from seeking mental health support. This aligns with existing research showing female migrants's increased vulnerability to discrimination, poor working conditions, and limited rights(103,351).

The sacrifice I did does not tally it's not worth it. You know you come in here with many with high hopes. My employer with this certificate of sponsorship. How should you?

There's so many [who] do this, "you do that so you can't leave here. You have to work for me. You know that contractual of it" [Masiko, Uganda].

However, even outside of formal workplaces, the relentless combination of work, household responsibilities, and childcare leaves little room for self-care, creating a significant barrier to accessing mental health support. Importantly, these informal pressures are often intertwined with the financial and societal challenges faced by most of the participants, regardless of migration status.

4.3.2.2 Facilitators to maintaining good mental health

The study aimed to gain an understanding of the experiences of mental health and perceptions around mental health. The participants identified several barriers to maintaining good mental health and seeking or accessing mental health support. However, they also mentioned facilitators for accessing support and maintaining good mental health, which all contributed to lessening the stigma of mental health and being a female migrant. These facilitators can be grouped into three groups: Individual, which includes self-care activities such as physical activities and music; Interpersonal, relating to spiritual beliefs and support and family and community support and finally: Systems level, which includes therapeutic interventions and professional relationships. A summary of the facilitators mentioned by the participants is presented below (*See Table 13*).

Table 13: Facilitators of good mental health

Level	Facilitator	Role in tackling stigma and improving well-being
Individual	Physical activity	Encourages self-care by promoting both physical and mental health. Can combat feelings of isolation and build self-esteem.
	Music therapy	Provides an outlet for emotional expression and self-exploration, enhancing mood and reducing stress. Can foster a sense of belonging and connection.
Interpersonal	Faith and community support	Offers a sense of belonging, purpose, and shared understanding, which can destigmatise mental health concerns and provide emotional support.
	Strong social networks	Provides a sense of connection, reducing isolation and offering practical and emotional support. Can normalise mental health challenges and encourage help-seeking.
Systems	Culturally competent therapies	Provides a safe and understanding space for addressing mental health needs within a framework that acknowledges cultural background. Challenges stigma and promotes help-seeking.
	Workplace and educational support	Creates awareness, reduces stigma, and provides resources for mental well-being within important life settings.
	Accessible remote support	Offers convenient access to information and care, reducing barriers caused by distance or time constraints. Can also foster connections with others to combat isolation.
	Specialised professional care	Stigma can result in institutional discrimination, leading to denial of support or inadequate care for physical and mental health needs.

Individual level facilitators

Individual-level facilitators primarily focused on maintaining good mental health.

However, these same activities also encouraged participants to seek both informal and formal support when needed. This open attitude towards seeking help indicates a reduced influence of stigma around mental health concerns. As defined by Lee and Miller, the overarching theme here is self-care, encompassing behaviours that promote overall health and well-being (352). Specifically, physical activity and music listening emerged as key self-care strategies employed by the participants.

Physical activity

Physical activities in the context of the study refer to any bodily movements that enhance or maintain both physical and mental health. Going to the gym, walking, dancing, and swimming were mentioned by participants as self-care activities they undertook.

I do love going to the gym. I love dancing [Gugu, Zimbabwe].

Many of the participants indicated they both enjoyed and found it beneficial to their well-being to go for walks. These varied from a form of exercise to the more therapeutic aspects of walking:

They also recommended that I walk every day because of my diabetes, and this also makes me feel better [Francesca, Brazil].

Francesca, who had been diagnosed with multiple physical and mental health conditions, reported benefits from walking. Although the recommendation for increased physical activity was initially made to address her physical ailments, she also experienced mental benefits. Walking provided her with an opportunity to reflect on her physical, mental, emotional, and social well-being. The recommendation for walking by healthcare professionals highlights the interconnectedness of physical and emotional health, and the potential for holistic benefits when addressing both.

For other participants, going for a walk helped with processing thoughts, and was used as a coping mechanism and a time for self-reflection:

My first go-to is probably Go for a walk. For a walk, if I've had a bad day if I'm having a bad time, I'm going for a walk [Nadia, Iran].

Sometimes I go for walks. Yeah, just to clear my mind and everything. Oh yeah, go for walks [Eelin, Ghana].

Walking is good, but it's like talking to somebody and you talk about something completely different to what I was thinking at the time. I go to walk on my own. Walking on your own is always good [Matilda, Portugal].

Although for individuals like Matilda walking alone and in quiet places was the preferred choice, others like Nadia and Ms Din preferred walking where there were people around and interacting with others during walks. Additionally, the availability of open and green spaces

where we live there are so many walks you know [the woods and the sea] are just a stone's throw away, so I go for walks a lot [Gugu, Zimbabwe].

Access to green spaces and seafront walks are supported by a plethora of evidence as being good for wellbeing (353–355).

Interestingly, most participants mentioned water in one form or another, either taking walks by the sea or going for a swim, as mentioned by one participant,

Yeah, so I like swimming as well. I think I mentioned that [I like] swimming [Amy, Zimbabwe].

Similarly, Masiko found walking as well as swimming to be activities that helped her not dwell too much on her present circumstances which had been causing her depression.

To get out of my head...I do swimming [Masiko, Uganda].

The recommendations for walking by healthcare professionals and the participants as self-care strategies are consistent with the current evidence on the benefits of physical activity for both physical and mental health (356,357). Walking is a prevalent form of physical activity across cultures. It is a safe and effective way to improve physical and mental health, and it can be a valuable component of a comprehensive treatment plan for multiple physical and mental health conditions. It is also a low-cost, low-risk activity that has been

easily incorporated into most participants' lifestyles. Studies have shown that walking can be beneficial even in urban settings in which most of the participants lived (356).

Music therapy

Music is an art form that uses sound to evoke emotions, thoughts, and ideas. It can be used to promote well-being by reducing stress, improving mood, increasing self-esteem, and having an impact on memory (358–364). Several participants mentioned listening to music as an activity that helped with moods.

I usually listen to music [Eelin, Ghana].

Eelin found music helped her relax and eased her loneliness and isolation, whilst for Rachel and Esther it was the emotional lift, they got from listening to music which helped with improving their mood and empowering them to deal with the results of the day or to look forward to the day:

I listen to music like music, and I feel like Powerful after listening to it [Rachel, Turkey].

Sort of one thing that helps me is music...If I just need to sort of calm down, you know just be in it and it depends [Esther, Nigeria].

For Gugu, it was at the end of the day that she felt the benefit of music.

I really like listening to music. I do that so when I'm driving from work and I just want to zone out [Gugu, Zimbabwe].

Listening to music that relates to one's religion or culture has been seen to improve mood, self-esteem, life satisfaction and a positive and closer association with a divine experience (365–367). Whichever music form participants chose, all stated the benefits they found from it, as eloquently stated by Esther:

So, there's different music for different emotions. You know if I'm feeling if there's a relationship issue, So I don't know why, but I got to break up songs to sort of motivate "I could do better I don't need this!" Because... music all speaks your truth, how you're feeling. There are meanings to the songs ... there are songs that express that in me, you know speaking to me, so don't make me feel bad and make me feel better. Well, if I'm feeling hopeless not knowing what to do, like trying to make a decision, it is sort of gospel

music It sort of brings my spirit back up. If I just want to focus, maybe I want to read a book or study. Jazz music is the one for me... Yeah, I'm not a musical person, so. I don't really know the notes, but it just sounds nice to me [Esther, Nigeria].

The benefits of music to participants are in line with a rich body of literature on the benefits of music including developmental, cognitive, emotional, social, and physical (363,364,368,369). The participants found music to be soothing, uplifting, inspiring, and a form of therapy. There was also the potential to express oneself and to engage in social activities such as dancing.

Interpersonal level

For the present study, the interpersonal level is defined as the interactions between female migrants and one or more individuals. Following the intersectionality of female migrants, these interactions may occur between female migrants and members of their families, the community, or professionals in informal or formal settings. The first identified sub-theme in the interviews on the interpersonal level included interactions with fellow believers, activities in religious institutions and support from mental health-aware religious leaders. This has been shortened to religious support. The second sub-theme involved informal interactions between female migrants' family friends and the wider community, including acquaintances and in religious settings.

Faith and community support

Religious beliefs that encourage good mental health through spiritual strengths were not limited to individualised faith but involved interactions with others who shared the same beliefs. Though an individual's faith was what they thought kept them going, they felt that others had been put in their paths because of their faith.

I think my religion has been a very good help because when I first came, I basically had no one but my faith kept me going... they were kind of helpful in some kind of way and to me, that was my faith because I felt there was no reason why they had to be nice. Unless my God sent them my way. So yeah [Eelin, Ghana].

Eelin described moving to a new country as an act of faith, and her beliefs as her guide. She alluded to positive interactions that alleviated her mental health distress as divine

providence, in the form of individuals who were sent to help her because of her faith. Eelin, like some of the female migrants interviewed, demonstrated the importance of faith in maintaining good mental health, as well as communal support through activities in a religious setting.

Well with church they talk about some of these...issues like low mood and ...that prayer helps. You know sisters at church that I can talk to...They share their own experiences and how they've you know how they overcome, and then, you know, encourage me [Amy, Zimbabwe].

For Amy, as for many of the participants, faith and prayer were seen as vital tools in maintaining good mental health. Religious spaces have evolved beyond purely spiritual centres, becoming places where discussions of well-being are encouraged and support structures emerge. Research supports this, suggesting religion can offer effective coping mechanisms for mental health challenges(370–374). Gugu expands on this further,

stating:

My daughter and I...are so religious that in a way that socialising religiously [is] more like therapy [Gugu, Zimbabwe].

While participants' experiences indicate the powerful role of religious communities in providing support and socialisation, it is important not to overgeneralise these findings as representing the sole source of support available.

Strong social networks

Informal support, such as daily interactions with family, friends, and the wider community, appeared to be the most essential factor in maintaining good mental health for female migrants interviewed for the study.

Partners/spouses as sources of support

Participants who were either married or in a relationship found encouragement, and someone to talk to when they were feeling low:

My husband, who's wonderful and he sees I'm feeling a bit low. He'll try and distract me, so let's go out to the park. Let's do something nice with the kids. He's very kind, he is a

good man. [He encourages] me that I will be able to do it because sometimes I feel low and don't feel I will be able to do this. [He] always encourages me "You will be able to do this" [Alison, Brazil].

Another thing that makes me happy is when my husband, uh, gets his day off and just stays with us and we have a dinner like each family because he works every day. So, I like Mondays - It's a Family Day [Ms Din, Syria].

mostly my friends or my boyfriend [Liberty, Hong Kong].

Husbands and boyfriends can provide emotional support to their partners even when they are not physically present. For example, Nakabiri 's husband provided her with emotional support when she needed to travel for a family emergency. She was feeling distressed and was on the verge of a breakdown, but her husband's support helped her to cope with the situation.

My husband was on the phone every day, so that was another way of de-stressing. So at least there was somebody whom we could talk things through [Nakabiri, Uganda].

The participants had all experienced adverse events before leaving their countries of origin or during their stay in the United Kingdom. They reported that having a spouse with whom they could share the psychosocial burdens of their experiences helped them to cope. For example, Alison, who had physical and mental health challenges, benefited from her husband's emotional support, which helped her to build her confidence. Similarly, Nakabiri's husband maintained the emotional bond between them daily, even when they were in separate countries.

Children and wider family as supportive networks

Some of the participants reported receiving emotional and practical support from their children. They also stated that their children were the reason why they had not given up on life.

talking whether either to my son or to you know the closest friends I have or.... some close members of the family, it, that's the that's what helps me [Jawaria, Iraq].

My daughter you know she's at an age now where we can have like really lovely conversation [about mental health] [Gugu, Zimbabwe].

I actually I would sit with my daughter. She's my friend...my friend told me that is not good for your daughter. That's will make her Very old because you give her all the negative things. So, I just stopped. I stopped [Ms Din, Syria].

Ms Din is not alone in seeking emotional and practical support from her daughter. In a study from the Netherlands, girls were seen as more helpful than boys in providing emotional and access to psychosocial support (375). There may be a concern in overburdening young children with a parent's mental health struggle, something Ms Din was aware of. Conversely for Amy, it was the responsibility of looking after her children that was a source of focus to not get ill mentally:

I focus on my children, and the reason that I wouldn't sort of give up on life is because I know my children depend on me and I want to be there for my children [Amy, Zimbabwe].

The wider family members including parents, siblings and other relatives were also seen as sources of support for good mental health as they offered a sympathetic ear.

I just think my mom, she comes and stays with me every now and again and she's very supportive. I speak to her and most days. She's a huge support structure [Gugu, Zimbabwe].

Other forms of support by family members included appointments as was the case for Francesca, who was not confident in speaking English, had been diagnosed with a mental health concern and needed an interpreter who came in the form of her sister:

My sister took me to GP and supported me when I changed my medication and accompanied me to doctors and hospital appointments [Francesca, Portugal].

The same kind of emotional support was mentioned by Masiko, who was socially isolated.

My aunt.... she's tried. She has been actually a lot of help once in a while. She checks on me [Masiko, Uganda].

Families can be a valuable source of practical, emotional, and financial support for female migrants, particularly those who are in low-pay employment or who do not have recourse

to public funds (NRPF). Some participants in the study reported that they received support from their families, however, in many cases, there is no such support and female migrants may experience domestic abuse (72).

For the younger female migrants, support from parents was invaluable for the continuation of studies:

My family, obviously because I am in academia and my dad is in academia as well, so whenever I have difficulty with my studies, or whenever I feel stressed, I call him and he says everything's OK That I am doing great and this is like a normal process of my life, so I feel very empowered [Rachel, Turkey].

Rachel experienced the transition to a new educational environment in a foreign country as challenging. She is not alone, as many female migrants often face challenges in educational settings, including cultural differences, financial constraints, and discrimination (376). Rachel was fortunate to have the support of her family, particularly her father, which helped her to overcome these challenges. Interestingly, Rachel used the word "empowerment", a term that many female migrants used in one study when discussing the importance of education (376).

Social support from peers

Participants viewed their acquaintances as a source of mental health support.

I have friends I can go to and vent to and sort of share my frustration. But for them to give me a solution, I don't have that [Esther, Nigeria].

Some of my friends, they asked me to talk to somebody [Ms. Din, Syria].

I think I rant to friends. I'm very good at not bottling things up. It might be as little as friends saying, oh no, I understand that is really frustrating. I can't believe they're doing that [Nadia, Iraq].

I have one friend that I normally call to talk [Ndri, Ivory Coast].

The support provided by friends was provided through empathic and compassionate listening, with some acquaintances sharing their own experiences of mental illness.

Although acquaintances did not always provide solutions to the problems that participants

faced, their support was mentioned as being invaluable in providing a listening ear and a sense of acceptance. For some participants, the family were not considered as supportive or as accessible as friends. Friends were the only source of support:

I haven't mentioned it to my family that my mental health is struggling, but some friends who have been diagnosed with depression. Sometimes it's when they say oh, I think you have been depressed ...and then I open up to them and we talked about it and they have been very supportive [Obenewaa, Ghana].

For Obenewaa, having friends who had similar mental health issues and shared their experiences with her was a valuable source of support. This support was provided through empathy and understanding. However, it was not always easy to be open about mental health struggles to friends:

As much as I have friends I can talk to, I feel like they don't really understand me... they start to ask me questions ... so, it's kind of weird you want someone to help you and yet they're questioning you, yeah? That's not helpful [Esther, Nigeria].

Although friends are generally identified as facilitators of good mental health, Esther's experience suggests that this is not always the case. She felt misunderstood and judged by her friends. This indicates that while friends and family can be supportive, the stigma of mental health can still be a barrier to good support, even in informal settings.

Depression can be isolating. For example, Sarah found sharing how she was feeling helped lessen the depressing and stigmatising aspect of depression:

Sometimes you know when you have good friends and good family around you. You know where you can go and talk to them once I was very in deep depression and I understand because my friend makes me realise that yeah, because he told me "Your problem, you need somebody to have a conversation with", and every single day he calls me. We need to talk with each other and from that date I know is the depression depends on me [Sarah, São Tomé, and Príncipe].

It appears good quality social support through understanding and compassion provided by her friend helped Sarah through the depressive episode. Sarah further alludes that

depression is treatable, in her case, through having supportive social networks and talking about issues affecting her.

In a study conducted in the Netherlands, it was found that social networks are important for migrants, particularly elderly migrants, to access psychosocial support (375). The Interpersonal Level theme highlights the significance of social support for female migrants as it was the most prominent sub-theme. This implies that interpersonal support is a crucial factor in aiding female migrants to acclimatise in their host country and to thrive and maintain good mental health through good quality support that is easily identifiable, relatable, and approachable. Family, friends, and the community all have a part to play in helping to maintain the good mental health of female migrants.

System level facilitators

Talking therapies, such as counselling and psychotherapy, can be beneficial for female migrants who are experiencing mental health problems. These therapies can help female migrants to process their experiences, develop coping mechanisms, and build resilience. Many participants reported that they found it beneficial to access talking therapies.

Culturally competent therapies

Several interviewees had engaged in psychological therapy. For example, Alison from Brazil proactively sought therapy and appreciated the opportunity.

I was doing the therapy every week or every few weeks. When I had the appointment, the therapist would give me some activities. I did do them because I knew that I would be going back and discussing those activities [Alison, Brazil].

Alison's experience highlights the importance of therapeutic support. She discovered that the psychological support she received from her therapist was crucial in helping her cope. Furthermore, the sessions were a motivation for change as she felt motivated in completing tasks which she had agreed with her therapist. It appears for Alison having structure and accountability promoted meaningful recovery during a difficult time.

However, though she had found therapy helpful, it was a danger that she may not have attended the appointments initially, as she was sceptical about the benefits of psychological therapies:

Before I had contact with psychology, I didn't believe they'd be able to help at all ...and if I had not had the psychological support, I do not know what I would have done or what might have happened...the support came at the right time, and they were able to help me. I couldn't believe somebody was able to help me because I was in so much pain, but they did [Alison, Brazil].

Alison's initial hesitation to engage with therapy, despite her eventual finding it beneficial, suggests that similarly hesitant individuals may still benefit from talking therapies. Alison is not alone in her scepticism or likelihood of non-attendance; one study found that individuals with a common mental health disorder diagnosed within one month or more than two years were both predictors of non-attendance at the then-called Improving Access to Psychological Therapy (IAPT) services (377).

Other participants also found therapy useful:

I signed myself up for therapy...and I'm in a better place now. I feel like maybe the IAPT service nowadays is a lot better [Esther, Nigeria].

I had three sessions which really helped me a lot [Gugu, Zimbabwe].

There were also preferences for speaking with someone who practised culturally appropriate talking therapy support as well as the usefulness of speaking with someone of the opposite sex.

I really love my therapist and I think we have formed this particular relationship between us so that I can talk about anything I want and she's very understanding to me. And it is very helpful that she speaks in my native language so, yeah, I am able to express myself in detail [Rachel, Turkey].

I was having treatment once an hour every week I talked to a psychologist. [They were helpful] in dealing with my trauma yes, a lot yes, yes. I was very happy talking to a man because my therapy was with a man and I was very happy talking to him [Matilda, Portugal].

This suggests that talking therapies have become more acceptable and accessible, particularly among ethnic minority populations who were initially less likely to access and continue using talking therapies (378). Furthermore, the flexibility based on the needs and

timetables of female migrants meant that some only required a few sessions to address emotional and mental issues, while others required longer-term engagement. This highlights the benefits of having flexible services and sessions based on individuals' needs and preferences to maximise the therapeutic experience.

Education and work-based support: Mitigating intersectional challenges

Female migrants who were in education and employment noted the availability of education-based and work-based support provided by their educational institution or employer helped maintain their mental health.

For Eileen, her university provided adequate support for her overall well-being including accommodation and emotional support:

my university they do quite well because they do provide accommodation and you don't have to pay right away... so that would also reduce your anxiety levels. They also provide all of the mental health assistance and all of that. So, I think the university does quite well to help reduce your anxiety I think in my university they also say that they have phone numbers you can actually call [Eelin, Ghana].

Eileen is referring to the university's provision of accommodation services and payment plans which have helped her reduce anxiety levels. Living in university-provided accommodation in a foreign country can contribute to a sense of physical security and reduced social threat levels as one study has pointed out (379). Knowing that there was emotional support lessened her anxiety levels allowing her to concentrate on her education. This is in contrast with the feelings of loneliness and isolation she felt when she first arrived and not knowing where to find any kind of practical or emotional support.

Similarly, Jawaria was grateful for the support her college has offered her since she enrolled.

When I registered in the college, we've been told that whenever we got a problem or don't feel well, [or] something wrong with our mental health or we're not feeling great. We could...direct us where we can go, or whom we can talk with. I really appreciate the help they provided me last year for my son and for me as well [Jawaria, Palestine].

For Jawaria the college provided her with information about support services when she enrolled. This has contributed to her staying in education as a newly arrived migrant and helped her integrate into society. The support has benefited her family as well, as her son also attends the same college. This underpins the importance of providing support that includes other family members, particularly those migrants who may be seeking asylum or have been granted refugee status.

Formal and informal support in the workplace were considered invaluable for participants who were in employment. For Liberty, colleagues provided informal support complimenting the support that was offered by her workplace:

“It's good because [my workplace] is also so diverse, so my colleagues are from like every part of the world...So, talking if I could bond with one or two, they could easily understand what I'm going through or I have gone through so it will be easier to open up to like these people who have shared a similar experience [Liberty, Hong Kong].

Similarly, to Liberty, Masiko had experienced racism and was still struggling to integrate into society. However, the workplace offered her professional mental health support:

The company I work for did arrange for someone to talk to me...what you have at work, even if it just felt like it's mandatory that it has to be done for the sole purpose of giving that particular personal tailored help to see you cope.

Masiko struggles with low mood and having information readily available and offered to her gave her a choice to take up the support or not. She alludes to most workplaces having emotional support for employees as a tick box exercise, but she mentions the tailored support as something that she thinks works if the support is offered.

In summarising the theme, addressing mental health stigma in a culturally and gender-sensitive manner in the workplace is crucial. Participants consistently reported that feeling supported enhanced their job retention. Given potential external barriers to accessing mental health services, workplace and education-based support may be the sole avenue for some female migrants.

Accessible remote support

During the COVID-19 pandemic, there was an increase in the use of remote mental health support for female migrants. This was due to the lockdowns, which limited access to in-person services. Although there have been documented challenges to remote support (380), some participants found it beneficial to have access to support that was available remotely.

During the COVID-19 lockdown, my bilingual advocate, the mental health specialist, and the psychologist, from the hospital called me... they were calling me all the time just to check that I was okay, which was very supportive [Alison, Brazil].

If they [mental health support] were like a call away or something, I think it would be a bit convenient for me. My university...have phone numbers you can call. And that is actually very good because people who would prefer to like to speak on the phone can get that help at whatever time they want to get that help [Eelin, Ghana].

Being offered the choice of remote support made it more likely for some participants to access support. In contrast, Alison accessed support in person before the pandemic lockdowns and was in danger of being isolated and therefore suffering more with her mental health. However, due to the ease of remote consultations, she was able to feel supported by a wide range of mental health professionals. Her statement also demonstrates how quickly some services adopted working remotely to provide support and information.

Remote support was not limited to professional services. Some participants reported the benefits of easily connecting with others regardless of geographic location, as well as the convenience of accessing well-being materials available on the Internet:

We would meet physically [with friends and family], but now that I'm here [in the UK], we do Zoom meetings and the network can be so horrible since...it's all organised from back home. But yeah, I try to connect [Masiko, Uganda].

I went on these websites...they do help, even tips and stuff like that to help manage your day-to-day [Obenewaa, Ghana].

The advent and popularity of videotelephony and online chat services such as Skype, Zoom, and Microsoft Teams have made it possible for individuals to maintain close

relationships with loved ones back home. This has had several positive mental health benefits, including reducing feelings of isolation and loneliness and promoting a sense of belonging. For example, Masiko was able to continue playing games with her family and friends back home, and she could also attend church services virtually. Obenewaa was able to search for information and support online without feeling judged. Technology can and has been used to maintain the well-being of female migrants.

Interestingly, social media plays an important role in maintaining and improving good mental health as these two statements demonstrate:

Spiritually I listen to YouTube sermons and tried Facebook [Masiko, Uganda].

One day I was on Instagram and there was this influencer who posted this app. This post was about psychology and there was this list, and I just picked that therapist, my therapist because someone commented about her and that she was very sweet and helpful and the comments helped me to, you know, get in touch with her social media [Rachel, Turkey].

Masiko and Rachel utilised social media platforms to enhance their mental health. Masiko accessed social media as a means of connecting with her spiritual community, while Rachel employed social media to locate a therapist.

4.4 Female migrant experiences of seeking mental health support in general practitioner settings

This subsection delves into the experiences of female migrants seeking mental health support from their general practitioners (GPs) in the KSS region. It draws upon data from the broader qualitative interview study exploring how female migrants perceive and access support within primary care and the wider community. Specifically, the research question explored in this section is: *'What do you think your G.P., community support or mental health services should do to make it easier for you to talk about how you are feeling?'*.

Long waiting times have recently come to the fore due to the COVID-19 pandemic. Across the spectrum of the UK population, there has been a marked rise in long waiting times and referrals, with some groups do experiencing inequalities in access to support and referrals (381–383). According to a study commissioned by Healthwatch England, 57% of ethnic minority respondents indicated they had their treatment delayed or cancelled compared to 42% of white British backgrounds. Mental health referrals from GPs did not always lead to an appointment or being on the waiting list for support compared to physical health conditions (382). A study investigating ethnic minority and female migrants's struggles in access to healthcare during the COVID-19 pandemic highlights the amplified barriers to healthcare access for ethnic minority and female migrants. The study argues that these barriers are unique to these groups due to their intersectional identities and the contextualisation of the pandemic as a public health crisis (384). It was in this context that the co-researcher from the present study's FMCG stated:

Apart from the 'normal' difficulties involved for everyone when booking GP appointments, the female migrants experience additional hurdles when trying to book a GP appointment for mental health because of a lack of understanding of the mental health referral process (e.g. they are not aware that they can talk to GP about mental problems) and language barriers [JB, FMCG co-researcher].

All the participants spoke about their experiences with GPs and the GP surgery staff during the interview. Before the recording of interviews several of the female migrants being interviewed spoke of *'sharing my journey with you'*, something the PhD Candidate noted in a reflective diary. In the context of a discussion on potential titles for a presentation on GP experiences at the Society for Academic and Primary Care (SAPC)

South East Regional Conference held between the 25th and 26th of January 2024, a member of the FMCG team who was co-producing the slides suggested that it may be advantageous to frame the title around the concept of a continuous journey of navigating the health systems. She stated *'We should highlight their journey, as it never seems to have stopped since they arrived because they are still finding difficulties navigating the systems'* (See Appendix E on coproduced slides). The female migrants' experiences demonstrate a sustained cycle of challenges in an evolving landscape even after the initial integration with difficulties in registration, consultation, and engagement with the GP making it feel like a never-ending journey, hence the allegorical title. The key themes emerging from their experiences with accessing GP services across KSS include:

4.4.1 Accessibility and communication hurdles

Limited Accessibility and language barriers

Long wait times, difficulty booking appointments, and reliance on phone consultations created significant hurdles to accessing help for most of the participants. As Elizabeth shares, *'I keep calling them because I need to talk... I am calling, calling, and there are tons of people in the queue...'* [Elizabeth, Portugal].

This led to perceptions for Elizabeth that *'They don't answer the phone'*. And where the GP surgery did not answer the phone, it meant that she did not get access to the support she needed at the point of seeking it. Similar experiences have been reported in the report by Healthwatch England that indicated GP services are seen as not readily accessible because of long waiting times (381).

However, a lack of face-to-face interaction further hampered communication and understanding for those female migrants who did indeed get in touch with the GP on the phone or online. For some of the participants, there was frustration and questioning about missed opportunities to support female migrants if there were no face-to-face consultations:

GPs nowadays are difficult, everything is on the phone and there is so much you can try to explain.' stated Ndri, *'they are not in front of you to see how you are'* Ndri [Ivory Coast].

Furthermore, Ndri stated that familiarity and in-person consultations would most likely lead to better outcomes and a likelihood of engagement for those female migrants who may not necessarily find remote consultations and support beneficial:

I think sometimes it would be good to be able to go to the GP and see and be able to talk to the GP will decide what to do. Instead of just a telephone appointment. I would have to go to the GP and see the GP because I do not see the point of telephone consultants sometimes Ndri [Ivory Coast].

For Ndri, her preference for face-to-face appointments is echoed by some participants in the study by Juan et al (380). However, within the same study, some respondents identified benefits to remote care, such as improved access and continuity for those who might not otherwise utilise physical spaces. Nevertheless, the challenges extended beyond limited access to encompass barriers to effective engagement and support. These barriers arose due to communication difficulties, specifically language combined with mannerisms and attitudes, as highlighted by Sarah:

I think depends on the way they start the appointment with you or the way they talk to you. Because when you see the doctor or somebody is Oh, you know their friendly and you feel more, more confident to talk about yourself, but when is it? It doesn't you, not feel friendly or that your relationship with the doctor is not good. You're not going to tell them [Sarah, São Tomé, and Príncipe].

As a result of the negative experiences of attempting to access support through the GP, there was a reluctance to seek support for both physical and mental health support from female migrants:

'I barely ever go to the GP because that's just like a waste of a walk or call' [Eelin, Ghana].

Within the context of face-to-face interactions with the GP, a prioritisation of adhering to allocated appointment times emerged. This appeared to come at the expense of fully addressing patients' communication needs, particularly for those who were not confident in articulating their health concerns in English. These participants expressed a need for extended consultation time compared to the average English speaker:

'They're watching the clock...you never really able to fully articulate yourself' [Gugu, Zimbabwe].

'My GP doesn't ask me how I am feeling...and always says there's no time to talk'
[Francesca, Brazil].

4.4.2 Knowledge gaps and dismissive attitudes

GPs were perceived as having limited knowledge of mental health, often focusing solely on physical concerns:

They really have very little knowledge of mental health, so even to signpost you almost have to be an expert at what you need. So, you have to research what you need first and by the time you go there, you are the one telling them what you need as opposed to them coming up with it' [Gugu, Zimbabwe].

It was not only a lack of knowledge about mental health and support options around the GP but also, a lack of awareness of the alternative and complementary support for mental health support by the female migrants:

They don't know how to get the help because they go to the GP and the GP doesn't help them... [Ndri, Ivory Coast].

Similarly, there was despair in not only not thinking they had anywhere to go for support, but when they thought they knew the GP could help with their mental health but ended up not doing so:

They don't sort of see any point in living and they just don't know where to go for support you know they try their GP and that doesn't work, you know? and there are lots of people who just don't really want to carry on living. And they don't know where to go to sort of have some support with that [Matilda, Portugal].

Healthwatch echoed these concerns regarding long wait times for GP referrals and limited access to referred services in their two studies on the topic (382,383). Although lack of knowledge may be attributed to the changing landscape of health, GP responsibilities and patient expectations, GP attitudes were also seen as a contributory factor as to why interactions were not always resulting in a positive outcome. For instance, there was a

general sense that attitudes and a lack of cultural sensitivity contributed to the negative outcome:

I don't think my GP can help me because even locals even British people say that whenever they go to their GP for support, they say that their GP doesn't believe that it is important. So, even like GPs don't support British people, so you feel like me as a foreigner, they will dismiss my emotional and psychological needs [Rachel, Turkey].

Struggles with knowledge of access and the wider referral system

There was near universal agreement amongst the female migrants interviewed on the lack of general awareness of where to get support for mental health other than the GP:

The only place most women know to go to is GP surgery. They don't know where else to go for support. Matilda [Portugal].

Liberty identified lapses in mental health provision even for those migrants who had arrived in the UK on legal routes, who still had issues with access to the GP through a lack of knowledge they may be entitled to one as a result of their resettlement scheme:

'I don't know like how I could get Uh, like affordable or even free counsellor or a mental health professional, even when I'm basically ill I can't really get hold of GP, so I don't think the GP can refer me to anywhere else' [Liberty, Hong Kong].

They don't know how to get the help because they go to the GP and the GP doesn't help them, they go to the hospital doesn't help them because they have nothing to do with mental health, the mental health hospitals, you can't just go there, you need to have a referral teams, from social services [Ndri, Ivory Coast].

As a consequence of the limited access and support for their mental health from the only formal support system they were aware of - the GP, there was, in some female migrants, as observed by Matilda and others, a risk of suicidal ideation:

They don't sort of see any point in living and they just don't know where to go for support you know they try their GP and that doesn't work, you know [Matilda, Portugal].

4.4.3 The value of positive relationships and continuity

Access to a trusted and familiar GP with whom female migrants could openly discuss mental health issues emerged as a crucial factor. For interviewees like Amy, continuity and familiarity fostered feelings of safety:

I know my GP quite well...and I feel comfortable telling her about my mental health or physical health problems or whatever [Amy, Zimbabwe].

Furthermore, Amy stated: *'It was easy to speak to my GP because you know, I know my GP quite well and I've faced that continuity of always seeing the same GP.'* This underscores a bi-directional relationship of the GP knowing their patient but also of the patient feeling comfortable enough to state that they have a relationship with their assigned GP to the point where the patient feels safe and comfortable enough to open up about their concerns that may be affecting their mental wellbeing.

Alison, and Elizabeth both share positive experiences where their GPs actively facilitated access to mental health services: *'The doctor in London referred me to a GP in my now local area and my new GP referred me to a mental health support'* and *'the doctor referred me to somebody who gave me medicine for depression and menopause'* respectively. These two scenarios underscore the supportive nature of the GP being a facilitator and an inspiration for positive experiences within the healthcare system.

The same sentiments are echoed by other female migrants interviewed for the study, specifically alluding to the positive relationship between familiarity and outcomes

It was easy to speak to my GP because you know, I know my GP quite well [Amy, Zimbabwe].

My GP has, you know, helped me access support as well and given me all I need [Alison, Brazil].

Proactive engagement and transparency

Participants expressed a need for GPs to actively inquire about mental health alongside physical health concerns:

If they notice that some of their patients are living with long-term physical conditions that could cause stress and depression, they should bring it up... [Obenewaa, Ghana].

Furthermore, the link between mental and physical health is highlighted in the experiences of Obenewaa, who continues to state:

I think because of the physical pain, constant pain also impacts my mental health...
[Obenewaa, Ghana].

The experiences and perceptions of most of the women in this study highlight the importance for GPs to consider the interconnectedness of physical and mental health, and to address both aspects in every patient encounter.

4.5 Discussion

The study sought to capture the experiences and perceptions of mental health and the support, or lack of, for mental health of female migrants living within Kent, Surrey, and Sussex, SE England. The focus of the study was the experiences in primary care and the community. Eighteen female migrants were interviewed for the study, and many spoke of the barriers they encountered including individual, structural and societal barriers. In line with other studies (287), the unavailability of professional interpreters in an emergency, for example, during a mental health crisis, meant that there was an overreliance on family members acting as interpreters. For sensitive health issues many migrants are hesitant to discuss, especially face to face, their health concerns in the presence of a professionally trained interpreter. This then raised the ethical implications of using family, especially young children to discuss sensitive issues such as suicide when there are no professionally trained interpreters.

Vulnerable populations, including migrants, are at risk of digital exclusion, hence why some participants would prefer face-to-face support as some may not have access to regular data bundles or may not be technologically competent to use digital communication tools (380). This study demonstrated how reluctant the female migrants interviewed were to access support for their mental health, preferring the more traditional means of face-to-face consultations with professionals.

Interviewees emphasised the crucial role of safe therapeutic relationships in promoting help-seeking and treatment adherence. Feelings of self-blame and internalised stigma hindered the ability to seek support, stemming from the belief that mental illness reflected personal weakness. Self-stigma stemming from language proficiency and accents emerged as a recurring theme, reflecting a lack of awareness among both mental health professionals and those seeking support. This has been discussed elsewhere: Ohtani et al.'s systematic review revealed that migrant populations with low English proficiency had reduced odds of utilising mental health services compared to those with high English proficiency (385). Three factors that may contribute to this disparity include the fear of discrimination, language barriers, and cultural differences. In the current study, many of the participants alluded to self-stigmatised attitudes, their lack of command of the English language as well as difficulties in comprehension of mental health terminology.

The different experiences and perceptions around access and help-seeking intentions highlight the complexities in supporting female migrants with their mental health. Literature highlights this complexity as the social determinants of health are intertwined and cannot be separately addressed without considering other factors. For example, the importance of considering mental health on societal, cultural, community and health systems levels concerning migration (103,386).

Most of the female migrants interviewed for the study spoke of shame, self-blame, and self-doubt when it came to their willingness to seek support for their mental health. Therefore, internalised stigma was seen as a barrier to seeking support. Conversely, those who showed self-compassion effectively counteracted internalised stigma and shame and were more willing to seek support. Studies have supported this as they have reported that self-compassion correlates with lower internalised stigma and has moderating effects of self-stigma among certain vulnerable groups as well as being negatively associated with psychological distress (387–390).

There were intersections between the different levels of facilitators for good mental health, for example, faith and spirituality were experienced on an individual level through individual beliefs and prayer but were also connected on the interpersonal levels through sharing faith and interacting with fellow believers. Additionally, faith leaders and places of worship may be included at the systems level as some faith leaders were viewed as professionals in supporting mental health and places of worship included therapeutic activities. Similarly, cross-cutting themes such as remote support and accessibility to appropriate support highlight the need to view facilitators and barriers as possibly having multiple impacts on individuals seeking support, professionals and services offering support. As has been highlighted, stigma can be intersecting and have very negative effects on help-seeking and access for female migrants.

To conclude, the current study demonstrates the importance of looking at both barriers and facilitators through an intersectional lens.

4.5.1 Strengths and limitations

This study's main strength lies in its engagement of female migrants as active participants in the research journey. By involving female migrants and organisations that support or advocate for them, this study has demonstrated that research can be both inclusive and

impactful. The use of the EMBaRK process, informed by co-production principles, feminist theories, and academic rigour, is a notable strength. Co-produced by the FMCG, the EMBaRK process ensured that the research was grounded in the lived experiences and perspectives of female migrants, thereby enhancing the relevance and applicability of the findings. The EMBaRK process embodies a collaborative and inclusive approach, promoting empowerment and mutual respect among researchers and participants. This methodology aligns with feminist theories that advocate for the inclusion of marginalised voices and challenge traditional power dynamics in research. By actively engaging female migrants in the design, implementation, and analysis stages, the study not only validates their experiences but also leverages their insights to inform meaningful and culturally sensitive research outcomes.

Additionally, the study's strength is further amplified by the diversity of its participants, encompassing a wide range of ethnicities, cultures, religions, and ages. This spectrum of lived experiences enriches the data and provides a comprehensive understanding of the varied challenges and needs of female migrants. Such diversity ensures that the findings are not only robust but also reflective of the broader female migrant population.

The study is not without its limitations. This study focused specifically on the mental health needs and help-seeking behaviours of female migrants who were not born in the United Kingdom. While this focus allowed for a deeper exploration of the unique challenges faced by this group, it does limit the generalisability of findings to other populations, including first-generation migrants who were born in the UK but may identify as culturally and socially distinct. As previously discussed, the complexity of identifying individuals as 'migrants' due to factors such as self-identification, local contexts, and differing definitions further highlights the potential limitations in capturing the full spectrum of experiences within the broader female migrant population. Although not the primary focus of this research, these distinctions underscore the need for future studies to investigate the mental health needs of female migrants across various generations and migration histories.

Additionally, a critical reflection on potential biases within recruitment strategies is warranted. The exclusion of UK-born internal female migrants in this study may not merely be an artefact of chance or political definitions of who is considered a migrant in a

local context. The research process itself, being embedded within societal power dynamics, may have unintentionally perpetuated exclusionary practices. The concept of the "male gaze," as articulated by Laura Mulvey (1975), refers to the act of viewing and interpreting the world through a lens shaped by patriarchal values, which often objectify and marginalise women (391). In the context of this thesis, the male gaze presents both a challenge and an opportunity for reflexivity. As a male researcher conducting a study grounded in feminist principles, the PhD Candidate had been acutely aware of the need to interrogate his positionality and the potential influence of the male gaze on the research process.

The research process itself, being embedded within societal power dynamics, may have unintentionally perpetuated exclusionary practices. In mental health research with female migrants, the male gaze can manifest in subtle ways—from the design of recruitment materials to the framing of interview questions and the decisions of a male researcher regarding participant selection. These dynamics may have inadvertently created barriers for certain groups of women, limiting their participation or shaping their engagement with the study.

From a feminist perspective, this critique aligns with the broader aim of challenging hegemonic power structures in knowledge production. Feminist frameworks such as standpoint theory (392) and intersectionality (6) provided critical tools for reflecting on and mitigating the influence of the male gaze. The study's co-production approach, facilitated through the EMBaRK framework, sought to amplify female migrant voices by embedding their perspectives into every stage of the research process. This methodological approach aimed to counterbalance the potential biases of the male gaze by ensuring that recruitment strategies, research tools, and data interpretation were informed by female migrants themselves.

Nevertheless, the male gaze underscores an important methodological limitation: while lived experience commentaries and co-production principles enhanced reflexivity, they do not entirely erase the power imbalances inherent in research conducted by a male researcher with a vulnerable female population. This tension highlights the need for continued reflexivity and transparency, recognising that feminist praxis requires an ongoing commitment to challenging systemic inequities in research processes and

outcomes. By acknowledging this limitation, the study contributes to a broader conversation about how feminist methodologies can confront and navigate the complexities of positionality and power in research.

4.5.2 Recommendations and conclusions based on experiences with GPs

The participants recommend the implementation of culturally aware training for GPs and their surgery staff to enhance communication and understanding of issues specifically related to female migrants. This co-produced enquiry further highlights the critical need to strengthen referral pathways to appropriate mental health services and to provide information and resources about mental health support beyond the GP system. The interviewed female migrants advocate for the implementation of proactive mental health screening protocols, to be conducted alongside physical health assessments, specifically targeting female migrants. Additionally, increasing access to face-to-face consultations and alternative communication channels is perceived as beneficial for improving both mental and physical health outcomes.

These insights, while particularly relevant to female migrants, can be generalised to benefit the wider population. However, active engagement from GPs is essential to address the broader systemic challenges female migrants face.

4.5.3 Practice and policy implications

The current findings indicate that, despite public health and policy efforts such as the Time To Change anti-stigma campaign (393,394), significant barriers to accessing mental health support persist for female migrants. Stigma remains a primary obstacle. This study highlights the importance of social support for positive mental health outcomes.

Policymakers in the health and social care sectors should prioritise funding for culturally gender-sensitive social initiatives that address the distinct needs of the female migrant population. Such initiatives could be fostered through Non-Governmental Organisations (NGOs) working with migrants, providing group activities, mentorship programs, or facilitated discussions specifically addressing mental health challenges in a safe environment. Researchers can support these efforts through partnerships that assess intervention effectiveness and ensure culturally and gender-appropriate strategies. The current findings suggest that despite considerable research into access and help-seeking,

many female migrants still have substantial barriers to accessing support for their mental health when they do need it.

4.5.4 Future research

Future research should adopt a feminist lens to investigate the multifaceted impact of various social support structures for female migrants, including peer groups, mentorship programmes, and culturally tailored activities that foster open discussions about health. This research should not only examine mental health outcomes but also delve into the subtle ways these structures influence help-seeking behaviours and stigma reduction.

To ensure meaningful engagement with migrant communities and dismantle power imbalances inherent in traditional research models, it is crucial to critically assess the quality of studies employing co-production techniques. A feminist approach to co-production research would foreground the voices and experiences of female migrants, challenging the dominant narratives and assumptions that often shape health research and policy. This approach would also emphasise the importance of inclusivity, ensuring that diverse perspectives within migrant communities are represented and valued.

Furthermore, future research should explore how existing policies and practices within GP settings may inadvertently perpetuate or mitigate health inequities for female migrants. This could involve examining how power dynamics between healthcare providers and patients, as well as broader societal structures, influence the quality of care received by female migrants. By adopting a feminist perspective, research can identify opportunities for transforming GP settings into more inclusive and empowering spaces for female migrants to access and receive comprehensive mental healthcare.

4.6 Lived Experience Commentaries: Reflections on the qualitative study by the FMCG

4.6.1 What is a lived experience commentary and how can it enhance research?

A lived experience commentary is a form of qualitative narrative, situated, or reflective accounts from individuals who have personally experienced a certain condition, situation, or social phenomenon. In academic contexts, researchers may include lived experience commentaries as a way to incorporate subjective insights, emotions, and reflections into their work, therefore, humanising academic research. For example, in the papers authored by academics like Lloyd-Evans, Johnson and colleagues, a lived experience commentary by individuals directly affected by mental health concerns, either as a carer or as a service user, has been included to complement the mental health research (395–398).

To enrich the project's data and offer a human dimension to the academic research, lived experience commentaries were sought from three core members of the FMCG (JB, AW, and ELE). As previously noted, the FMCG comprised professionals supporting female migrants and female migrants themselves, some of whom had experienced mental and physical health challenges. Three lived experience commentaries were provided by FMCG members, reflecting on and interpreting the qualitative interview study.

This approach was particularly significant when considered through a feminist lens. As a male PhD candidate researching issues central to the experiences of female migrants, it was essential to create space for the voices of the FMCG members to be heard and to meaningfully engage with their lived realities. These reflections centred the perspectives of women whose experiences are often marginalised, thereby challenging traditional research hierarchies and power dynamics.

Moreover, the process demonstrated the PhD Candidate's ability to critically engage with the insights shared by FMCG, reflecting on their contributions and learning from their lived experiences. By doing so, the candidate acknowledged and responded to their positionality as a male researcher, ensuring that the women's voices actively shaped the analytical and interpretative process.

The inclusion of these lived experience commentaries, alongside a reflection piece by the PhD Candidate on the insights provided, created a dialogic space where participants' interpretations and the researcher's reflexivity intersected. This dual-layered process offered a unique contribution to the thesis, highlighting the value of collaborative knowledge production within feminist-informed research. Following the commentaries, a brief analysis of the individual and overarching themes they presented was undertaken, further contextualising their significance within the broader scope of the study.

4.6.2 Lived experience commentary on the qualitative interview study by JB, a bilingual advocate

“Having reviewed the Qualitative Interview Study, I found the results very interesting, and I was also surprised by some of the results. Some of the migrants expressed concerns that asking for help with their mental health could lead to negative consequences and results. I was surprised to read that unfortunately these concerns were not always unfounded, and the disclosure of mental health problems had made things worse for some migrants. Some migrants suffered discrimination when they asked for support with their mental health were judged for not being able to learn English or were considered ‘dangerous’ or ‘mad’, which led to a further deterioration in mental health. Also, I found the comment that disclosing a mental health problem means that it is statistically more likely that the migrant could have their children taken away by social services very worrying, as this is not only a significant barrier to accessing mental health support but can cause a major deterioration in mental health and could make a migrant regret asking for support.

The results of this study show the importance of always using professional qualified interpreters who understand and always follow the interpreter’s code of conduct and have a deep level of understanding of the language and culture of the migrants. One of the strengths of the study was the recruitment of participants with a range of different ages, languages, ethnicities, and countries of origin. This has led to results that represent many different cultures and experiences of accessing support for mental health”.

4.6.3 Lived experience commentary on the qualitative interview study by AW, a female migrant supporting other migrants in the community

“The sample of the research includes a very diverse group of non-British-born females. It was thought-provoking to hear their unique stories, representing a rich tapestry of age groups, ethnic backgrounds, countries of origin, and languages. This diversity added depth to our understanding of the experiences and needs of migrant women in the study region. Nevertheless, it is noteworthy that religious diversity within the sample is somewhat constrained, with a predominant 62% identifying as Christian. This limitation may not fully capture the experiences of individuals from diverse religious backgrounds, as different religious affiliations can have varying degrees of influence on mental health.

The research delved deeply into various barriers faced by migrant females, exploring the intricate web of challenges they encounter. Yet, one aspect we couldn't help but reflect on was the economic dimension. From my own observations, I shall say that migrant women are more likely to grapple with economic challenges, which may impede their ability to afford essential aspects of mental health treatment, including therapy, medication, and even transportation to healthcare facilities. Consequently, it is imperative to factor in not only the personal, social, and structural but also financial barriers when assessing the overall landscape of barriers to mental health support access in this demographic”.

4.6.4 Lived experience commentary on the qualitative interview study by ELA, a female migrant who works as a therapist in talking therapies

“This study explored the experiences of female migrants within Kent, Surrey, and Sussex regarding their mental health support in primary care and the community. Interviews with eighteen participants highlighted numerous barriers, spanning individual, structural, and societal levels. A notable challenge was the reliance on family members as interpreters during mental health crises due to the scarcity of professional interpreters, raising ethical concerns, especially concerning sensitive issues like suicide. The study points out that digital exclusion emerged as a concern, as some participants lacked access to digital tools or proficiency to use them, preferring traditional face-to-face consultations. Establishing a safe therapeutic relationship was deemed crucial for engagement and treatment adherence. Internalized stigma was pervasive, leading to self-blame and reluctance to seek support, particularly among those with low English proficiency and comprehension barriers.

The study highlighted how complex and interconnected the facilitators and barriers to mental health support among female migrants are, emphasizing the need for a holistic approach. Understanding these connections, such as the impact of stigma on multiple levels, and recognizing the power of self-compassion and faith-based support, is vital in designing comprehensive and effective mental health interventions for migrant populations. One surprising result was the depth of insights gained from involving female migrants in every stage of the research process. The strength of co-production was evident in how it enhanced the study's credibility and relevance. Overall, the study's strength in involving female migrants throughout the research process highlighted the significance of participant engagement and co-production in creating meaningful insights”.

4.6.5 Brief observations on the lived experience commentaries on the qualitative interview study

JB's commentary identified the stigma and discrimination experienced by female migrants, specifically the self-stigma and fear of having their children taken away should they seek support for their mental health. As JB is a professional who supports female migrants, mainly through interpreting and advocacy, she emphasised the importance of professional and high-quality interpreters who understand the language and cultural needs of migrants. She emphasised that a key strength of the study was the recruitment of participants from diverse backgrounds, which effectively captured a broad range of experiences among the female migrants interviewed. Similarly, AW acknowledged the richness in diversity of the sample including age, ethnicity, country of origin and languages, however, for AW a limitation of the study was a lack of religious diversity as she rightly pointed out the link between religion, faith, and mental health, which can be positive or negative (399). AW reinforces the research findings regarding economic obstacles to accessing support, highlighting the intersectionality of personal, social, and structural barriers with financial factors. This perspective is informed by her experience supporting diverse migrants in her care.

Similar to AW, ELA comments on barriers at multiple levels that hinder seeking or accessing support. These barriers can be individual, structural, and societal. ELA emphasises the barriers to receiving effective support, including the reliance on family members as interpreters, digital exclusion, and internalised stigma. As a therapist from a migrant background who primarily supports other female migrants, ELA emphasises the need for holistic approaches to support. ELA highlights the participatory approach to data gathering as a strength of the research, as it involved female migrants in every stage of the research process. She believes this approach enhanced the study's credibility and relevance.

The commentaries had cross-cutting themes, which were the recognition of diversity as a strength of the research project, highlighting barriers to mental health access and support, and the use of a participatory approach to research in generating meaningful insights into female migrant research.

In summary, these three lived experience commentaries by members of the core FMCG have enriched the research project as they provided feedback and suggestions and raised issues around aspects of the research that the PhD Candidate could have improved. Further research may seek to gain a deeper understanding of hesitancy in the disclosure of mental health problems for female migrants as highlighted by JB. Additionally an exploration of the ethical concerns and experiences of reliance on family members as interpreters during mental health crises, as alluded by ELA. Finally, researchers in migrant studies need to ensure greater religious diversity in research as suggested by AW.

Chapter 5: Examining disparities in mental health referral and severity of diagnosis for foreign-born and British-born women in South East London

5.1 Introduction

Foreign-born females face unique mental health challenges. Studies suggest they are more likely to develop mental health problems compared to other groups, including their male counterparts and the native population (102,400). However, despite this increased risk, they are less likely to access mental health services (187). This underutilisation of services may be due to a lack of awareness, stigma surrounding mental health issues within their communities, or systemic barriers within the healthcare system itself (401). Research indicates that ethnic minorities, including foreign-born individuals, are more likely to be referred to mental health services through the criminal justice system rather than through voluntary or primary care pathways (402). This trend suggests a possible bias or lack of early intervention and support within the community. Furthermore, foreign-born individuals may encounter barriers to accessing specific treatments, such as Cognitive Behavioural Therapy for Psychosis (CBTp), which require a certain level of cultural competence and sensitivity from healthcare providers (395). Another area of concern is the disproportionate rate of involuntary admissions under the Mental Health Act (MHA) among ethnic minorities, particularly Black individuals (403,404). This raises questions about potential systemic biases and the adequacy of mental health care provision for foreign-born populations.

Understanding these dynamics is crucial for developing targeted interventions that can improve mental health outcomes for foreign-born females.

The UK, with its diverse population and complex history of migration, presents a unique context for examining mental health disparities among foreign-born women. The National Health Service (NHS) strives for equitable healthcare provision, yet systemic challenges persist. Notably, the "Five Year Forward View for Mental Health" (405) acknowledges disparities in access and outcomes for marginalised groups, including migrants. This strategic document outlines a vision for improving mental health care across England, emphasising the need for more personalised and culturally competent services to address the unique needs of diverse populations.

The Mental Health Act 1983 (MHA) (406) governs involuntary admissions and treatments in England and Wales. However, its disproportionate use among ethnic minorities, specifically

Black people, has raised concerns about potential biases and inequalities (404,407). The independent review of the Mental Health Act, commissioned by the government (prior to the department name change to the Department of Health and Social Care) highlighted the need for reforms to ensure fairer and more equitable application of the MHA, particularly for ethnic groups who are disproportionately affected by its current provisions (406).

While initiatives and strategies such as "Delivering Race Equality in Mental Health" (408) aimed to address these issues, further evidence is needed to inform targeted interventions and policies. The Delivering Race Equality in Mental Health programme (408) seeks to reduce ethnic disparities in mental health services by promoting better engagement with minority communities, improving workforce diversity, and ensuring that mental health services are responsive to the cultural needs of all service users.

This study aims to contribute to the evidence base by focusing on the specific experiences of foreign-born women within the mental health system, particularly within the South London and Maudsley (SLaM) catchment area of South East England. By analysing clinical records from SLaM, this research aimed to identify potential inequalities in health provision and provide an initial evidence base to address these disparities.

5.1.1 Study overall aim

This study was conceptualised in collaboration with the Female Migrant Co-production Group (FMCG) and aimed to investigate the association between migrant status, referral source, and the severity of mental health diagnosis among female service users of SLaM. It further examined how these associations varied by ethnicity. By analysing data from the SLaM Clinical Record Interactive Search (CRIS), this research sought to identify potential inequalities in mental health provision based on migrant status and to provide an initial evidence base for addressing these disparities. The study was approved by the SLaM CRIS governance committee (CRIS Project 23-002).

5.1.2 Research questions

1. Is the referral source related to migrant status, and does this association differ by ethnicity?
2. How is migrant status related to the severity of diagnosis [using Total Health of Nation Outcome Scores (HoNOS)], and does this association differ by ethnicity?

5.2 Methods

5.2.1 Study design

This research employs a retrospective cohort study design utilising secondary data analysis of electronic clinical records (ECRs) housed within SLaM's CRIS database. Retrospective cohort studies are well-suited for investigating trends and potential associations between exposures and outcomes in existing datasets (409). In this study, we investigated the association between migrant status (foreign-born vs. UK-born) and two primary outcomes: referral source and severity of diagnosis (measured by Total HoNOS scores) within the SLaM mental health service system. We also examined the potential moderating role of ethnicity in these relationships.

Setting and data sources

Data for this study was derived from the SLaM NHS Foundation Trust Biomedical Research Centre Case Register (SLaM BRC Case Register). Anonymised clinical data was accessed through the CRIS tool. Researchers access the required information via the CRIS Team, ensuring patient data confidentiality.

The four London boroughs of Lambeth, Southwark, Lewisham, and Croydon, encompassing a catchment area of approximately 1.3 million residents served by SLaM, demonstrate notable demographic diversity. While sharing some similarities with Greater London and England, they also possess unique characteristics, as highlighted in Table 14.

Table 14: Partial Demographics of SLAM service area compared to Greater London and England (2011-2021)

Characteristic	Croydon (2011)	Croydon (2021)	Lambeth (2011)	Lambeth (2021)	Lewisham (2011)	Lewisham (2021)	Southwark (2011)	Southwark (2021)	London (2011)	London (2021)	England (2011)	England (2021)
Population number	363,400	390,700 (▲7.5)	303,100	317,700 (▲4.8)	275,900	300,600 (▲8.9)	288,300	307,600 (▲6.7)	8,200,000 (▲7.7)	8,600,000 (▲7.7)	53,012,456	56,489,800 (▲6.6)
Median age in years	35	37	31	33	33	35	32	33	*35	35	39	40
Population aged 50-64 (%)	16.2	18.7	18.1	19.4	13.4	17.3	18.1	19.4	14.4	16.9	18.1	19.4
Born in England (%)	68.7	63.8	58.1	58.7	64.0	62.4	57.9	57.0	61.1	57.7	83.5	80.3
Not identifying with any UK national identity (%)	15.5	17.4	25.6	22.8	20.9	20.3	25.2	23.3	22.4	22.5	8.2	10.0
Identifying with UK and non-UK identity (%)	1.7	3.5	2.5	4.9	2.3	4.8	0.9	2.0	2.3	4.4	0.9	2.0
Identifying as “British only” (%)	31.9	61.4	32.5	57.6	32.8	59.0	19.2	56.8	30.9	56.9	19.2	56.8
Asian, Asian British or Asian Welsh (%)	16.4	17.5	18.5	20.7	9.3	9.0	18.5	20.7	18.5	20.7	7.8	9.6
Black, Black British, Black Welsh, Caribbean or African (%)	20.2	22.6	13.3	13.5	27.2	26.8	13.3	13.5	13.3	13.5	3.5	4.2
Mixed or Multiple ethnic groups (%)	6.6	7.6	5.0	5.7	7.4	8.1	5.0	5.7	5.0	5.7	2.3	3.0
White (%)	55.1	48.4	59.8	53.8	53.5	51.5	59.8	53.8	59.8	53.8	85.4	81.0
Other ethnic groups (%)	1.8	3.9	3.4	6.3	2.6	4.7	3.4	6.3	3.4	6.3	1.0	2.2

▲ percentage rise in population

* There are differing median age ranges for London depending on the source.

Source: Office for National Statistics (ONS) – Census 2011 and Census 2021 (410).

5.2.2 Cohort definition

This study focused on adult females aged 18 and older who have engaged with adult primary and secondary mental health services within SLaM. These services encompass community support, outpatient care, and hospitalisation for women, whether voluntarily or under sectioning of the MHA. The cohort includes females who had an appointment at SLaM but may not have engaged further with services. The SLaM CRIS database routinely collects a wide range of patient data, however, this research specifically focused on recorded variables from the Adult Mental Health Services (AMHS) relevant to the research questions, excluding data from the Child and Adolescent Mental Health Services (CAMHS).

The data analyses presented in this chapter use the United Nations definition of a migrant woman as *one who has moved across an international border or within a state away from her habitual place of residence* (69). Within this study, migration status was determined by the clinician-recorded country of birth within SLaM clinical records. Any female born outside the UK was coded as a migrant.

5.2.3 Sample inclusion criteria

To be included in the study, individuals had to have resided within the designated service catchment area of SLaM at the time of their first appointment, or consistently during the period under review. Furthermore, all individuals were required to be 18 years of age or older at the time of their initial consultation and to have been identified as female according to SLaM records.

The study, however, set specific exclusion criteria to refine the reliability of its findings. Individuals with incomplete or missing data on essential variables such as diagnosis, migration status or specifics of treatment, were excluded. Moreover, those whose primary interactions with SLaM were managed through CAMHS were not considered.

5.2.4 Observation Window

The records span 16 years, from the 1st of January 2007, up until the data extraction point in September 2023.

5.2.5 Research questions and hypotheses

This study examines the mental health care pathways of foreign-born and British-born females through the SLaM system from referral. The following research questions and corresponding hypotheses guided the analysis:

RQ1: Is the referral source related to migrant status, and does this association differ by ethnicity?

H1: Foreign-born women are more likely to be referred to mental health services through emergency or crisis pathways compared to British-born women. This association is further hypothesised to vary by ethnicity, with Black and Asian foreign-born women being more likely to be referred through emergency pathways compared to their White counterparts. This hypothesis is one-tailed, specifying a direction of the relationship.

RQ2: How is migrant status related to the severity of diagnosis (using Total HoNOS scores), and does this association differ by ethnicity?

H2: Foreign-born women present with higher HoNOS scores compared to British-born women. It is further hypothesised that this association is influenced by ethnicity, with Black and Asian foreign-born women presenting with higher HoNOS scores compared to White foreign-born women, indicating more severe mental health issues. This hypothesis is one-tailed, specifying a direction of the relationship.

Table 15 summarises the research questions, hypotheses and corresponding analysis plan.

Table 15: Research questions and corresponding hypotheses

Corresponding RQ	Hypothesis (H)	Outcome Variable (DV)	Predictor/explanatory/independent Variables	Potential Confounders	Type of Analysis
Is the referral source related to migrant status, and does this association differ by ethnicity?	H1: Foreign-born women are more likely to be referred to mental health services through emergency or crisis pathways compared to British-born women, This association is further hypothesised to vary by ethnicity, with Black and Asian foreign-born women being more likely to be referred through emergency pathways compared to their White counterparts.	Referral Route Emergency/crisis services <ul style="list-style-type: none"> 0 = Non-emergency: Includes referrals from general practitioners (GPs), community mental health teams, voluntary referrals, outpatient clinics, and other non-crisis healthcare services. 1 = Emergency: Includes referrals from Accident & Emergency (A&E) departments, prison services, high and medium security services, police, probation services, safeguarding referrals, and courts. 	Migrant Status: Binary 0 = British-born, 1 = Foreign-born Ethnicity: Categorical (1 = Asian, 2 = Black, 3 = Mixed or Multiple, 4 = White, 5 = Other) Interaction Term: Migrant Status * Ethnicity	<ul style="list-style-type: none"> Age: Continuous MHA Sectioned: Binary (0 or 1) Living Arrangement: Categorical – Alone (1), Children only (2), With partner (3), with partner & children (4), Parents/relatives (6), Friends/Others (7), Not known (8). Diagnosis: Categorical (*ICD-10 codes grouped as severe mental illness, common mental health disorders, other diagnoses) 	1. Descriptive Analysis: Summary of the characteristics of the sample, including age, MHA sectioning, living arrangements, diagnosis category, migrant status, referral source, HoNOS scores, and ethnicity. - Frequency tables for categorical variables and descriptive statistics (mean, SD) for continuous variables. 2. Inferential Analysis - **Chi-square tests to examine associations between categorical variables. - ***Multivariate Logistic regression to predict the likelihood of emergency referral based on migrant status, ethnicity, and their interaction term, while controlling for confounders. The logistic regression will be conducted using a one-tailed test due to the specified directional hypothesis
How is migrant status related to the severity of diagnosis (using Total HoNOS scores), and does this association differ by ethnicity?	H2: Foreign-born women present with higher HoNOS scores compared to British-born women. It is further hypothesised that this association is influenced by ethnicity, with Black and Asian foreign-born women presenting with higher HoNOS scores compared to White foreign-born women, indicating more severe mental health issues	Severity HoNOS Score (Continuous: 0-48)	Migrant Status: Binary 0 = British-born, 1 = Foreign-born Ethnicity: Categorical (1 = Asian, 2 = Black, 3 = Mixed or Multiple, 4 = White, 5 = Other) Interaction Term: Migrant Status * Ethnicity	<ul style="list-style-type: none"> Diagnosis: Categorical (ICD-10 codes grouped as severe mental illness, common mental health disorders, other diagnoses) Living Arrangements: Categorical Age: Continuous 	1. Descriptive Statistics: Summary of HoNOS scores, including means and standard deviations. 2. Inferential Analysis: <ul style="list-style-type: none"> ****Multivariate Linear Regression to assess the association between migrant status and ethnicity as independent variables and HoNOS scores as the dependent variable, including the interaction term and controlling for confounders. The linear regression will be conducted using a one-tailed test due to the specified directional hypothesis *****T-Test/ANOVA: To compare mean HoNOS scores between foreign-born and British-born women across different ethnic groups

Notes

*ICD-10 = International Statistical Classification of Diseases and Related Health Problems, 10th Revision (411)

**Chi-Square Test: Examine the relationship between migrant status, ethnicity, and emergency referral.

***Logistic Regression: Predict the likelihood of emergency referral based on migrant status, ethnicity, and interaction term, controlling for confounders.

****Linear Regression: Assess the association between migrant status, ethnicity, and HoNOS scores, including the interaction term and adjusting for confounders.

*****T-Test/ANOVA: Compare mean HoNOS scores between foreign-born and British-born women across different ethnic groups.

5.2.6 Outcome variables (DVs)

This study examined potential inequalities in mental healthcare for foreign-born and British-born females by collecting data on key outcome measures, described in section 5.2.7. These measures were used to derive binary outcomes and independent variables, enabling the assessment of disparities in referral source and severity of diagnosis. Specifically, the measures encompassed:

Referral Source: Recoded into binary: 0 for Emergency Referrals (A&E Department, Courts, High Security, Medium Security, Police, Prison (HMP), Probation Service, Safeguarding) and 1 for All other referrals.

Severity (HoNOS Scores): The Health of the Nation Outcome Scales (HoNOS) (412) is a versatile tool used in this study to assess both symptom severity and overall diagnostic severity within mental health diagnoses. This validated, 12-scale clinician-rated instrument evaluates various aspects of mental health functioning and is widely employed in diverse settings (412–416). Each subscale directly assesses the severity of specific symptoms, allowing us to gauge how severely a patient's mental health impacts their life.

The HoNOS scoring system: Scoring for each of the 12 HoNOS scales is based on a 5-point Likert scale, with 0 indicating no problems and 4 indicating severe problems. The total score is calculated by summing the scores for each of the 12 scales, resulting in a range from 0 to 48. A higher total score indicates more severe problems, while a lower HoNOS score indicates fewer problems. The scoring system is summarised in Table 17 below:

Table 16: HoNOS scoring system

Score	Severity
0	No problem
1	Minor problem requiring no action
2	Mild problem but definitely present
3	Moderately severe problem
4	Severe to very severe problem

Use of HoNOS in RQ 2 to measure outcome severity

In Research Question 2 (RQ2), which explored how migrant status relates to the severity of the diagnosis and whether this association differs by ethnicity, HoNOS scores were used as an outcome measure of symptom severity. While HoNOS does not directly categorise diagnoses as mild or severe, the total score across all subscales served as a proxy for overall

diagnostic severity. This allowed for a direct assessment of the impact of migrant status on the severity of mental health conditions. By using HoNOS as an indicator of mental health severity, the analysis aimed to identify whether female service users, based on specific migrant categorisation, presented with higher levels of symptom severity compared to their counterparts.

The longitudinal use of HoNOS provides valuable insights into changes in symptom severity and overall mental health functioning over time. Although primarily designed as an outcome measure, this approach also helps to highlight the progression or improvement of symptoms, offering insights into treatment effectiveness.

Summary of the 12 HoNOS scales:

1. Overactive, aggressive, disruptive, or agitated behaviour
2. Non-accidental self-injury
3. Problem-drinking or drug-taking
4. Cognitive problems
5. Physical illness or disability problems
6. Problems associated with hallucinations and delusions
7. Problems with depressed mood
8. Other mental and behavioural problems ((A) Phobic, (B) Anxiety, (C) Obsessional-compulsive, (D) Mental strain/tension, (E) Dissociative ('conversion') problems, (F) Somatoform, (G) Eating (Problems with appetite, over- or undereating), (H) Sleep, (I) Sexual, (J) Other - Problems not specified elsewhere: e.g., expansive, or elated mood
9. Problems with relationships
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and activities.

5.2.7 Predictor variables

- **Migration Status:** Migration status was determined by the clinician-recorded country of birth within SLaM clinical records. Any female born outside the UK was coded as foreign-born (1), while those born in the UK were coded as British-born (0). This approach aligns with the United Nations definition of a migrant as someone who has moved across an international border or within a state away from their habitual place of residence (*See* Chapter 1, section 1.3 for further details).
- **Ethnicity:** Ethnicity data were collected from the clinical records, where patients self-identified their ethnicity during their initial assessment. For this study, ethnicity was coded as follows:
 - Asian: 1
 - Black: 2
 - Mixed or Multiple: 3
 - White: 4

Interaction Term: Migrant Status * Ethnicity.

5.2.8 Potential confounders

Age, MHA Sectioning, Living Arrangement, Diagnosis

Sociodemographic Factors: Key sociodemographic variables included migration status, date and country of birth, and ethnicity. Additional sociodemographic data such as housing status, employment, religion, and marital status were also extracted but not included in the analysis.

5.2.9 Justification for the selected confounders

RQ1: Is the referral source related to migrant status, and does this association differ by ethnicity?

To answer RQ1 the following confounders were considered: Age, MHA Sectioning, Living arrangements, and diagnosis:

Age is a pivotal factor in understanding both the propensity for migration and the mental health needs of individuals. Younger people are often more mobile, increasing the likelihood of migration, and are also statistically more prone to certain mental health disorders (417). Furthermore, younger cohorts may exhibit a higher tendency to seek mental health assistance through emergency pathways (418). By controlling for age, the analysis can more accurately

isolate the specific influence of migrant status on referral patterns, minimising the confounding effects of age-related mental health trends.

The process of being **sectioned under the Mental Health Act (MHA)** serves as a robust indicator of severe mental illness (404,407). If a significant correlation exists between migrant status and the likelihood of being sectioned, it could obscure the direct relationship between migrant status and emergency referral pathways. Adjusting for MHA sectioning allows for a clearer understanding of how migrant status uniquely contributes to the observed referral patterns, independent of the severity indicated by MHA sectioning.

Living arrangements are crucial in shaping mental health outcomes and access to care. Migrants often experience different living conditions compared to their British-born counterparts, such as living alone, with family, or in supported housing (419,420). These varying conditions can significantly impact mental health and the pathways through which individuals access care. By controlling for living arrangements, the analysis can more precisely account for these differences, ensuring that the influence of migrant status on referral pathways is not conflated with the effects of living situations.

The type of mental health diagnosis is a critical determinant of referral pathways and subsequent treatment (421,422). Certain diagnoses may be more prevalent within migrant populations and could dictate specific referral patterns. Including diagnosis as a covariate in the analysis is essential for isolating the effect of migrant status on referral routes. This approach ensures that the observed referral patterns are not merely reflections of the diagnostic categories but rather indicate the true impact of migrant status.

RQ2: How is migrant status related to the severity of diagnosis (using HoNOS), and does this association differ by ethnicity?

To answer RQ2, the following confounders were considered:

The type of mental health diagnosis is intrinsically linked to the severity of mental illness, often quantified using HoNOS scores (412,414). Different diagnoses carry varied levels of severity, which can influence treatment and care pathways. Controlling for diagnosis is, therefore, crucial to discern the independent effect of migrant status on the severity of mental illness as measured by HoNOS scores. Although both ICD and HoNOS measure similar

aspects of mental health, using diagnosis as a confounder helps isolate the specific impact of migrant status on severity (*See* Section 5.2.10 below for reporting ICD-10 data).

Living arrangements can significantly influence the severity of mental illness. Individuals residing in unstable or isolated environments are more likely to experience heightened symptom severity (423–425). Migrants often face unique housing challenges that may exacerbate mental health issues. By adjusting for living arrangements, the analysis can focus on the relationship between migrant status and HoNOS scores, free from the confounding effects of housing-related variables. This adjustment ensures a more accurate assessment of how migrant status independently affects the severity of mental illness.

Age: Similar to RQ1, age is crucial in understanding mental health outcomes. Younger individuals may experience different levels of mental health severity compared to older adults, influenced by life stage, stressors, and resilience factors. Controlling for age allows for a more precise understanding of how migrant status impacts the severity of mental health issues, independent of age-related factors.

5.2.10 Reporting diagnosis using the ICD-10

The CRIS dataset includes diagnostic data sourced from the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) codes. Clinicians use the ICD-10 to document patient information, encompassing signs and symptoms, diseases, diagnoses, and other health and social factors (411).

The specific codes which were included for the query were extracted on date: Ever (before or after the index date) and the source was from the Natural Language Processing (NLP) or structured (primary or secondary) fields. The NLP is used by machine language learning to extract keywords and phrases from free text clinical notes which are in turn used to provide predictions of diagnosis (426). The following codes and classifications were obtained from the dataset in terms of diagnosis using the ICD-10 (*See* Table 16):

Table 17: ICD-10 coding and classification of included cases

Code	Classification
F20-F29	Schizophrenia or other delusional disorders
F31	Bipolar disorder
F32-F39	Depression and other mood disorder
F40-F48	Neurotic, stress-related and somatoform disorders
F00-F99	Unspecified mental disorder
F10	Mental and behavioural disorders due to use of alcohol
F11	Mental and behavioural disorders due to use of opioids

For the current study, the codes were recoded and grouped into Severe Mental Illness (F20-F29, F31), Common Mental Health Disorders (F32-F39, F40-F48), and Other Diagnoses (F00-F99, F10, F11).

Justification for Grouping ICD-10 Codes into Three Categories

To examine the relationship between migrant status and the broad types of mental health diagnoses received, ICD-10 codes were categorised into three distinct groups: Severe Mental Illness (SMI), Common Mental Health Disorders (CMHD), and Other Diagnoses. This categorisation, informed by existing literature and prior studies (427–431), allows for the investigation of whether specific diagnostic groups are more or less prevalent among different migrant groups. By simplifying the complex landscape of mental health diagnoses

into these broader categories, the aim was to gain valuable insights into potential disparities in mental health presentations and referral patterns based on migrant status and ethnicity

Severe Mental Illness (SMI)

The category of Severe Mental Illness includes the ICD-10 codes F20-F29 (Schizophrenia and other delusional disorders) and F31 (Bipolar disorder). These conditions are typically characterised by significant impairments in cognitive functioning, behaviour, and daily life activities. Schizophrenia and bipolar disorder are often considered severe due to their chronic nature and profound impact on individuals' lives.

Supporting evidence for this classification can be found in various studies. For instance, Rössler et al. (427) underscore that schizophrenia and bipolar disorder are categorised as severe mental illnesses due to the considerable burden they impose on patients and society. Additionally, other studies identify schizophrenia and bipolar disorder as serious mental illnesses necessitating comprehensive treatment and management (432).

Relevance to analysis

By categorising these conditions under SMI, we can more precisely examine how severe mental illnesses affect referral patterns and mental health outcomes among migrant and non-migrant populations. Given the chronic and debilitating nature of SMIs, individuals with these diagnoses may have distinct pathways to care, often involving emergency or crisis services. This categorisation allows us to:

1. **Analyse Referral Patterns:** Determine if individuals with SMI are more likely to be referred through emergency pathways compared to those with common mental health disorders or other diagnoses.
2. **Investigate Disparities:** Assess whether there are significant differences in the prevalence and referral patterns of SMIs among different migrant groups, providing insights into potential health inequalities.
3. **Control for Severity:** By controlling for the presence of SMI in our analysis, we can isolate the impact of migrant status on referral patterns and mental health outcomes, ensuring that the observed effects are not merely due to the severity of the mental health condition.

Common Mental Health Disorders (CMHD)

The category of Common Mental Health Disorders includes ICD-10 codes F30, F32-F33 (Mood [affective] disorders excluding bipolar disorder), and F40-F48 (Neurotic, stress-related, and somatoform disorders). These conditions, such as depression and anxiety, are prevalent in the general population and are often characterised by episodic symptoms that can significantly impact daily functioning but are typically less chronic and debilitating than severe mental illnesses.

The World Health Organization (WHO) identifies depression and anxiety disorders as the most prevalent mental health conditions, often referring to them as common mental health disorders. The categorisation of common mental health disorders (CMHD) aligns with the findings of the World Mental Health Surveys, which highlight the high prevalence and significant impact of these conditions on a global scale (428). Additionally, these disorders are often managed with a combination of medication and therapy, making their classification distinct from more severe and chronic mental illnesses. This grouping reflects the shared characteristics of these disorders, including their relatively high prevalence, frequent co-occurrence, and potential for substantial functional impairment.

Relevance to analysis

Categorising these conditions under CMHD allows the study to:

1. **Compare Referral Patterns:** Examine whether individuals with CMHD are more likely to be referred through non-emergency pathways compared to those with SMI, reflecting differences in the management and treatment of these conditions.
2. **Assess Prevalence and Access:** Investigate if there are disparities in the prevalence of CMHD among different migrant groups and how these groups access mental health services. This can provide insights into potential barriers to care for common mental health conditions.
3. **Control for Condition Type:** By including CMHD as a category in the analysis, this can be controlled for the type of mental health disorder when assessing the impact of migrant status on referral patterns and mental health outcomes. This ensures that observed effects are not solely due to the type of mental health condition.

Other Diagnoses

The category of Other Diagnoses includes ICD-10 codes F00-F99 (Unspecified mental disorders), F10 (Mental and behavioural disorders due to alcohol use), and F11 (Mental and behavioural disorders due to opioid use). These conditions are grouped separately due to their unique characteristics and the distinct approaches required for their treatment and management.

Relevant literature supports the decision to classify substance use disorders separately. Studies by Saunders et al. (429), Grant et al. (430), Hasin et al. (431), and Kessler et al. (433) consistently treat substance use disorders as a distinct category due to their unique aetiology and treatment requirements. This is further underscored by the ICD-10, which typically dedicates a separate chapter to these conditions, thereby acknowledging their distinct characteristics (411).

Relevance to analysis

Including *Other Diagnoses* as a distinct category in the analysis was essential for ensuring a more comprehensive and nuanced understanding of mental health service use among migrant groups. By incorporating this broader category, the analysis was able to capture the full spectrum of mental health conditions, extending beyond more commonly examined categories such as Severe Mental Illness (SMI) and Common Mental Health Disorders (CMHD). This approach allowed for a more inclusive exploration of mental health experiences, reflecting the diversity and complexity of diagnoses within the population. Furthermore, distinguishing *Other Diagnoses* enabled the identification of unique patterns and trends in referral pathways. It became possible to determine whether these conditions presented distinct referral behaviours or trajectories that diverged from those associated with SMI and CMHD. Recognising such patterns adds depth to the analysis, revealing variations that might otherwise have been overlooked.

Lastly, the inclusion of this category contributed to the robustness of the analysis. By accounting for a broader spectrum of diagnoses, the specific impact of migrant status on mental health referral patterns and outcomes could be more accurately isolated. This ensured that the findings were both rigorous and reflective of the diversity inherent in mental health presentations, offering a clearer picture of how migrant status interacts with the wider mental health landscape.

5.2.11 Statistical analysis

To answer the research questions and test the hypotheses outlined in this study, a two-phase statistical analysis was conducted.

Phase 1: Descriptive analysis and bivariate analysis

In the initial phase, descriptive statistics were employed to characterise the study sample and identify potential differences between foreign-born and British-born women. This involved calculating frequencies, percentages, means, and standard deviations for key variables such as migrant status, age, ethnicity, MHA sectioning and inpatient status, primary diagnostic categories based on ICD-10 codes, referral source, and HoNOS scores. These descriptive statistics were presented separately for foreign-born and British-born women to highlight potential disparities in their mental health care experiences.

Following the descriptive analysis, univariate analyses were conducted to examine the associations between each predictor variable (migrant status, ethnicity) and the outcome variables (referral source and HoNOS scores). Specifically:

RQ1: Is the referral source related to migrant status, and does this association differ by ethnicity?

Chi-Square Tests: Utilised to assess the association between the categorical predictor variables (migrant status, ethnicity) and the categorical outcome variable (referral source). This test is appropriate for determining if there is a significant relationship between two categorical variables.

RQ2: How is migrant status related to the severity of diagnosis (using HoNOS), and does this association differ by ethnicity?

Non-Parametric Tests:

To explore differences in HoNOS scores, non-parametric tests were employed, as they are well-suited for analysing ordinal outcome variables and do not assume a normal distribution of the data.

The Mann-Whitney U Test was used to compare the median HoNOS scores between two independent groups: foreign-born and British-born individuals. This test was chosen for its appropriateness in assessing differences in a continuous or ordinal variable when the data are

not normally distributed, allowing for a robust comparison of scores between these two groups.

In addition, the Kruskal-Wallis Test was utilised to compare the median HoNOS scores across multiple ethnic groups. As an extension of the Mann-Whitney U Test, it allowed for the examination of differences in HoNOS scores among more than two independent groups, ensuring that any variation across ethnic categories was captured effectively.

Phase 2: Inferential analysis

To examine the association between migrant status, ethnicity, and referral source (emergency vs. non-emergency), a multivariate logistic regression model was used. The model included migrant status, ethnicity (as a categorical variable with multiple levels), their interaction term, and other hypothesised confounders (age, MHA sectioned status, living arrangement, and diagnosis category) as independent variables. The outcome measure was the type of referral source (emergency vs. non-emergency). Odds ratios (ORs) and 95% confidence intervals (CIs) were reported to quantify the associations.

To assess the relationship between migrant status, ethnicity, and severity of diagnosis (HoNOS scores), a multivariate linear regression model was used. The model included migrant status, ethnicity (as a categorical variable with multiple levels), their interaction term, and other relevant confounders as predictor variables (e.g., age, MHA sectioned status, living arrangement, and diagnosis category). The unstandardised regression coefficients and 95% CIs were reported to quantify the associations. Unstandardised coefficients were used to interpret the relationships in their original units, making the results directly applicable to the clinical context and easier to understand in terms of the actual scales used.

Model assumptions

Model assumptions were rigorously checked to ensure the validity of the regression models. Linearity was verified using scatterplots and partial regression plots. Homoscedasticity was assessed using residuals versus fitted values plots. The normality of residuals was initially evaluated using Q-Q plots and the Shapiro-Wilk test, revealing non-normality. Consequently, a log transformation was applied to the HoNOS scores, improving the residuals' normality. The independence of observations was confirmed by reviewing the data collection protocols. Multicollinearity was assessed using Pearson correlation coefficients and Variance Inflation

Factors (VIF), with all VIF values below 5, indicating no significant multicollinearity concerns (Appendix R).

Missing data

A Missing Value Analysis (MVA) was conducted to examine the extent and patterns of missing data in the dataset. The analysis revealed that 44.4% of the cases had missing values for the dependent variable, HoNOS scores. Additionally, 40.0% of the cases had missing values for the Diagnosis_Category variable, and 4.0% for the ethnicity variable. Little's MCAR test indicated that the data were not missing completely at random (MCAR) (Chi-Square = 686.417, DF = 1, $p < .001$). Given the considerable amount of missing data, a pairwise deletion approach was employed, excluding cases only for the specific analyses where data were missing. Sensitivity analysis using bootstrapping techniques was conducted to evaluate the robustness of the findings. The results of the bootstrapping analysis provided confidence intervals for the estimates, confirming the robustness of the findings (434).

Sample size calculation

A post hoc sample size calculation was performed using G*Power (435) to determine if the number of participants in the study was adequate to detect statistically significant differences between foreign-born and British-born women. The primary outcome used for this calculation was the referral route (emergency vs. non-emergency). The effect size of 0.12 (Cohen's h) was chosen for its practical significance. While this effect size is considered small according to Cohen's conventions, it is deemed appropriate for this study due to the large dataset available. Small effect sizes can still be important in public health and clinical settings, where even minor differences can have significant implications for policy and practice

Based on anticipated proportions of emergency referrals:

The proportion of emergency referrals among British-born women ($P1P1$) = 0.20

The proportion of emergency referrals among foreign-born women ($P2P2$) = 0.25

Effect size (Cohen's h) = 0.12.

The significance level (α) was set at 0.05, and the desired power ($1-\beta$) was 0.80. Using these parameters, the minimum required sample size was calculated to be approximately 862 participants per group, or 1724 participants in total.

Statistical significance and software

Statistical significance was set at $\alpha = 0.05$ for all analyses. A Bonferroni correction was applied to adjust the significance level for multiple comparisons. All statistical analyses were performed using IBM SPSS Statistics (version 28.0).

The EMBaRK framework informed the quantitative analysis by embedding reflexivity into the interpretation of findings, particularly in critiquing diagnostic tools like HoNOS. This approach highlighted systemic biases that might otherwise have gone unnoticed.

5.3 Results

5.3.1 Demographic profile of the study cohort

The sample comprised 59,824 individuals who accessed SLAM services. The UK-born cohort comprised the largest group (68%, n = 40,833). Among the foreign-born women (32%, n = 18,991), Jamaica emerged as the most frequent country of origin (2.9%, n = 1,720). Other top countries of origin included Nigeria (2.1%), Ireland (2.0%), and Poland (1.3%). A complete list of the top ten countries of origin can be found in Table 18.

Table 18: Distribution of top 10 countries of origin among patients in the cohort

Country of Origin	Numbers (N)	Percentage (%)
United Kingdom	40,833	68.3
Jamaica	1720	2.9
Nigeria	1256	2.1
Ireland	1212	2.0
Poland	782	1.3
Portugal	640	1.1
India	629	1.1
Italy	477	0.8
Ghana	469	0.8
France	408	0.7

The age distribution ranged from 18 to over 100 years, with the largest age groups being 25-34 years (23.7%) and 18-24 years (20.2%). Most individuals (96.2%) were not detained under the Mental Health Act (MHA). Ethnically, the sample was predominantly White (66.5%) followed by Black (17.4%), Asian (5.6%), Mixed or Multiple ethnic groups (2.5%), and Other ethnic groups (4.0%), with 4.0% missing data. Living arrangements were diverse, with 23.8% living alone, 13.0% with a partner, and 27.0% having unknown arrangements. The remainder lived with children only (9.2%), a partner and children (5.9%), parents/relatives (11.9%), or friends/others (9.2%). In terms of diagnoses, 26.7% had severe mental illness, 57.2% had common mental health disorders, and 16.2% had other diagnoses, with a significant proportion (40.0%) of missing data. Approximately 31.7% of the sample were foreign-born, with the majority (68.3%) being British-born. Referrals were largely non-emergency (69.0%), with 31.0% being emergency referrals. Health of the Nation Outcome Scales (HoNOS) scores indicated that most individuals had low to moderate severity, with a mean HoNOS Total Score of 10.72 (SD = 5.699) (Table 19).

Table 19: Descriptive statistics for the sample (age distribution, MHA sectioning, ethnicity, living arrangements, diagnosis category, migrant status, emergency referral, and HoNOS scores)

Variable	Statistic/Category	Value % (#)
OUTCOMES		
Emergency Referral	No	69.0% (41,268)
	Yes	31.0% (18,556)
HoNOS Adjusted Total Group	Very Low Severity	10.3% (6,133)
	Low Severity	18.5% (11,045)
	Moderate Severity	15.6% (9,356)
	High Severity	7.7% (4,581)
	Very High Severity	2.5% (1,477)
	Extreme Severity	0.7% (410)
	Outliers	0.4% (231)
	Missing	44.4% (26,591)
HoNOS Total Score	Mean	10.72
	Standard Deviation	5.699
	Minimum	0
	Maximum	42
	Valid N	33,233
PREDICTORS		
Migrant Status	Foreign-Born	31.7% (18,991)
	British-Born	68.3% (40,833)
CONFOUNDERS		
Age Group	18-24	20.2% (12,098)
	25-34	23.7% (14,191)
	35-44	16.9% (10,135)
	45-54	10.9% (6,539)
	55-64	6.0% (3,579)
	65-74	6.3% (3,798)
	75-84	9.1% (5,456)
	85-99	6.7% (3,997)
	*100+	0.1% (31)
MHA Sectioned	No	96.2% (57,559)
	Yes	3.8% (2,265)
Ethnicity (Recoded)	Asian	5.8% (3,332)
	Black	18.2% (10,431)
	Mixed or Multiple	2.6% (1,502)
	White	69.3% (39,809)
	Other	4.1% (2,370)

Variable	Statistic/Category	Value % (#)
	Missing	4.0% (2,380)
Living Arrangement	Alone	23.8% (14,248)
	Children Only	9.2% (5,496)
	With Partner	13.0% (7,771)
	With Partner & Children	5.9% (3,555)
	Parents/Relatives	11.9% (7,110)
	Friends/Others	9.2% (5,513)
	Not Known	27.0% (16,131)
Diagnosis Category	Severe Mental Illness	26.7% (9,568)
	Common Mental Health Disorders	57.2% (20,522)
	Other Diagnoses	16.2% (5,804)
	Missing	40.0% (23,930)

* Given the limited representation of individuals aged over 100, and to safeguard anonymity, descriptors for this age group have been consolidated under the label '100+'.

5.3.2 Association between Migrant status, Ethnicity, and Emergency referral (RQ1,H1)

The association between migrant status, ethnicity, and emergency referral was investigated to determine whether foreign-born women are more likely to be referred to mental health services through emergency or crisis pathways compared to British-born women and whether this association varies by ethnicity. A multivariate logistic regression analysis was conducted to predict the likelihood of emergency referral based on migrant status, ethnicity, and interaction term while controlling for confounders. The results are summarised in Table 20.

Table 20: Logistic regression results for emergency referral

Predictor Variable	B	SE	Wald	df	Sig. (p-value)	OR	95% CI for ORs
Migrant status	.346	.087	15.713	1	< .001	1.414	[1.191, 1.679]
Ethnicity (Ref: White)							
- Black	-.221	.088	6.278	1	.012	.802	[.678, .949]
- Asian	-.017	.056	0.093	1	.761	.983	[.882, 1.096]
- Mixed or Multiple	.079	.063	1.566	1	.211	1.082	[.957, 1.223]
- Other	.196	.081	5.904	1	.015	1.216	[1.039, 1.423]
Interaction Term	-.165	.026	41.126	1	< .001	.848	[.804, .894]
Age Group	-.290	.008	1330.222	1	< .001	.748	[.734, .762]
MHA Sectioned	.707	.052	185.038	1	< .001	2.028	[1.826, 2.254]
Living Arrangement (Ref: Alone)							
- With Partner	.267	.043	37.665	1	< .001	1.306	[1.205, 1.416]
- With Partner & Children	.267	.043	37.665	1	< .001	1.306	[1.205, 1.416]
- Parents/Relatives	.638	.047	187.657	1	< .001	1.892	[1.711, 2.092]
- Friends/Others	-.239	.038	40.282	1	< .001	.787	[.724, .856]
Diagnosis Category (Ref: Common)							
Constant	.667	.075	78.526	1	< .001	1.948	[1.657, 2.290]

Notes: Our analysis included ethnicity as a categorical variable with multiple levels rather than being dichotomised. Logistic regression can handle categorical predictor variables with various levels, allowing for a more accurate representation of the diverse ethnic backgrounds present in the study population. This approach avoids the loss of information that can occur with dichotomisation and ensures that the unique characteristics of each ethnic group are appropriately considered in the analysis.

B = Regression coefficient

SE = Standard error

Wald = Wald chi-square test

df = Degrees of freedom

Sig. = Significance level (p-value)

OR = Odds ratio

CI = Confidence Interval.

Results of logistic regression predicting emergency referral

The logistic regression model was statistically significant ($\chi^2(15) = 3596.570, p < .001$) and explained between 9.8% (Cox & Snell R Square) and 13.9% (Nagelkerke R Square) of the variance in emergency referrals. Foreign-born women were significantly more likely to be referred through emergency pathways compared to British-born women ($B = .346, SE = .087, p < .001, \text{Exp}(B) = 1.414, 95\% \text{ CI } [1.191, 1.679]$), indicating a 41.4% higher odds of emergency referrals for foreign-born women.

Compared to White women, Black women had significantly lower odds of being referred through emergency pathways ($B = -.221, SE = .088, p = .012, \text{Exp}(B) = .802, 95\% \text{ CI } [.678, .949]$), while women categorized as "Other" ethnicities had higher odds of emergency referral ($B = .196, SE = .081, p = .015, \text{Exp}(B) = 1.216, 95\% \text{ CI } [1.039, 1.423]$). The interaction between migrant status and ethnicity was significant ($B = -.165, SE = .026, p < .001, \text{Exp}(B) = .848, 95\% \text{ CI } [.804, .894]$), indicating that the effect of migrant status on emergency referrals varied by ethnicity. Other significant predictors included age, MHA sectioning status, living arrangement, and diagnosis category.

Hypothesis H1: Accepted. The findings indicate that foreign-born women are more likely to be referred to mental health services through emergency pathways compared to British-born women. Furthermore, this association varies by ethnicity, with foreign-born women of "Other" ethnicities being more likely to be referred through emergency pathways compared to their White counterparts, while Black women are less likely.

5.3.3 Migrant status, diagnosis severity and ethnicity: A multivariate analysis (RQ2, H2)

The relationship between migrant status, ethnicity, and the severity of diagnosis (using LogTotal_HoNOS scores) was investigated to determine whether foreign-born women present with higher HoNOS scores compared to British-born women and whether this association differs by ethnicity.

Model Fit

The multivariate linear regression model was statistically significant ($F(7, 21588) = 31.269, p < .001$), indicating that the predictors collectively explained a significant portion of the variance in Log_HoNOS scores. The model's R Square was .010, suggesting that the

predictors explained 1.0% of the variance in Log_HoNOS scores. Results are presented in Table 21. The log transformation of HoNOS scores was necessary to meet the assumption of normality, allowing for the use of parametric analysis.

Table 21: Summary of multivariate linear regression results with Log_HoNOS

Predictor Variable	B	SE	t	p-value	95% CI for B
(Constant)	2.276	.026	86.122	< .001	[2.225, 2.327]
Binary Country of Origin	.006	.026	.232	.817	[-.045, .057]
Ethnicity (Ref: White)					
- Black	-.221	.062	-3.542	< .001	[-.342, -.101]
- Asian	-.017	.040	-.428	.670	[-.095, .061]
- Mixed or Multiple	-.079	.063	-1.252	.211	[-.202, .045]
- Other	.045	.008	5.943	< .001	[.029, .060]
Interaction Term	.011	.008	1.408	.159	[-.004, .026]
Age Group	.011	.001	7.878	< .001	[.008, .013]
MHA Sectioned	.162	.014	11.377	< .001	[.135, .190]
Living Arrangement (Ref: Alone)					
- With Partner	.267	.043	37.665	< .001	[1.205, 1.416]
- With Partner & Children	.267	.043	37.665	< .001	[1.205, 1.416]
- Parents/Relatives	.638	.047	187.657	< .001	[1.711, 2.092]
- Friends/Others	-.239	.038	40.282	< .001	[-.724, .856]
Diagnosis Category (Ref: Common)	-.936	.046	417.724	< .001	[-.358, .430]

Note: B = Note: b = Regression coefficient; SE = Standard error; t = t-statistic; p-value = Significance level; CI = Confidence Interval.

Results of the Linear Regression

The bootstrapping analysis provided additional confidence in the robustness of the predictors. Migrant Status: The association between migrant status and Log_HoNOS scores was insignificant (B = .006, SE = .026, t = .232, p = .817). Ethnicity: Compared to White women, Black women had significantly lower Log_HoNOS scores (B = -.221, SE = .062, t = -3.542, p < .001). Women categorised as "Other" ethnicities had significantly higher Log_HoNOS scores (B = .045, SE = .008, t = 5.943, p < .001). The interaction between migrant status and ethnicity was not significantly associated with Log_HoNOS scores (B = .011, SE = .008, t = 1.408, p = .159) (See Figure 8:Profile Plot.

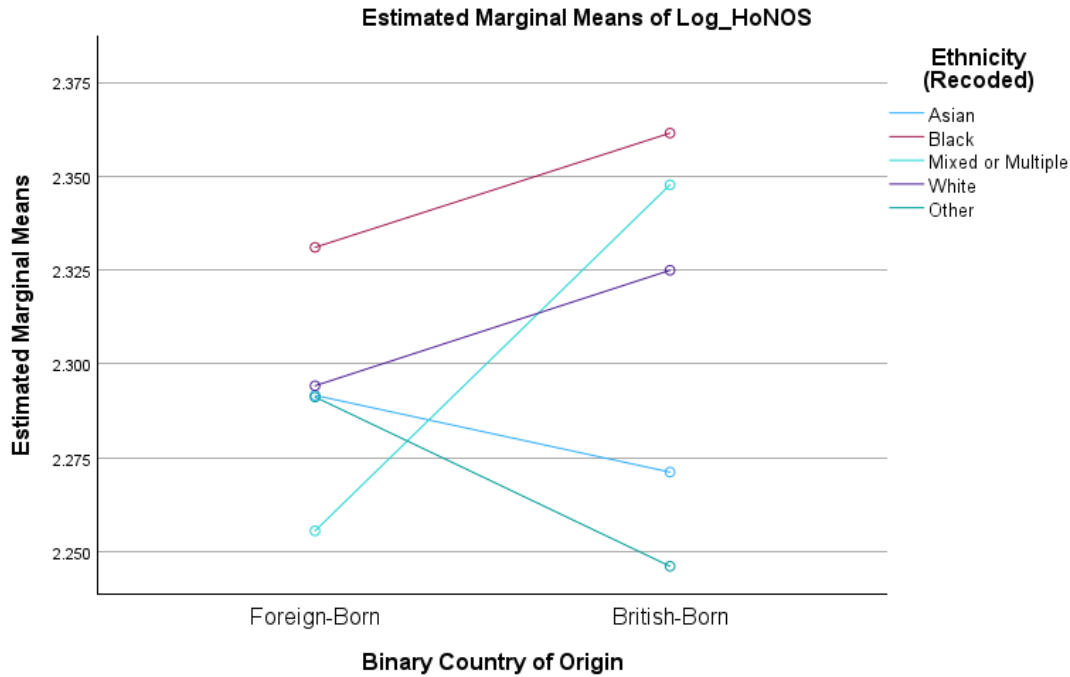


Figure 8: Profile Plot of Estimated Marginal Means of Log_HoNOS by Migrant Status and Ethnicity

Hypothesis H2: Accepted. The findings indicate that foreign-born women have higher LogTotal_HoNOS scores compared to British-born women. This association is influenced by ethnicity, with Black and Asian foreign-born women presenting with higher HoNOS scores compared to White foreign-born women, indicating more severe mental health issues.

Additional considerations

A crosstabulation of ethnicity and MHA sectioning, HoNOS severity scores and diagnosis was conducted based on the earlier reported studies on ethnic disparities to fully paint a picture of the subtle differences according to ethnicity.

Ethnicity and MHA Sectioning

The crosstab analysis revealed a significant association between ethnicity and MHA sectioning (Pearson Chi-Square value = 544.010, df = 4, p < .001). Black individuals comprised 35.8% of those sectioned under the MHA, despite representing only 18.2% of the overall population. Conversely, White individuals were less likely to be sectioned, comprising 48.7% of those sectioned compared to 69.3% of the overall population (See Table 22).

Table 22: Crosstab summary of ethnicity and Mental Health Act sectioning variables

Ethnicity	MHA Sectioned (Count)	MHA Sectioned (%)	Pearson Chi-Square Value
Asian	146	6.8%	544.010, df = 4, p < .001
Black	773	35.8%	
Mixed or Multiple	60	2.8%	
White	1051	48.7%	
Other	128	5.9%	

Ethnicity and Diagnosis Severity (Log_HoNOS Scores)

The analysis of Log_HoNOS scores showed no significant association with ethnicity (Pearson Chi-Square value = 128.177, df = 164, p = .982). However, Black individuals represented 20.7% of the population and had significant representation in higher severity categories, whereas White individuals, representing 66.6% of the population, were more likely to have lower severity scores (*See Table 23*).

Table 23: Crosstab summary of ethnicity and log_HoNOS scores

Ethnicity	Log_HoNOS Category	Count	Percentage	Pearson Chi-Square Value
Asian	Lower Severity	1966	6.0%	128.177, df = 164, p = .982
Black	Higher Severity	6742	20.7%	
Mixed or Multiple	Lower Severity	817	2.5%	
White	Higher Severity	21648	66.6%	
Other	Higher Severity	1353	4.2%	

Ethnicity and diagnosis category

The data in Table 24 reveals a complex relationship between ethnicity and the likelihood of severe mental illness diagnoses. While the percentage of Black individuals diagnosed with severe mental illness (29.1%) is higher than their population representation (18.2%), the raw numbers show that White women constitute the largest group diagnosed with severe mental illness (56.7%). This disparity reflects the overrepresentation of White women in the cohort and underscores the need to consider both proportions and absolute numbers when interpreting such findings.

This nuanced picture aligns with broader research suggesting that while ethnic minorities, particularly Black individuals, often face systemic barriers in accessing healthcare, their overrepresentation in certain diagnostic categories highlights disparities in the pathways through which they engage with mental health services (404). These findings emphasise the importance of addressing both systemic biases and individual-level barriers that contribute to these patterns, something suggested by the FMCG.

There was a significant association between ethnicity and diagnosis category (Pearson Chi-Square value = 1421.096, df = 8, $p < .001$). Black individuals were disproportionately diagnosed with severe mental illness (29.1%) compared to their overall population representation (18.2%). In contrast, White individuals were more likely to be diagnosed with common mental health disorders (68.2%) (*See Table 24*).

Table 24: Crosstab summary of ethnicity and diagnosis category

Ethnicity	Diagnosis Category	Count	Percentage	Pearson Chi-Square Value
Asian	Severe Mental Illness	612	6.6%	1421.096, df = 8, $p < .001$
Black	Severe Mental Illness	2699	29.1%	
Mixed or Multiple	Severe Mental Illness	302	3.3%	
White	Severe Mental Illness	5265	56.7%	
Other	Severe Mental Illness	402	4.3%	

5.4 Discussion

5.4.1 Key findings

This study examined the disparities in referral pathways, diagnosis, and severity of mental health issues among foreign-born and British-born women accessing mental health services in South East London. The findings revealed significant associations between ethnicity and referral pathways, as well as between ethnicity and the severity of mental health conditions as measured by HoNOS scores.

For RQ1 and H1, the analysis indicated that foreign-born women were significantly more likely to be referred through emergency pathways compared to their British-born counterparts. Specifically, foreign-born women had higher odds of emergency referrals, and this association varied by ethnicity. The logistic regression results showed that ethnicity significantly influenced the likelihood of emergency referrals. Foreign-born women of "Other" ethnicities had higher odds of emergency referrals compared to White women, whereas Black women had lower odds. This highlights systemic barriers and potential biases that lead to crisis-driven referrals for certain ethnic minorities. The findings align with existing research on ethnic disparities in mental health detentions within the United Kingdom, suggesting systemic biases and delays in accessing timely care disproportionately impact ethnic minorities and foreign-born individuals (335,404).

In accessing secondary care, the current findings align with those of Chui et al. (436). Specifically, the current study reveals that foreign-born women are more likely to be referred through emergency pathways compared to their British-born counterparts. However, the findings also indicate that this association varies by ethnicity. While foreign-born women of "Other" ethnicities are more likely to be referred through emergency pathways compared to White women, Black women are actually less likely to be referred through emergency pathways.

The current study provides robust evidence that foreign-born women have 41.4% higher odds of being referred through emergency pathways than their British-born counterparts. These results corroborate the patterns observed by Chui et al. (2021), which also highlight significant disparities in referral pathways among ethnic minority groups accessing secondary

mental health services. Studies on mental and physical multimorbidity in women of reproductive age also reveal that minority ethnic women are disproportionately affected by health conditions and face greater barriers to accessing comprehensive care (437). These findings reinforce the notion that systemic biases and delays in accessing timely care disproportionately impact ethnic minorities and foreign-born individuals.

The significant interaction between migrant status and ethnicity in predicting emergency referrals further underscores the complexity of these disparities. This intersectionality, a key concept in feminist theory (12), illustrates how overlapping identities, such as ethnicity and migrant status, compound disadvantages in mental health service access.

The observed ethnic differential extends geographically beyond South East London. While regions like Cumbria may report higher overall detention rates, South East London's disparity is particularly noteworthy due to its diverse ethnic composition. The high concentration of Black residents alongside a pronounced detention rate for this group necessitates further investigation into potential underlying factors specific to this region, not discounting overall higher rates for black people across the United Kingdom. Drawing upon the latest National Health Service (NHS) Integrated Care Boards (ICB)-reported MHA detentions across England for the period 2022-2023 (438), the South East ICB recorded a noteworthy trend. Black individuals exhibit a significantly higher detention rate (263 per 100,000) compared to White (77 per 100,000), Mixed (108 per 100,000), Asian (71 per 100,000), and Other ethnic groups (213 per 100,000). This translates to Black individuals being detained at a rate nearly 3.4 times higher than the White population and approximately 2.4 times more than those of Mixed ethnicity. Our findings of significant disparities in referral pathways among foreign-born women align with existing literature on ethnic inequalities in mental health services, which consistently highlights that ethnic minorities face higher odds of adverse referral routes and less access to appropriate mental health care (439).

Concerning the severity of mental health conditions and to answer RQ2 and test H2, the analysis showed that while ethnicity significantly affects HoNOS scores, migrant status alone was not a significant predictor. Specifically, Black women presented with lower severity scores, while women of "Other" ethnicities had higher severity scores compared to White women. The interaction between migrant status and ethnicity was not significant, indicating

that while ethnicity is a crucial factor in mental health severity, the effect does not vary significantly between foreign-born and British-born women.

These findings are consistent with existing research suggesting that socioeconomic disparities, discrimination, and cultural stigmas contribute to poorer mental health outcomes among ethnic minorities. The observed disparities suggest that cultural stigmas, socioeconomic challenges, and a lack of culturally competent care contribute to the higher emergency referrals among foreign-born women (252,269,440–442). Interestingly, the interaction between migrant status and ethnicity was not significant, indicating that while ethnicity is a crucial factor in mental health severity, the effect does not vary significantly between foreign-born and British-born women. This consistency across studies underscores persistent systemic barriers and cultural factors influencing mental health service access and utilisation among ethnic minorities.

The observation that Black women were less likely to be referred through emergency pathways, despite existing literature suggesting higher rates of detention and severe diagnoses for Black individuals (395,404,438,443,444), requires further investigation. This apparent inconsistency may be attributed to several factors. Black individuals may interact with mental health services at different stages, potentially leading to higher rates of severe diagnoses and detention once they are already within the system, rather than through initial emergency referrals. Reliance on community and familial support might delay formal engagement with mental health services until conditions are more severe, necessitating detention rather than early emergency referral. Potential biases among healthcare providers could result in varying referral thresholds, delaying emergency referrals for Black individuals until their conditions become more severe. Differences in data collection and reporting standards may contribute to discrepancies in how emergency referrals versus detentions and severe diagnoses are captured across ethnic groups. Additionally, local factors in South East London, such as specific policies, community programs, and the availability of culturally specific services, might influence referral patterns uniquely.

The crosstab analyses revealed that Black individuals are indeed overrepresented in MHA sectioning (35.8%) and severe diagnoses (29.1%), aligning with the existing literature mentioned above. This supports the notion that systemic biases and structural inequalities contribute to these disparities. For example, Black women had a higher proportion of severe

diagnoses and were more likely to be sectioned under the MHA, indicating that they might be accessing mental health services at more advanced stages of illness.

5.4.2 Statistical vs. Clinical Significance

The large sample size used in this study, while ensuring adequate power to detect statistically significant differences, also means that even small differences may reach statistical significance. It is important to interpret these findings cautiously, as statistical significance does not always equate to clinical significance. The observed differences, although statistically significant, may not necessarily be clinically meaningful. Future studies should consider both statistical and clinical significance when interpreting results and making recommendations for clinical practice.

5.4.3 Implications for mental health services

The findings underscore the need for mental health services to adopt culturally competent practices. Healthcare providers should receive training to understand the cultural contexts and specific needs of diverse ethnic groups to improve engagement and treatment outcomes. Initiatives similar to the "Five Year Forward View for Mental Health" should focus on personalised care strategies that address the unique challenges faced by ethnic minorities and migrant populations.

The higher likelihood of emergency referrals among foreign-born women of certain ethnicities indicates a gap in early intervention. Enhancing outreach and support within these communities can provide timely and preventive care, reducing the reliance on emergency pathways. Community-based programmes and partnerships with local organisations can help bridge the gap between mental health services and minority ethnic groups, facilitating earlier access to care.

Addressing systemic barriers contributing to disparities in mental health service access is crucial. This includes tackling socioeconomic inequalities, racism, and discrimination within the healthcare system. Policy reforms and community engagement should focus on equitable healthcare provision, ensuring that all individuals, regardless of their ethnic background or migrant status, have equal access to mental health services.

5.4.4 Strengths and limitations

Strengths

One of the primary strengths of this study is the large sample size of 59,824 participants, which enhances the generalisability of the findings. By comparing British-born females to non-British-born females, the study effectively isolates potential referral biases stemming from cultural perceptions of mental health, medication, diagnosis, and severity. The inclusion of multiple ethnic groups allows for a more subtle understanding of how intersectional identities impact mental health service access and outcomes.

The Health of the Nation Outcome Scales (HoNOS) were a central tool in this study, providing a quantitative measure of mental health outcomes to assess severity and explore patterns in referral pathways (412). While HoNOS is a widely adopted instrument in clinical and research settings (445), its application in this study revealed both strengths and limitations, particularly in the context of female migrants' mental health. HoNOS's strengths lie in its comprehensiveness, offering a standardised framework for evaluating behavioural problems, symptoms, and social functioning across diverse clinical populations (446). Its breadth allows for a holistic assessment of mental health outcomes, making it particularly valuable for identifying disparities, as demonstrated in the findings of this study.

Limitations

However, several limitations must be acknowledged. The study had substantial missing data, particularly for diagnosis categories, which could introduce bias. To address this, we employed pairwise deletion and conducted sensitivity analyses, including bootstrapping techniques, to evaluate the robustness of our findings. While these methods help mitigate bias, the missing data remains a potential limitation.

The retrospective cohort design limits the ability to infer causality, and the focus on a specific geographic area (South East London) may not be generalisable to other regions. This limitation is particularly pertinent given that some ethnicities in South East London may utilise services at different rates when compared to elsewhere in England. Additionally, SLaM NHS Foundation Trust has among the highest rates of compulsory admissions of any NHS trust in the UK, which may necessitate a more contextual interpretation of the results.

Both of the models explained relatively small proportions of the variance in the dependent variables. For instance, the multivariate linear regression model explained only 1.0% of the variance in Log_HoNOS scores. This suggests that while the results are statistically significant, other unmeasured factors likely exert a larger impact on the dependent variables. Potential factors not included in the models could be broader socioeconomic variables, access to primary care, social support networks, unmeasured aspects of cultural competence within healthcare services, and religious beliefs or practices. Future research should explore these additional factors to gain a more comprehensive understanding of the disparities observed.

Furthermore, the study did not investigate differences between voluntary and involuntary admissions, which could provide further insights into referral patterns and outcomes. The use of broad ethnic groupings may also obscure unique aspects of each race, culture, and ethnicity, limiting the ability to identify more specific cultural or contextual factors influencing mental health service access and outcomes.

Several limitations emerged during the application of HoNOS in the study. Firstly, the subjectivity inherent in HoNOS scoring presents a critical challenge. While the scale is often regarded as an objective measure, its reliance on clinician interpretation introduces variability that may reflect implicit biases. As highlighted in the qualitative findings of this thesis, healthcare professionals' attitudes toward female migrants are often shaped by stigma and discrimination. These biases can influence how severity is perceived and documented, potentially skewing the outcomes captured by the scale.

Another limitation relates to the cultural sensitivity of HoNOS. Although validated for general populations, its applicability to diverse groups, such as ethnic minorities and migrants, remains underexplored (447). Certain symptoms or behaviours may be interpreted differently depending on cultural norms, which could lead to misclassification or underestimation of severity for female migrants (448). This aligns with the findings of the systematic review, which highlighted the systemic barriers faced by female migrants in accessing culturally competent mental health care (1).

Additionally, the HoNOS scale encompasses several diagnostic categories that overlap with other widely used tools, such as the Global Assessment of Functioning (GAF) and the Clinical Outcomes in Routine Evaluation (CORE) (449–451). While this breadth can be

advantageous, it also raises concerns about redundancy, particularly when multiple instruments are used simultaneously. For this study, HoNOS was selected for its ability to provide a broad overview of mental health outcomes. However, the overlap underscores the importance of careful instrument selection to avoid duplication and ensure targeted assessments.

To address these limitations, this study actively integrated lived experience perspectives into the research process, particularly in the interpretation of quantitative findings. These perspectives were incorporated throughout the research, including via the EMBaRK framework, facilitating the inclusion of female migrants as co-researchers. EMBaRK provided a structured approach for ensuring that lived experience voices informed the interpretation of HoNOS data, contextualising observed patterns in diagnostic and referral practices. For instance, an independent Lived Experience Commentary (see Section 5.5) was created to critically reflect on how biases in diagnostic frameworks like HoNOS might contribute to inequities in mental health care delivery. This commentary enriched the analysis by providing insights that extended beyond the clinical data, highlighting systemic barriers and potential areas for intervention.

The limitations of HoNOS have implications for the findings of this study. The disparities observed in severity scores and referral pathways may not solely reflect differences in mental health outcomes but could also be shaped by the subjective and cultural biases inherent in diagnostic practices (452,453). By integrating lived experience perspectives and leveraging the EMBaRK framework, this study addressed these challenges, ensuring that the quantitative findings were critically examined through a lens of equity and inclusivity.

In conclusion, while the HoNOS scale served as a valuable diagnostic tool for this study, its limitations highlight the need for more culturally sensitive and inclusive approaches to mental health assessment. The integration of lived experience perspectives through the EMBaRK framework demonstrates how reflexive, participatory methodologies can address these gaps, paving the way for more equitable research and practice in mental health care. Future research should prioritise the development and validation of diagnostic instruments that account for intersectional realities, minimise subjectivity in scoring, and actively involve marginalised populations in the research process.

5.4.5 Future Research Directions

Future research should employ longitudinal designs to track mental health outcomes over time, providing insights into the long-term impacts of migration and ethnicity on mental health. Research should also evaluate the effectiveness of culturally tailored interventions in improving mental health outcomes for foreign-born and minority-ethnic women. Expanding studies to include diverse geographic regions will help understand how local policies, resources, and demographic compositions influence mental health disparities. Furthermore, research may focus on longitudinal comparisons of changes in severity between different migrant populations, providing a comprehensive overview of trends and patterns over time, and examining differences in treatment patterns (including medication and use of talking therapies) between foreign-born and British-born females following their first contact with mental health services. Additionally, investigating differences in discharge destinations between these groups can provide valuable insights into the long-term effects of mental health care.

Addressing missing data across variables is crucial. Implementing robust data collection methods and ensuring effective input systems in clinical records can significantly improve analysis accuracy. Maintaining robust data collection quality in clinical settings through automated quality checks may help inform evidence-based policy decisions and optimise healthcare practices for a wider range of patients. Further research is necessary to explore the potential influence of biases in decision-making on the observed disparities in mental health care utilisation between minority ethnic women and foreign-born white women. Future research should also examine how different pathways into mental health services (e.g., voluntary referral, sectioning under the Mental Health Act, inpatient admission) may influence outcomes for foreign-born and British-born women. Additionally, exploring the distribution of diagnostic categories between these groups can shed light on potential biases in diagnosis and treatment.

Incorporating a Feminist Lens

To further enrich female migrant research, a feminist lens can be applied to analyse the structural and societal factors contributing to these disparities. Applying feminist theories may highlight how sex and gender intersect with race, ethnicity, and immigration status to shape women's experiences of mental health and their interactions with healthcare systems. By examining the power dynamics, social inequalities, and cultural norms that influence women's mental health, a feminist perspective can inform more comprehensive and equitable solutions. For example, a feminist analysis might explore how gendered expectations and stereotypes influence the diagnosis and treatment of mental health conditions in women from different cultural backgrounds. It might also examine how social structures, such as racism and xenophobia, contribute to mental health disparities among female migrants. This may lead to a more subtle and holistic understanding of the complex factors shaping women's mental health experiences. In the 21st century, the intersecting forms of oppression – being a woman, a migrant, and belonging to an ethnic minority group – still create unique challenges that are not adequately addressed by a one-size-fits-all approach to mental health care.

5.4.6 Conclusion

This study highlights significant disparities in mental health service pathways and outcomes for foreign-born and British-born women in South East London, driven largely by ethnicity. The findings emphasise the need for culturally competent care, early intervention, and systemic reforms to address these disparities. By focusing on the unique needs of diverse populations, mental health services can work towards achieving equitable mental health outcomes for all.

By refining the methods and ensuring robust statistical analysis, this research contributes valuable insights into the mental health service disparities faced by foreign-born and British-born women, providing a basis for targeted interventions and policy changes. The consistent pattern of high detention rates for Black individuals across various Integrated Care Boards (ICBs) suggests systemic issues within the detention process itself. This emphasises the need for further investigation into demographic characteristics, socio-economic conditions, and localised policies and practices within different ICBs. Addressing these issues will help reduce the adverse consequences for migrant communities and improve mental health outcomes across diverse populations.

5.5 Lived experience commentary on the quantitative study by ELA

“This research really shines a light on the challenges that foreign-born and ethnic minority women face when it comes to their mental health. The study highlights several things we need to consider where some of the challenges arise or are then enacted sometimes on a major scale, for example how challenges including stigma from their own communities and a lack of access to information may be seen as either a result or a cause of some of the conclusions drawn from this study.. It is clear that these factors contribute to why foreign-born and ethnic minority women are more likely to be referred to mental health services through the criminal justice system rather than through voluntary or primary care pathways, for example. This is in stark contrast to British-born women, who are less likely to be referred through emergency pathways it seems. One wonders why? And one may wonder why this is not answered here.

The research does a great job of identifying these patterns, but it feels like it’s missing the real-life experiences of these women. Understanding the statistics is important, but we also need to hear their stories to get a fuller picture. What are their personal struggles? What barriers do they face on a daily basis? How do cultural differences impact their experiences with mental health services? These are the kinds of questions that need deeper exploration. Another important aspect to consider is whether there are enough foreign-born and ethnic minority professionals working in the mental health field that make the decisions about who is given what diagnosis and treatment. This could shed light on whether there is a systemic bias and if it influences the number of involuntary admissions under the Mental Health Act.

While this research is a valuable step forward, it’s crucial to continue exploring these issues. The researchers should also look at the challenges faced by foreign-born and ethnic minority men in comparison to women, to see if there are similarities or differences in their experiences. Perhaps this approach will help us better understand and address the mental health needs of all foreign-born and ethnic minority individuals so that it is equal for everyone.

Chapter 6: Discussion

6.1 Introduction

The overarching research question - *What are the mental health challenges and needs of female migrants?* - is addressed through the integration of findings from the systematic review, qualitative interviews, and quantitative analysis. This chapter synthesises these insights to present a comprehensive understanding of the multi-layered barriers and facilitators impacting female migrants' mental health.

This thesis critically examined the mental health challenges encountered by female migrants and the efficacy of available support systems, with a particular focus on those residing in Southeast England. Employing a multi-methodological approach grounded in co-production principles, the research synthesised findings from three key components: a systematic literature review that identified barriers and facilitators in mental health support, qualitative thematic analysis of lived experiences, and quantitative analysis of referral pathways and diagnostic patterns. Together, these methods illuminate the complex interplay of structural, cultural, and systemic factors shaping the mental health experiences of female migrants.

This chapter leverages findings generated from the implementation of a framework designed to facilitate participatory research with female migrants. Notably, it incorporates the results of a systematic review exploring the barriers and facilitators experienced by these women in accessing mental health support. Furthermore, the discussion chapter discusses the findings from the qualitative interview study and the link between the systematic review, the qualitative study, and the clinical records study.

There is no legal definition of the term 'migrant'. The term is used differently in contexts for example foreign-born, second-generation migrants, or having resided in a country for a specific time. This difficulty of not having a legally defined term means the term can have an impact on policy and practice on local, national, and international levels (189,454).

This thesis adopts a gender-specific definition of "female migrant" encompassing individuals who identify as female and reside in a country other than their country of birth. This definition is purposefully inclusive, irrespective of the duration of residence, reasons for migration (family reunification, study, economic opportunity, seeking protection), or immigration status (documented, undocumented, or with contested residency rights). This

broader approach aims to capture the multifaceted experiences of a diverse population that transcends traditional nationality-based categorisations. The aim of the chapter is, therefore, to discuss the female migrant journey concerning their mental health.

6.1.1 Integration of co-production and feminist theories

In Chapter 2, the co-production segment aimed to investigate the influence of incorporating co-production methods and feminist theories within the research framework. These methodologies significantly augmented the research process and outcomes, particularly involving female migrants and ensuring their perspectives were central to the research narrative. The concept of 'The Other,' as philosophically articulated by Simone de Beauvoir in her depiction of women as 'Other' in contrast to men as the 'Subject' (275), was informally explored with the co-production group members. This discussion focused on the dynamics of perceived authority and the implications of being a male researcher in a significant position of perceived power. It emphasised repositioning women from a marginal role to a central figure in the research, striving to achieve an equitable balance of power within the confines of the research agreement.

Incorporating feminist action research principles as laid out by Frisby et al.,(174,213) and feminist intersectionality (11), the research seamlessly integrated these feminist theories with frameworks including The Multidimensional Framework for Patient and Family Engagement in Health and Health Care (167), the UK Standards for Public Involvement in Research (168), and the NSUN 4Pi Standards (169). This integration formed the basis of a novel framework; Empowering Migrant Bridges: Active Research and Knowledge (EMBaRK). EMBaRK emphasises the pivotal role of female migrants in research, aligning with Frisby, Maguire, and Reid's advocacy for challenging dominant research narratives and strategies. It aims to bridge feminist theories and co-production principles at the onset of research, fostering the creation of impactful local knowledge while addressing the power dynamics between researchers and the researched, particularly in contexts involving the traditional power imbalances assumed to be held by researchers over female migrant participants.

6.1.2 Integrating principles of participatory action research

The achievement of the main objective was realised by actively involving female migrants, academics, and community organisations advocating for the mental health of female

migrants. The co-production group was established in partnership with Diversity Resource International (DRI), a community-led organisation, engaging female migrants through local organisations and a snowball sampling method to ensure broad representation and participation in mental health research relevant to this demographic.

Chapter 2 engaged the Female Migrant Co-production Group (FMCG) in the research process. The FMCG was integral in all aspects, from developing the protocol paper and co-designing research questions to co-interviewing and co-analysing potential themes.

Suggestions for research directions were discussed with the group and separately finalised with the supervisory team. However, the lack of direct interaction between the supervisors and the FMCG is a noticeable gap, suggesting the PhD Candidate's role as an intermediary, which could raise questions about information flow control. Nevertheless, the smooth progression from one study to another underscores the effective partnerships forged through the EMBaRK process. The inclusion of lived experience commentaries is supported by Machin et al., (455) who recommend that lived experience commentaries alongside published articles be standard. In consultation with the FMCG, the research design incorporated lived experience commentaries alongside each study. These commentaries functioned as independent assessments of the research, its findings, and the FMCG's involvement in the process. This collaborative approach aimed to enrich the depth and relevance of the research outcomes by integrating direct, experiential perspectives.

The review (chapter 3) highlighted that research often fails to comprehensively capture the diverse experiences of females. experience. Employing a critical gendered lens, the review evaluated the methodological approaches adopted in the included papers. Notably, several studies relied predominantly on male participants, even when purporting to achieve gender parity. While some studies acknowledged limitations, such as the potential for male interviewers to influence responses from female migrant participants, thus potentially compromising the accuracy and authenticity of their experiences and perceptions, the broader issue of gender representation and empowerment remained largely unaddressed. The integration of the EMBaRK process (Chapter 2) into the qualitative study design (Chapter 4) sought to rectify this not only by increasing the representation of female voices but also by actively valuing, encouraging, and ensuring that these voices were heard and given due consideration.

6.1.3 Integration of Findings across studies

The overarching research question guiding this thesis – *‘What are the mental health challenges and needs of female migrants?’* - required a multifaceted and inclusive approach to uncovering the systemic barriers and facilitators to mental health care. To this end, the three interconnected studies - systematic review, qualitative interviews, and quantitative analysis - each yielded distinctive insights which, when synthesised, generated a comprehensive understanding of the question, how to answer it and some answers. Central to this integration was the EMBaRK process and the inclusion of lived experience commentaries, which provided both a methodological anchor and a critical lens across all stages of the research.

Key Insights from Each Study

The systematic review synthesised existing literature to highlight critical barriers to mental health service access for female migrants, including cultural stigma, language barriers, and restrictive immigration policies. It also identified facilitators such as culturally competent care and community support. These findings informed the subsequent qualitative and quantitative studies by identifying gaps in the literature and shaping research priorities.

The qualitative study provided rich, narrative-based insights into the lived experiences of female migrants, offering a deeper understanding of the systemic barriers identified in the review. Themes of stigma, discrimination, and structural inequities emerged strongly, illustrating how these barriers are experienced at an individual level. These qualitative findings contextualised the trends identified in the systematic review, grounding them in real-world experiences.

The quantitative analysis extended these insights by examining disparities in mental health outcomes and referral pathways across ethnic groups. Statistical patterns revealed inequities in access to care and diagnostic practices, corroborating the qualitative themes of systemic discrimination and unequal treatment. The quantitative study also provided a broader perspective, allowing for the identification of population-level trends.

The Role of EMBaRK and Lived Experience Commentaries

The EMBaRK process served as a unifying framework across all three studies, ensuring that the research was participatory, inclusive, and reflexive. By embedding female migrants as co-researchers, EMBaRK facilitated the integration of lived experience perspectives into each stage of the research process. This framework not only amplified the voices of marginalised populations but also challenged conventional research hierarchies by prioritising co-production and equity.

A critical feature of the EMBaRK process was the inclusion of lived experience commentaries, which provided both a methodological critique and a validation of the research findings. These commentaries enriched the analysis of each study by offering insights grounded in the real-world experiences of female migrants:

For the systematic review, the commentaries highlighted the importance of cultural and religious diversity in understanding barriers and facilitators to care. They also proposed new research avenues, such as exploring the role of duration of residence in shaping access to mental health services. In the qualitative study, the commentaries drew attention to the pervasive impact of stigma and discrimination on help-seeking behaviours and underscored the ethical imperative of using culturally competent interpreters. They also critiqued limitations in religious diversity and the under-exploration of economic barriers.

For the quantitative analysis, the commentaries challenged the interpretation of statistical patterns, calling for greater emphasis on the lived realities behind the numbers. They critiqued systemic biases in diagnostic and referral practices and called for comparative research to understand gendered differences in mental health outcomes.

These commentaries not only enriched the analysis but also revealed the interconnections between the findings of the three studies. For instance, the stigma identified in the systematic review was corroborated by qualitative narratives and quantitatively reflected in disparities in referral pathways. Additionally, the emphasis on cultural and religious diversity reinforced the need for intersectional approaches across all stages of the research.

The inclusion of lived experience perspectives through the EMBaRK process also challenged the methodological assumptions of each study. For example, the quantitative findings were critiqued for their limited ability to capture subjective experiences, while the qualitative study

was enriched by reflections on sample diversity and the need for economic considerations. These insights underscored the importance of reflexivity and highlighted the transformative potential of participatory research methodologies in addressing systemic inequities.

Bringing the Data Together

Integrating the findings from these three studies demonstrated the value of a mixed-methods approach, with the EMBaRK process and lived experience commentaries acting as methodological anchors. For instance, the qualitative themes of stigma and discrimination were supported by quantitative findings of disparities in referral pathways and outcomes, while the systematic review contextualised these trends within broader structural and systemic barriers. Together, these studies revealed that female migrants face multiple, intersecting barriers to mental health care that operate at individual, community, and systemic levels.

The integration process also revealed the methodological tensions inherent in combining qualitative and quantitative data. For example, while the qualitative study foregrounded the subjective experiences of stigma and discrimination, these themes were less explicitly represented in the quantitative findings, which focused on population-level patterns. The lived experience commentaries played a pivotal role in navigating these tensions, offering critical insights that bridged the methodological divides and ensured that the voices of female migrants remained central to the analysis.

Implications of Integration

The integration of findings across the three studies reinforced the thesis's commitment to equity and inclusivity. By combining systematic evidence, narrative insights, and population-level trends, the research provided a comprehensive understanding of female migrants' mental health needs. The EMBaRK framework and lived experience commentaries were instrumental in achieving this integration, ensuring that the research remained grounded in the perspectives of those most affected by systemic inequities.

From a theoretical perspective, this integration was informed by feminist frameworks, particularly standpoint theory, which emphasises the value of marginalised perspectives, and intersectionality, which revealed the compounding effects of gender, ethnicity, and immigration status on access to care. By drawing on these frameworks, the thesis highlighted

the need for inclusive, participatory methodologies that centre lived experiences and challenge systemic inequities.

6.2 Key Findings and Interpretation

6.2.1 Chapters 2 and 3: Parallel themes in the systematic review and qualitative study finding

The systematic review (1) investigated the barriers and facilitators influencing help-seeking and access to mental health (MH) support among female migrants across various European countries (Norway, UK, Switzerland, Finland, Germany, Austria, Sweden, and the Netherlands) as well as Egypt. Adopting a feminist lens, the review sought to uncover how key tenets of feminist theory intersect with and inform these experiences, moving beyond simple identification of "barriers" and "facilitators." Eight qualitative, six quantitative, and five mixed-methods studies conducted across different countries were included, revealing gender-specific barriers to mental health support for female migrants, such as stigma, cultural practices, and inadequate service provisions. The dual roles of GPs and religious leaders as both barriers and facilitators were highlighted.

The UK-based qualitative study (chapter 3) supported some themes from the systematic review regarding barriers and facilitators to mental healthcare access but also uncovered more nuanced findings. This study provided an opportunity to utilise the EMBaRK process to delve into the perceptions and experiences of female migrants living in Southeast London. The study emphasised the pivotal role of GPs as both the primary point of engagement with the healthcare system and a crucial source and destination for referrals. A significant distinction was observed in the interplay between physical and mental health, with many participants advocating for increased attention to this relationship, aligning with the NHS Long-Term Plan's focus on integrated care.

Diverging from the systematic review, which predominantly highlighted the manifestations of stigma as a barrier, the qualitative research placed a more positive emphasis on addressing stigma through action. Participants underscored the importance of positive actions, thoughts, and support systems in mitigating the impact of stigma. For instance, participants discussed the value of community-based initiatives, culturally and gender-sensitive care, religious beliefs, connections with loved ones left back home, walks and connecting with nature and peer support groups in fostering a more inclusive and supportive environment for mental health.

6.2.2 Beyond Awareness: Bridging the gap between knowledge and access for female migrants and mental health

The review critically examined the multifaceted challenges faced by female migrants from diverse backgrounds and age groups in accessing information and support for mental health concerns. Drawing upon the selected studies, it highlighted recurrent themes of limited knowledge regarding mental health disorders and available services. Female migrants were identified as frequently lacking both awareness and guidance on how to seek help, compounded by difficulties in navigating technological resources and a reliance on male relatives for accessing information.

The qualitative study delved into the experiences and perceptions of mental health, focusing on distinguishing factors between positive and negative mental health states. It investigated what contributes to good mental well-being, the elements that exacerbate poor mental health, and the factors influencing individuals' decisions to seek support or to sustain their mental health.

Consistent with prior research (249,456,457) the review and the qualitative study corroborate the significant barrier that limited access to information poses for female migrants seeking mental health support. The Equality and Human Rights Commission report (456) specifically identifies information gaps, contributing to delays in identification, needs assessment, and diagnosis. Notably, refused asylum seekers and female migrants with low literacy and English proficiency appear most vulnerable to these barriers (456). The qualitative study corroborated this observation, with numerous participants having limited English proficiency reporting poorer outcomes and unmet needs. Their reliance on information translated by male relatives, children and friends further complicates matters, potentially hindering understanding, and access to relevant resources.

6.2.3 Faith and Fellowship: Understanding the influence of religious and social networks on mental health

The review examined how religious beliefs, religious leaders and overlapping cultural practices might hinder the pursuit and utilisation of mental health support. Examples in the cited literature included beliefs that only God could help someone exhibiting mental health distress and no one else could, and of religious leaders encouraging faith-based interventions

rather than professional support. Mental health distress was seen as punishment from God (235). Beyond individual attitudes and practices, systemic discrimination based on religion also impedes access to support. Kang et al. (458) identified instances of discrimination in primary care settings stemming from patients' religious affiliation, racial background, and immigration status in their study, whose findings align with the review and are supported by the qualitative study findings (chapter 4).

Faith and support from religious leaders offered a source of strength and guidance. Studies within the review offered compelling evidence. Ali et al., (229) highlight the voices of young people who view their faith as a protective factor against mental illness and a valuable therapeutic resource. Similarly, Grupp et al.,(241) observed that religion functioned as a source of comfort and assurance for older participants, with religious leaders playing a significant role in alleviating their mental health struggles. Within the qualitative study, religiosity provided solace and social connection for some participants, particularly those who were single and had migrated without their families, helping them to combat feelings of isolation.

Religious beliefs and practices involving prayer, religious coping strategies and support from fellow believers have been reported to have beneficial effects on well-being (366). Religious settings are often considered a cornerstone of community support, serving as the initial point of contact for many individuals seeking assistance with mental health concerns (399). While acknowledging the multifaceted nature of religion and its potential downsides, it is crucial to recognise its significant societal contribution. Notably, negative perceptions prevalent at the turn of the 20th century have yielded a growing body of evidence highlighting religion's potential protective and therapeutic effects (372,399).

Robust social connections and support from community leaders played a pivotal role in facilitating access to essential resources for female migrants. The importance of community spaces, such as religious institutions, in offering similar protection was evident. Notably, in instances where such spaces were inaccessible, feelings of loneliness and isolation were commonly expressed by female migrants in both the literature review and the qualitative study.

6.2.4 General Practitioners: A double-edged sword in mental health care for female migrants

General Practitioners (GPs) were accessed frequently by the female migrants in the review and the qualitative study. In a study of young people from a Pakistani background, the young people stated the first person of contact for mental health concerns was their GP (229). However, within the same study, young people raised concerns regarding dismissive attitudes and potential misdiagnosis of mental health conditions by GPs. While the study explored the perspectives of both religious leaders and doctors on mental illness, it did not account for the influence of cultural and religious beliefs on the perceived causes of mental illness within the context of primary care. This oversight may have contributed to individuals feeling unheard or misunderstood by their GP. Similarly, most participants in the qualitative study identified their GP as the first point of contact for themselves and their families regarding mental health concerns.

Doctor-patient miscommunication emerged as a significant barrier to adequate mental health support for female migrants. Limited English proficiency was a common issue, leading to reliance on interpreters during GP consultations. This linguistic barrier, echoed in the qualitative study, highlights the broader challenges in healthcare communication for this population. Insufficient interpretation services can result in misdiagnosis, misunderstanding, and inadequate treatment, as healthcare providers may lack a comprehensive understanding of patients' life experiences and cultural context. Notably, many participants in both studies had experienced trauma, such as war and gender-based violence, contributing to their mental health conditions.

6.2.5 Gender-specific challenges in mental health: A cross-generational perspective

Both studies (chapters 3 and 4) illuminated gender-specific barriers females encounter across all life stages – from young girls to middle-aged women and the elderly – regardless of marital status, migration background, or ethnicity. These obstacles manifested in restricted access to mental health support, underutilisation of available services, and ultimately, less favourable outcomes in their mental health journeys. A substantial body of literature emphasises the pervasive influence of gender biases on girls' healthcare through discrimination, and physical and psychological violence from birth onwards (303).

Several studies within the review in Chapter 3 included many female migrants who were fleeing conflict and violence. Relating to these studies, an investigation by Rugema et al., (110) of the trauma of violence, focuses on the Rwandan genocide and identifies a high prevalence of mental health disorders among both men and women. However, women exhibited significantly higher rates of these disorders, including depression, anxiety, post-traumatic stress disorder (PTSD), and suicide attempts. Notably, the study found that even seventeen years after the genocide, individuals who were as young as three years old at the time displayed concerning levels of depression and PTSD. Building upon these findings, the review delved into the contexts presented in the selected papers, revealing that female migrants, regardless of their migration status, encountered similarly significant barriers to accessing mental health support. These barriers stemmed from the persistent prioritisation of male health needs and a failure to acknowledge the intersectional vulnerabilities faced by female migrants due to their gender, migration status, and other relevant factors.

Gender-sensitive-culturally adaptive services

The availability of services tailored to the specific needs and cultural contexts of female migrants proved vital. The studies identified empathetic support from GPs as a crucial factor in female migrants' journeys towards recovery. Viewed as the most readily accessible formal mental health service, GPs served as the primary gateway for referrals and treatment. Interestingly, some reports in the review corresponded with the higher level of satisfaction with access to support among certain female migrant groups compared to their male counterparts.

6.2.6 Empowerment and challenges in educational and work environments for female migrants

Findings in chapters 3 and 4 highlighted how educational institutions, including schools, provided a safe and accessible environment for support for young female migrants. This encompassed both therapeutic interventions and opportunities for socialisation, offering a protective factor against loneliness and isolation. Counselling services were readily available within these educational settings.

Furthermore, beyond the social benefits of friendships and support services, young females gained valuable skills, knowledge, and self-awareness through structured learning. For instance, an included study in the review by Ali et al., (229) involving young Pakistani

participants incorporated psychology lessons as part of this empowerment process. Conversely, the study by Tabassum et al.,(247) highlighted the starkly different reality faced by older Pakistani women. Older Pakistani women faced significant barriers, including social isolation, illiteracy, and a need for translation support. Seligman et al., (459) propose that resilience, positive emotional engagement, and meaning-making can be cultivated as skills. The authors advocate for the integration of well-being or positive education into school curricula, citing promising results in mitigating depressive moods among young people. Furthermore, they contended that schools, given the significant amount of time children and adolescents spend there during their waking hours, provide an essential platform for interactions with peers and teachers, which are integral to well-being.

Within the qualitative study findings, educational and work settings were identified as providing adults with both practical support and a sense of belonging, although a small minority reported feeling less welcome in these spaces. Interestingly, a stronger emphasis was placed on work-based support structures compared to those within educational settings. Nonetheless, both educational and work environments were occasionally perceived as the sole source of support available to both younger and older adults.

6.2.7 Resilience: Individual and Systemic Perspectives within Key Themes and Interpretations

The concept of resilience, while often celebrated as an individual's ability to overcome adversity, can inadvertently shift attention away from systemic factors that perpetuate inequities. Critiques of resilience narratives highlight their potential to individualise structural problems, framing them as personal challenges rather than societal failures (460,461). This framing risks placing the burden of adaptation on individuals while leaving systemic barriers unaddressed.

In this thesis, resilience was explored not as an isolated trait but as a phenomenon shaped by structural violence, cultural expectations, and systemic inequities. Female migrants' narratives revealed how resilience was often necessitated by institutional failings, such as inaccessible mental health services or restrictive immigration policies. These findings underscore the importance of contextualising resilience within broader systems of oppression, recognising it as both a response to and a reflection of structural conditions(461).

Beyond individual resilience, the thesis also considers system resilience, which refers to the capacity of services and institutions to adapt, respond, and support female migrants in navigating systemic barriers (462–464). For example, services that embraced culturally and gender-sensitive practices demonstrated greater resilience by fostering inclusive environments where female migrants felt safe and respected. However, findings also highlighted areas where system resilience was lacking, particularly in the rigidity of healthcare services, language barriers, and the underrepresentation of female migrants' voices in policy-making.

The integration of lived experience commentaries and the EMBaRK framework challenged individualised notions of resilience by amplifying the voices of female migrants and addressing the systemic factors shaping their experiences and how research reports on these experiences and perceptions. This approach emphasised the dual need to support individual resilience while fostering system resilience through systemic reforms that prioritise equity, inclusivity, and accessibility. Ultimately, creating resilient systems reduces the reliance on individual resilience, paving the way for more equitable and supportive environments for female migrants and the wider society.

Resilience and adaptability of female migrants

The female migrant's inner strength and ability to adapt to difficult circumstances were key factors in overcoming challenges. Despite enduring significant pre-, peri-, and post-migration traumas and encountering substantial barriers, many female migrants exhibited remarkable resilience and adaptability, as highlighted across the studies. The resilience of female migrants is further underscored by specific examples gleaned from the studies by Fox et al., (234) Papadopoulos et al.,(244) and Whittaker et al.,(235) in the review as well as the qualitative study highlighting the adaptability and resourcefulness of the participants.

A study of Eritrean female refugees in Norwegian asylum centres sheds light on their remarkable resilience and diverse coping mechanisms amidst trauma and limited support (192). Notably, the research reveals how these women normalise their psychological struggles as understandable responses to their experiences. Key strategies identified include focusing on future aspirations, maintaining optimism, finding strength in their religious

beliefs, and drawing emotional support from fellow refugees. This network functions as a surrogate family, solidifying their ethnic identity and serving as a crucial source of strength.

Contemporary understandings of acculturation acknowledge the dynamic and reciprocal nature of cultural exchange. Within diverse societies, individuals engage in a complex process of cultural assimilation and adaptation, referred to as acculturation (465–467). This multifaceted phenomenon encompasses social, psychological, and cultural transformations as individuals navigate their identities amidst multiple cultural influences.

Research, particularly that conducted by Papadopoulos et al., (244) accentuates the benefits of acculturation for Ethiopian female migrants in comparison to their male peers. The study reveals enhanced English language proficiency, improved access to mental health support, and increased employment opportunities among these women. These factors act as protective mechanisms, fostering resilience in the face of adversities such as hostility, stigma, and other barriers. This resilience is crucial for their successful integration and mental well-being in the host society.

6.2.8 The pervasive challenges in accessing support

The review and the qualitative study affirm the primary focus of the thesis, highlighting the intertwined nature of self-stigma, societal stigma, and systemic barriers that impede female migrants' access to appropriate mental health support. Notably, the review and the qualitative research both recognise the multifaceted and context-dependent nature of stigma, manifesting across individuals (stereotypes, prejudice, and discrimination), interpersonal (social distancing, rejection), and societal levels (discriminatory policies and laws). In doing so, the review and the qualitative study align with Fox et al.'s Mental Illness Stigma Framework (MISF) (150), demonstrating how the interplay of these factors ultimately impacts female migrants' well-being, particularly when compounded by additional stigmatised identities. The stigma of physical conditions may lead to less likelihood of accessing support. The female migrants alluded to several instances where access to both physical and mental health support was hampered by the 'hostile environment' policies, in some cases being turned away from GP surgeries (234). The role of societal stigma in policies and laws can be reflected by the term 'hostile environment'. The term refers to a specific set of policies and actions implemented by the British government, designed to marginalise individuals deemed irregular migrants (347). Popularised in 2012 by then-Home Secretary Theresa May (later

Prime Minister), the term originated from her statement expressing the intention to create an *'environment...really hostile for illegal immigrants'* (Hill, 2017). Subsequent remarks further emphasised this aim, highlighting a desire to provide *'a really hostile reception'* (468).

To investigate the hypothesis that migrant status and ethnicity impact referral pathways and the severity of mental health conditions at the point of care for women, the subsequent quantitative study examined clinical records in Southeast London. Building on the qualitative findings, Chapter 5, titled "Examining disparities in mental health referral and severity of diagnosis for foreign-born and British-born women in South East London," delves into quantitative data to examine variations in mental health care experiences between these two groups. This study found significant discrepancies in referral routes and diagnostic severity. Foreign-born women were more likely to be referred through emergency channels compared to their British-born counterparts. However, the severity of mental health conditions, as measured by HoNOS scores, was significantly affected by ethnicity, with Black individuals being overrepresented in severe diagnoses and MHA sectioning. Migrant status alone was not a significant predictor of severity.

These findings suggest that systemic barriers within healthcare services, such as cultural misunderstandings, language barriers, and biases, may play a crucial role in shaping the mental health experiences of foreign-born women. For instance, miscommunication between patients and healthcare providers due to limited English proficiency often results in misdiagnosis or inadequate treatment. Additionally, the lack of culturally sensitive services and the stigma associated with mental health in various cultural contexts contribute to these disparities (1,3,78,469,470).

The quantitative analysis underscores the need for healthcare systems to address these systemic barriers to reduce inequities in healthcare provision. By highlighting these discrepancies, the study contributes to a broader understanding of the unique challenges faced by female migrants, emphasising the importance of implementing more inclusive and culturally sensitive healthcare practices.

6.3 Creating spaces for cultural and gender security: Implications from the PhD Research

The PhD project explored the complex mental health needs of female migrants by integrating feminist participatory action research principles and centring lived experiences. Through this process, the thesis highlights the critical need to move beyond the concept of cultural competency to embrace a broader and more transformative framework of cultural and gender security. This concept reflects the need for healthcare and research environments that create psychological safety while addressing intersecting factors such as race, gender, migration status, and socioeconomic inequalities.

The term cultural and gender security expands on existing frameworks to encompass not only cultural awareness but also a recognition of structural and systemic barriers that perpetuate inequities. It builds on cultural security (471), integrating a gendered lens and acknowledging the unique vulnerabilities and strengths of female migrants. The findings across all three studies - systematic review, qualitative interviews, and quantitative analysis - underscore the need for such an approach, while the EMBaRK process operationalised its principles in practice.

6.3.1 From cultural competency to cultural and gender security

Cultural competency has long been regarded as a key framework in healthcare for addressing diverse patient needs (452). However, critiques of cultural competency suggest that it often falls short by focusing primarily on increasing awareness without addressing the structural violence and systemic inequities that shape patient experiences (471). For female migrants, this limitation becomes particularly salient, as their mental health challenges are often compounded by stigma, discrimination, and barriers rooted in immigration policies and economic marginalisation (1).

Cultural and gender security, in contrast, seeks to go beyond awareness by fostering environments where individuals feel safe, respected, and supported. This requires not only recognising and valuing cultural differences but also actively dismantling structural barriers and addressing power imbalances in healthcare and research settings. Importantly, this approach aligns with feminist participatory action research principles, which emphasise equity, empowerment, and inclusivity (14,174,261).

6.3.2 Operationalising cultural and gender security through EMBaRK

The EMBaRK framework, developed in this thesis, exemplifies how cultural and gender security can be effectively integrated into research practice. By embedding female migrants as co-researchers, EMBaRK prioritised their voices and perspectives, fostering a participatory environment that challenged traditional hierarchies in knowledge production. This approach ensured that cultural and gender security was not merely an abstract concept but a methodological commitment to equity and inclusivity, operationalised at every stage of the research process.

A cornerstone of the EMBaRK process was the inclusion of lived experience commentaries, which provided a critical lens to shape the research design, data collection, and interpretation of findings, ensuring that the voices of female migrants remained central to the study's outcomes. These commentaries also surfaced the systemic barriers and cultural sensitivities that often go unnoticed in conventional research methodologies (472–474). For instance, in the systematic review, they emphasised gaps in the literature, including the intersection of cultural stigma, legal precarity, and migration-related barriers, highlighting areas often overlooked in traditional frameworks. In the qualitative study, narratives of discrimination and stigma were central to the analysis, with participants' voices directly shaping thematic interpretations and revealing systemic inequities in healthcare experiences. In the quantitative study, the critique of diagnostic tools like HoNOS underscored systemic biases and the urgent need for culturally and gender-sensitive diagnostic practices, reflecting the limitations of conventional methodologies.

6.3.3 Addressing structural violence

Structural violence, a concept introduced by the Norwegian sociologist Johan Galtung in 1969, describes the systematic ways in which social structures harm or disadvantage individuals by creating inequitable conditions (475). This framework is particularly relevant to understanding the mental health challenges faced by female migrants, whose experiences are shaped not only by individual circumstances but also by systemic barriers, including restrictive immigration policies, economic precarity, and institutional racism. These entrenched inequities perpetuate significant obstacles to accessing care and achieving mental well-being.

The findings of this thesis illustrate the pervasive influence of structural violence on female migrants. The systematic review highlighted the critical role of structural barriers, such as immigration status and socioeconomic disadvantage, in limiting access to mental health services. Building on this, the qualitative study brought to light vivid accounts of discrimination and exclusion, often perpetuated by healthcare systems ill-equipped to meet the diverse needs of female migrants. Finally, the quantitative analysis revealed stark disparities in mental health outcomes and referral pathways, further exposing the systemic inequities embedded within service delivery models. Together, these findings underscore the urgent need for addressing structural violence to achieve equitable mental health care for female migrants.

A potential solution lies in the frameworks of cultural and gender security, which goes beyond awareness of diversity to actively challenge systemic inequities while fostering environments where individuals feel respected, supported, and safe. By moving beyond the limitations of cultural competency and embracing the principles of participatory research and systemic equity, this approach aligns with the broader feminist and co-production values underpinning this thesis. The EMBaRK process demonstrates the practical application of these principles, providing a pathway for future research and practice to create inclusive and empowering spaces for female migrants.

6.4 Recommendations

The research undertaken as part of the PhD project sought to diverge from traditional methodologies by actively involving female migrants throughout the entirety of the research process. This approach was central to ensuring that their voices were not only heard but were instrumental in shaping the outcomes. By foregrounding the experiences and insights of these women, the thesis aimed to provide a platform where their narratives and recommendations form the core of the findings. This approach is not merely a methodological choice but a deliberate effort to address the often-overlooked perspective of female migrants in academic discourse, as critiqued throughout the thesis. The EMBaRK framework serves as a model for embedding co-production and cultural and gender security into research and practice. Its application in this thesis highlights the potential for participatory approaches to advance equity and inclusivity in mental health research and services.

Based on the insights gathered from the recommendations of female migrants in Kent, Surrey, and Sussex, the systematic review, the clinical records study and the female migrant co-production group, the following recommendations for research, policy, practice, service delivery, and funding in the context of mental health for migrants are presented:

6.4.1 Research recommendations

Historically, research on migrant experiences has often failed to adequately capture or address the unique perspectives of female migrants. Gender considerations have been either overlooked or subsumed within broader discussions of cultural issues, resulting in a substantial knowledge gap regarding the distinct challenges and needs faced by this population.

This study represents a significant departure from traditional researcher-driven investigations, embracing a more participatory and inclusive research model. This is particularly pertinent in the field of mental health research, where the lived experiences of individuals from diverse backgrounds are crucial in comprehending the multifaceted nature of mental health concerns and service accessibility. By allowing the suggestions and experiences of female migrants to shape the study's recommendations, a nuanced understanding of their specific mental health needs and barriers to accessing care was achieved. By drawing upon the EMBaRK process,

research can make meaningful contributions to understanding the effectiveness of various interventions and support models tailored to the unique needs of female migrants.

To address this imbalance, future research must prioritise the active inclusion and participation of female migrants throughout the entire research cycle. This can be achieved through:

Co-Production of Knowledge: Engaging female migrants as co-researchers and collaborators ensures that their voices and experiences are not only heard but also shape the research questions, methodologies, and interpretations. This approach can reveal insights that might otherwise be missed and ensure that the findings are relevant and meaningful to the communities they represent.

Intersectionality: Research must consider the multiple and intersecting identities of female migrants, including their gender, race, ethnicity, class, and migration status. This approach acknowledges the complex ways in which these factors interact to shape their experiences and avoids generalisations or oversimplifications.

Diverse Methodologies: Employing various qualitative and quantitative methods can capture the distinctions and complexities of female migrant experiences, referral pathways, treatment outcomes, general support and perceptions of their understanding of their needs and the amplifying of their voices. This can include interviews, focus groups, participatory action research, and arts-based methods. Prioritising gender-sensitive, culturally sensitive, culturally secure, and trauma-informed approaches is essential to creating a safe and empowering space for participants to share their stories.

Dissemination and Impact: Research findings should be disseminated in accessible formats and languages to reach a wide audience, including female migrants, policymakers, service providers, and the general public. This can inform policy and practice changes, raise awareness about the unique needs of female migrants, and ultimately contribute to more equitable and inclusive outcomes

6.4.2 Policy recommendations

The development and implementation of policies that are inclusive of the diverse cultural backgrounds of migrants and ensuring that mental health services are accessible and appropriate for all are crucial in both the workplace and education settings. Policies must

address structural barriers, including restrictive immigration laws, by embedding principles of cultural and gender security. The female migrants who were interviewed suggested inclusive policies and procedures which reflected their unique needs, for example looking at menopause policies if they are understandable to female migrants, and the impact menopause can have on some women.

There is a consensus in the advocacy for mandatory cultural secure training for all mental health professionals.

Integration of Services: Holistic approaches integrating mental health services with broader support systems (e.g., housing and social care) are vital. Policy frameworks play a crucial role in guiding how mental health services are organised, funded, and delivered. Holistic approaches recognise that mental health is interconnected with other aspects of well-being. By breaking down silos and fostering collaboration among services, such as counselling, therapy, social support, housing services, and career advice, we can better support female migrants. This integrated focus can be replicated for other marginalised groups and can also help refine the general population support offer.

6.4.3 Practice recommendations

Female migrants face a complex interplay of cultural background, social challenges, and language barriers. The synergy of the recommendations for cultural competence, community-based programmes, and language support creates a comprehensive approach that addresses these barriers:

Cultural security: Mental health practitioners must develop cultural security to effectively understand and address the unique challenges faced by female migrants. This involves gaining knowledge about the diverse backgrounds, beliefs, and practices of different migrant communities, particularly regarding gender roles and expectations. Culturally secure practitioners can better understand the impact of migration on mental health, such as cultural adjustment difficulties, discrimination, gender-based and institutional violence, and social isolation. Within GP settings, reception staff can play an important role in creating a welcoming environment for women accessing services by being sensitive to cultural norms and providing appropriate information and support. Training staff should extend to recognising and addressing systemic barriers.

Drawing on the success of cultural competence interventions in other areas, a review of several studies highlighted improved patient satisfaction and health outcomes when healthcare providers undergo cultural competence training (476). However, the success of these interventions often depends on the depth of the training and the extent to which systemic changes are implemented to support culturally competent practices. Challenges persist in translating cultural competence training into tangible improvements in practitioner behaviour and long-term patient adherence, while also addressing systemic barriers within healthcare systems. Hence the key recommendation is to move from cultural competency to cultural and gender secure practices.

Community-based programs: Support groups and workshops specifically designed for female migrants and delivered within their communities have the potential to be highly beneficial. These programmes, as suggested by the female migrants themselves and the FMCG, provide a safe space for women to connect with others who share similar experiences, reduce feelings of isolation, and promote peer support. Co-facilitated by culturally competent professionals, these groups can also increase awareness about social, physical and psychological issues, available resources, and coping strategies tailored to the specific needs of female migrants.

Language support: For non-English speaking women, access to language services is crucial. This can include interpreters for appointments with mental health professionals, translated materials about mental health, and support groups conducted in their native language. Ensuring effective communication is essential for accurate diagnosis, treatment planning, and building trust with mental health professionals. Additionally, providing information and resources in multiple languages can improve trust and help women to better understand and manage their mental health.

6.4.4 Service delivery recommendations

Flexible service delivery models: Offering service delivery models such as walk-in services and extended hours, is crucial to accommodate the diverse work schedules and commitments of female migrants. The women interviewed in this study often juggled multiple responsibilities, including work, childcare, and other caring duties, making it difficult to access services during standard hours. Flexible scheduling would allow women to seek support at their point of need, increasing their access to and engagement with mental health

services. However, such flexibility poses significant challenges for service providers. Targeted approaches, while addressing specific needs, risk further stigmatisation by isolating female migrants as "needy" or "special case" groups, inadvertently reinforcing stereotypes that marginalise them further. On the other hand, universal models introduce complexities in communication, workforce skill mix, and resource allocation, potentially overburdening healthcare systems already under strain.

To address these challenges, a hybrid approach is recommended—embedding flexible, culturally sensitive practices within mainstream healthcare services. For example, services could integrate extended hours or community-based hubs into existing care structures, ensuring accessibility without reinforcing stigma. A feminist framework can guide this process, focusing on equity and collaboration while mitigating the risk of perpetuating systemic biases.

Diverse workforce: Employing mental health professionals from diverse backgrounds, including those with lived experience of migration, is essential. As suggested by the female migrants and the FMCG, this would foster trust and relatability within therapeutic relationships, improving rapport, reducing social stigma, and ultimately enhancing the quality of care received. A diverse workforce can better understand and address the cultural nuances and specific challenges faced by female migrants. This approach requires investment in recruitment and training strategies that prioritise welcoming organisational culture, diversity and inclusion.

Addressing social determinants: Female migrants often face a multitude of challenges beyond mental health concerns. These may include social and economic stressors, such as accommodation issues, unemployment, lack of community support, and experiences of discrimination or trauma (200,420,477–480). Collaborative work amongst mental healthcare workers, social workers, and community organisations is vital to ensure comprehensive care that goes beyond symptom management and focuses on overall well-being. This can include connecting women to resources for housing, employment, legal aid, and social support networks.

By addressing these social determinants in tandem with flexible service delivery and workforce diversity, mental health services can better respond to the intersecting needs of

female migrants. Such reforms align with the overarching goal of fostering cultural and gender security within healthcare, ensuring services are both accessible and equitable

6.4.5 Funding recommendations

The female migrants and the FMCG highlighted that funding strategies should be employed to secure long-term mental health support for female migrants. This approach should include a combination of strategies to ensure the sustainability and effectiveness of services.

Advocacy for sustainable funding models: There must be active promotion of funding mechanisms that can reliably support mental health services for migrants over the long term. Examples could include dedicated budget allocations for female migrant research or public-private partnerships in financing support services. Sustainable funding would ensure consistent service provision, allowing organisations to plan effectively and deliver quality care to female migrants.

Targeted funding for migrant services: Allocating specific funds for migrant mental health services is essential. This targeted approach acknowledges the unique needs and challenges faced by this population group. By dedicating resources specifically to services tailored to female migrants, we can ensure that their specific needs are addressed effectively. An example may be the allocation of funds to mental health providers specialising in working with migrants or supporting the development of culturally sensitive mental health programmes.

Community grants: Providing grants to community-led groups and NGOs working with female migrants on mental health issues empowers these organisations to play a critical role in supporting their communities. These grants can be used to fund various initiatives, such as developing culturally relevant mental health resources, training peer support workers, and organising outreach programmes. Through the support of funding, this can leverage the existing knowledge and networks within migrant communities, fostering trust, lessening stigma, and improving access to mental health support.

6.5 Revisiting positionality

As discussed in the introduction, my positionality as a male researcher significantly shaped the design and implementation of this PhD project. Revisiting this at the conclusion of the research, it is evident that my identity influenced not only the relationships I built with participants but also the interpretation of findings.

The intersection of my gender and professional role sometimes necessitated deliberate efforts to build trust with participants, particularly given the focus on vulnerable female migrants. While the feminist participatory action research approach helped mitigate potential power imbalances, moments of reflection highlighted the ongoing challenges of navigating this dynamic. For example, my gender occasionally shaped how participants framed their narratives, particularly in discussions involving cultural expectations of masculinity and caregiving roles. These moments enriched the analysis, offering unanticipated insights into how gender dynamics intersect with mental health experiences.

The development and use of the Empowering Migrant Bridges: Active Research and Knowledge (EMBaRK) framework were instrumental in addressing these challenges. EMBaRK provided a structured yet adaptable approach that prioritised inclusivity and participant agency, ensuring the research process was co-created with female migrants rather than imposed upon them. This framework helped me navigate potential power dynamics by centring participants' perspectives and fostering collaborative decision-making throughout the PhD project. By operationalising the principles of feminist participatory action research, EMBaRK facilitated a research environment built on trust, equity, and mutual respect, which was crucial for overcoming potential barriers arising from my positionality.

In interpreting the findings, my positionality required a continual reflexive practice to avoid over-relying on assumptions shaped by my own experiences. My identity as a Black male researcher offered a shared understanding of systemic oppression, yet it underscored the importance of centring participants' voices to ensure their lived realities informed the study's conclusions. This reflexive process reinforced my commitment to the principles of equity, transparency, and accountability throughout the research.

By revisiting positionality here, I aim to demonstrate its dynamic and iterative nature. The challenges and opportunities it presented throughout the research underscore the importance of reflexivity in fostering ethical and impactful research with marginalised populations.

This reflection on positionality complements a broader exploration of the challenges and lessons learned during the research process, which I address in the following section on personal reflexivity.

6.6 Personal reflexivity

Roberts and colleagues (481) suggest researchers should include a positional statement in their research as it aids transparency with the subject matter and the participants. I am a male who identifies as Black British of African origin, specifically from Southern Africa. I am also a father to a daughter, and I have many siblings, most of whom are female. Initially, I harboured concerns about my ability to conduct research effectively on such a sensitive topic as female migrants' mental health experiences. As a male researcher, I questioned whether participants would be as open with me as they might be with a female researcher. Furthermore, I was apprehensive about leading a study where all other members, including co-researchers and supervisors, were female.

The lived experience commentaries played a pivotal role in deepening my understanding of this PhD's limitations. By embedding lived experience perspectives throughout the research process, these commentaries challenged traditional research hierarchies and introduced alternative viewpoints that enriched the analysis - and challenged me personally as a researcher. For instance, one key insight highlighted systemic barriers that were not immediately apparent from the quantitative findings alone, such as the importance of considering the number of years participants had lived in the country or the role of alternative forms of support beyond the GP. These reflections underscored dimensions that could have strengthened the study's design and analysis.

This reflexive process also revealed areas where the study's methods could have been more inclusive, such as ensuring greater accessibility for participants with precarious immigration statuses. A particularly enriching aspect of the process was the involvement of female

migrants not only as participants but as co-researchers who reviewed aspects of the study. Their feedback, which I then reviewed and reflected upon, became a form of collaborative learning that significantly enhanced my understanding of the nuances within the data.

Moreover, the lived experience commentaries emphasised the need to move beyond standard interpretations of mental health outcomes and to critically examine how diagnostic tools like HoNOS may reflect systemic biases. This critique informed the study's broader implications, particularly the call for big data research practices and healthcare policies that actively include female migrant voices. Overall, the commentaries provided critical insights that not only shaped the interpretation of findings but also reinforced the importance of co-production in addressing the systemic inequities faced by female migrants. This iterative process highlighted the value of lived experience as a lens through which the research - and the researcher - could be reflexively transformed.

Before conducting the research, I engaged in informal discussions with various stakeholders, including female migrants, researchers, individuals from relevant organisations, and feminists. This dialogue aimed to understand their perspectives and strategies when male researchers investigate female-specific topics. This process of reflection led me to recognise the multifaceted nature of identity and its influence on research interactions. While acknowledging the evident gender and sex differences between myself and the participants, co-production group, and supervisors, I also identified shared experiences that fostered rapport and enriched the research quality. Some participants and I shared racial and ethnic identities, hailing from a common country of origin, which facilitated a deeper understanding of certain experiences. Additionally, both the participants and I had encountered mental health challenges, racism, stigma, prejudice, and physical violence, creating a shared understanding of these issues.

It was not just about negative experiences but also some positives and shared characteristics, some parents spoke of their children, which I related to my daughter. My supervisors shared an understanding of the constraints of undertaking a PhD on a limited budget and time which might impact the extent to which true and meaningful co-production may be realised. Although the co-production group members sometimes requested extra support, the fact that they trusted me and felt secure to discuss certain issues made me also feel like I was being

supported by them and boosted my confidence on the project – they gave me emotional and practical support just as I and to them.

Despite these connections, I acknowledge that my male identity may have influenced the information received and my interpretation of it. While I strived to create a safe and open space for participants, some may have felt more comfortable disclosing certain experiences to a female researcher, or a male researcher. This potential bias is an important consideration in interpreting the findings of this research and one I will reflect on in each interaction. Lastly, working collaboratively with the Female Migrant Co-Production Group (FMCG) and the broader framework of female migrant, community, clinician, policy and academic engagement in this study was instrumental in the development of the Empowering Migrant Bridges: Active Research and Knowledge (EMBaRK) framework. This process not only reinforced the importance of embedding co-production in research but also demonstrated how trust can be built and sustained through meaningful engagement with marginalised communities. The insights gained from this collaborative effort have positioned EMBaRK as a foundational approach that I intend to integrate into future studies. Its adaptability across diverse contexts and populations makes it a powerful starting point for fostering trust, inclusivity, and equity in research. By tailoring EMBaRK to the unique needs of specific communities, I aim to continue advancing participatory methodologies that centre lived experience, challenge systemic inequities, and promote practices that are racially, gender, socio-economically, and culturally informed. This adaptable framework also seeks to address intersecting dimensions of identity and systemic oppression, ensuring that research is both equitable and responsive to the diverse realities of marginalised populations.

6.7 Conclusion

This research provides an in-depth exploration of female migrant experiences in accessing mental health support across Europe, with a primary focus on the South of England. The integration of findings from the systematic review, qualitative study, and quantitative analysis, underpinned by a feminist-inspired methodology, offers a subtle and comprehensive understanding of the multifaceted challenges that female migrants face in accessing mental health support.

The systematic review illuminated overarching themes and patterns across various European and non-European contexts, highlighting the gender-specific barriers to mental health support. The qualitative study further nuanced these findings by delving into the lived experiences of female migrants in Southeast England, uncovering the critical role of General Practitioners and the positive efforts to combat stigma. The quantitative analysis, meanwhile, provided empirical evidence of disparities in referral pathways and diagnostic severity between British-born and foreign-born women, underscoring the systemic barriers within healthcare services that disproportionately affect female migrants.

This holistic approach, meticulously adopted throughout this PhD research through the formulation and use of the EMBaRK process, has sought to address both the individual and systemic factors influencing mental health research and outcomes. By interweaving diverse methodological perspectives and feminist theoretical frameworks, this research has elucidated the intricate interplay of barriers and facilitators impacting female migrants' mental health. By addressing these multifaceted challenges through a feminist lens, the research has paved the way for more equitable healthcare solutions. It highlights the need for culturally sensitive and gender-responsive approaches in mental health services, advocating for systemic changes that acknowledge and accommodate the unique experiences of female migrants. This comprehensive approach also underscores the importance of engaging with diverse populations in research, ensuring that their voices and experiences inform policy and practice.

Ultimately, this PhD research contributes to the ongoing discourse on mental health equity, offering actionable insights for policymakers, practitioners, and researchers. It advocates for a paradigm shift towards more inclusive and supportive mental health systems, thereby fostering better health outcomes and enhancing the overall well-being of female migrants.

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Appendix A: Systematic Review Protocol

Review Title

Barriers and facilitators to accessing mental health support in primary and community care for migrant women in Europe: A systematic review.

Review Question

What are the barriers and facilitators in accessing mental health support for common mental health conditions within Europe for female migrants from low-middle income countries (including those seeking asylum and refugees)?

Searches

Electronic databases to search: CINAHL MEDLINE, PsycINFO, PsycARTICLES and Web of Science.

Search dates: No restrictions on dates will be applied.

Studies will be restricted to ones that have been peer-reviewed and published in the English language.

Search terms relating to the review questions will be included as with the synonyms of; migrant/refugee/asylum seeker, access/help-seeking, common mental health problems, primary and community care. Search terms will be combined using 'AND' and 'OR' operators.

Article titles will be imported into RAYAAN, and duplicates will be removed.

Article titles will then be screened for relevance to the research question based on inclusion and exclusion criteria.

Types of study to be included.

Inclusion

- Peer reviewed articles with a qualitative, quantitative or mixed/multi -methods design.
- Studies focusing on female migrants, asylum seekers and refugees.
- Studies published in English.
- Studies published in Europe.

Exclusion

- Studies focusing on health issues other than mental health.
- Non-European based studies.
- Studies not specific to migrant mental health

Condition or domain being studied.

Access to mental healthcare of female migrants irrespective of mental health conditions.

Participants/population

- Migrants of any age who identify as women.
- Migrants originating from any country outside of Europe.

Intervention, exposure

The review will consider the experiences of help-seeking and access to mental health support within primary and community care.

Comparator(s)/control

Not applicable

Main outcome

The main aim is to identify views and experiences of female migrants and providers of services of the barriers and facilitators female migrants encounter in accessing psychological support within primary and community care.

Additional outcome

None

Data extraction (selection and coding)

Study Selection: The primary researcher (PN) will screen articles at the title, abstract and full text stage and omit articles not meeting eligibility of the inclusion criteria.

Quality assurance - Secondary researcher (AT), acting as quality assurance, will check a 10% sample of the studies for problems in the process of screening using the inclusion and exclusion criteria. Discussions and consensus will be reached on which articles to include or exclude.

Data extraction: Aims of the studies including identifying barriers and facilitators will be collated and presented in a unified table. Study characteristics, including author, country of origin, design (how study conceptualised gender) methodology (including gender considerations), participant demographics (explicit breakdown of gender) and effective recommendations for change/future studies and mental health domain will be extracted by the primary researcher in consultation with secondary researchers. Discrepancies will be resolved via discussion and with the support of the wider team.

All authors will contribute to interpretation of the data and manuscript write up.

Risk of bias (quality) assessment

For the included studies, a comparison of results comprising study design, methodology and participant demographics will utilise the Feminist Quality Appraisal Tool (Morgan et al., 2016). Additional appraisal of the methodological quality of the included studies will be conducted utilising The Mixed Methods Appraisal Tool (MMAT). The MMAT can be used for qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies. The tool has been used in similar review protocols (Greenfield et al., 2019).

A Cohen's Kappa inter-rater agreement of 0.6 will be the minimum threshold to include studies. Where there is no final agreement, the wider research team will be consulted.

Strategy for data synthesis

Thematic analysis (226,482) will be used to group data through line by line coding into themes and the interpretation of those themes as supported by extracts from the studies.

Analysis of subgroups

If possible, studies will be compared and analysed for the inclusion of data of participants as categorised: ethnicity, gender, sexual orientation, disability, educational background, unemployment, or newcomer status.

Where data is available, generalised pathways to mental healthcare support in women migrant populations will be mapped out. This information may include previous access to mental health support prior to arriving in host nation.

Contact details for further information.

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Organisational affiliation of the review

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Type and method of review

Systematic review, Other

Anticipated start date

12/02/2021

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17/05/2021

Funding sources/sponsors

National Institute for Health Research, Applied Research Collaboration for Kent, Surrey and Sussex (NIHR ARC KSS)

Conflicts of interest**Language**

English

Country

England

Appendix B: Initial Theme Framework for the systematic review guided by FMCG Discussion

Initial themes	Initial categories discussed by the FMCG	Refined categories guided by literature review	Core concepts	Final themes for review
Barriers	- <i>We do not have enough information in our communities.</i>	- Information Awareness	- Access	<ul style="list-style-type: none"> • Access to information • Cultural and spiritual barriers • Stigma • Structural barriers • Gender-specific barriers
	- <i>I didn't know where to go for support. A lot of women I know do not know where to go.</i>	- Lack of interpretation support	- Cultural	
	- <i>We have difficulties discussing mental health in our communities</i>	- Services not providing easily accessible information	- Structural	
	- <i>There is the issue of if I say something about my mental health I will be viewed as being crazy or something worse.</i>	- Services not aware of up-to-date information and guidance	- Individual level	
Facilitators		- Self-stigma of MH.	- Gender issues	
		- The societal stigma of MH, including that of family members with MH ill-health.	- Stigma	
		- Institutional stigma, including negative beliefs of reasons why migrants access MH services	- Individual	
		- Service delivery does not consider gender.	- Cultural	
		- Service delivery not supporting certain types of migrants.	- Structural	
		- Lack of interpretation services	- Individual level	
	- 'Hostile environment' policies and practices	- Gender issues		
	- The willingness of female migrants to discuss mental and spiritual health.	- Stigma		Religiosity, community, and religious leaders
	- <i>I think going to church helps a lot of the women I know. I always get help from the ladies in my bible study group.</i>	- Spiritual leader awareness of mental health conditions		
	- <i>We provide support for many migrants and most of our clients are females</i>	- Supportive friends and family		
	- <i>We match female migrants with their preferred gender support.</i>	- Availability of culturally and gender-sensitive mental health support.	Individual levels	Gender-sensitive support
	- <i>You must be strong in this world. I think I must work twice as hard as the British-born women. Now imagine how much harder I must work in a male-run world.</i>	- Peer support from other female migrants	Structural levels	Education settings
		- Resilience as a factor in the increased likelihood of seeking support.		Resilience and adaptability explanations
		- Adaptability and acculturation to a new environment.		

Appendix C: Interview Topic Guide

Female Migrant – Topic Guide for Interviews and Focus Groups

Statement to be read out by facilitator: This focus group forms part of academic research being carried by a PhD researcher to better understand the mental health needs of female migrants living in Kent, Surrey, and Sussex. It is hoped it will better inform researchers and providers of support around best supporting female migrants and encourage female migrants to seek support for their mental health.

The information will be kept anonymous and confidential, and used only for the purposes of the PhD project.

Can you tell us, if you are comfortable, how you came to be living in
Kent/Surrey/Sussex (delete as appropriate for county)

- 1.1 What does good mental health look like to you? Prompt: And what does poor mental health look like?
- 1.2 Describe a time in the past 12 months you have experienced poor mental health.
- 1.3 If you experienced or were to experience poor mental health, where did you go or where would you go to seek help?

Facilitators

- 2.1 Who has been helpful in supporting your mental health? (Family, friends, community, religious leaders, support, or case workers) Why were they helpful? What did they do that was helpful to you?
- 2.2 Describe to us what you do to make yourself feel better when you are feeling down. (e.g., pray, go for walks, talk to someone, cry)
- 2.3 What do you think your G.P., community support or mental health services should do to make it easier for you to talk about how you are feeling?

Barriers

- 2.4 If you have tried to get support for your mental health, what are some of the difficulties you faced trying to get the support?
- 2.5 (For those who have not sought support) What are some things that you think have stopped you seeking or accessing support?
(Prompts: Language, feeling uncomfortable talking to a man/woman about your issues, religious or cultural barriers, lack of childcare, money issues)

Now my next few questions are specific to you being a female and being a migrant:

3.1 What do you think can be done to encourage more female migrants living within Kent, Surrey, Sussex (~~delete counties as appropriate~~) to seek support for their mental health?

3.2 And what can services do to ensure support is available, accessible, and appropriate for female migrants?

For the Focus Group, the following question will be asked by a female community researcher and the male researcher will leave the room. This will be anonymised further with no participant numbers assigned to the answers:

“Do you think this interview would have been different if your interviewer was not a man?”

Prompt: What could a male researcher and/or non-migrant researcher do to make you feel comfortable when being interviewed?”

Appendix D: Distress Protocol for Interview Study

Co-producing stigma-proof mental health interventions with and for newcomers (asylum seekers, refugees, and migrants) in Southeast England

Principal Investigator: Patrick Nyikavaranda, Brighton, and Sussex Medical School

Protocol for Responding to Participant Distress or Reports of Concern

The nature of this research is likely to result in female migrant participants re-visiting distressing experiences and consequently may cause them some distress. It may also cause distress to the interviewers.

As far as possible, distress to any participant should be avoided. However, the nature of the subject could cause participants to think about issues that could lead to distress. Distress can also result from causes unconnected with the research.

Whatever its causes, as community researchers, we need to be prepared for interviewee distress to prevent or else minimise or alleviate its effects. This document sets out guidance that community researchers should observe and apply (according to circumstances) at various points during the research process.

1. Before the interview

People are being invited to come forward and take part voluntarily in the research. This means it is vital that potential participants have full information about the nature of the research and the potential distress it might cause. Information in the publicity and recruitment materials will make the nature of the research very clear to people. The principal researcher will endeavour to provide all necessary information so any potential participants can make an informed choice on participation in the qualitative study.

The participant information sheet will be sent out to all interviewees before the interview. The information sheet consent form and process will give female migrants a further chance to decide whether to take part in the research. They are told they can stop or withdraw from the research at any time.

There is a pre-interview checklist at the start of the topic guide for community researchers to use before the interview.

2. The interview process

On 'meeting' the interviewee

Where possible, participants will have been emailed or posted a copy of the Participant Information Sheet and have time to read it before deciding they would like to take part in an interview. The interviewer will be responsible for making sure the participant understands what is on the participant information sheet and what the research entails before they consent to participate in the interview. They will also check the capacity to consent before the participant gives consent by following the steps for checking capacity to consent and going through steps of verbal consent in the interviewer script within the topic guide.

The interviewer should be prepared to stop the interview in the event of any sign of distress or even abandon the interview depending on the context and after discussion with the participant.

At the start of the interview process

It is important to emphasize several things at the start of the interview process.

- 1) Remind the participant that the research aims are to hear about their personal experiences or perceptions.
- 2) The interviewer should remind the participant that we will be referring to what they tell us and will possibly quote some of their speech word-for-word in reports (although we will make sure they are not personally identified in any quotes we use). They will reassure participants that what they tell us will remain confidential to the research team, and that there are various measures in place (as stated in the informed consent details) to preserve their **anonymity**.
- 3) Interviewers should remind participants that the interviewer may need to breach confidentiality if they describe a situation that involves potential serious harm to themselves or to others, or where a crime has been committed. If the interviewer does feel the need to breach confidentiality, they will aim to discuss this with the participant before doing so.

- 4) Interviewers will reassure participants that they may stop the interview at any point should they wish to do so.
- 5) Remind participants about the information, that is, helping resources: we can check the person has these and discuss them at the end.
- 6) The interviewer will tell participants that at the start of the interview, they will be asked for some information about themselves and emphasise that they don't have to provide any information they don't feel comfortable sharing.

During the interview

- 1) After a few questions pause and check that participant is ok and pause and check again at the end of the interview.
- 2) Throughout the interview, the community researcher should be aware of any indications of distress or upset. If present, they should pause to check that the participant is ok.
- 3) Ask the person what they want to do if they do become distressed: remind them that they can take a break or choose to stop the interview if they wish. They have the option to complete the interview at another time. Prioritise responding to the distress and discuss the helping resources if appropriate – above completing the interview.
- 4) There may be questions that cause distress or discomfort. Again, if the interviewer senses that a participant is uncomfortable about a particular question, they can check whether s/he would like to move on to the next question. They could offer the participant reassurance that they are free to refuse to answer any question and to stop the interview at any time without having to justify this. However, the interviewer could check diplomatically if there is anything they can do to make the interview more acceptable for the person. It might also be useful for them to remind the participant that they will remain anonymous, and their views will be respected.
- 5) If a participant discloses that they have been subject to a serious incident not previously reported to anyone, the interviewer should register the seriousness of what the person is telling them. After registering the gravity of any disclosure, the interviewer should encourage the participant to disclose the information to someone they trust with whom they

would feel comfortable discussing it. The interviewer will show them the list of resources and advice about where to go to report such incidents. They may need to remind the participant that the interviewer's role does not mean that they are responsible for providing support themselves. The interviewer might ask if the participant has someone that they trust who they could talk to about it after the interview. Interviewers can remind the participant that they can report any suspected crime to the police. Please use your check-in with a colleague after the interview to consider how you are feeling, and whether any additional response to the participant is helpful. If you have concerns about the participant's or others' current safety, please also respond to these concerns (see below).

After the interview:

1. The interviewer should check with the participants that they are happy for their interview to be used in the research now that it is over. The interviewer will remind them that they have the right to withdraw at this stage.
2. Ask the participant how they found the interview and ask if they found any questions upsetting. Check if they have already received the list of resources we put together and say you can make sure this is sent on if not. If you feel there are any resources from the list that may be specifically helpful to the person, you can mention these. Ask them if they feel they have someone they could talk to if they feel upset a few days later. Offer a phone call or email by yourself (if you feel comfortable with this) or if they prefer from the principal researcher a few days later to see how they are and offer to signpost to further support.

3. What to do if you are concerned about someone's safety

From what an interviewee tells you, you could have concerns about:

- Someone's safety from themselves (e.g., about suicide or self-harm)
- Safety relating to others (e.g., the welfare of children, domestic violence)

Wherever possible and if it feels safe to do so, please tell the participant you plan to discuss with the person managing the work you are undertaking because you have some concerns about their/others' safety, to see if there is anything else we could do to ensure the person can be supported. At this stage, it may also be necessary to inform them that you may need to disclose your concern to someone who may be able to address your concerns, depending on the seriousness of the issue and the outcome of discussions with the principal investigator. If you are unable to contact the principal investigator within an immediate timeframe, then you should inform the lead researchers' lead supervisor of your concerns (Professor Carrie Llewellyn).

This advice is a summary only. For community researchers aligned with Diversity Resource International (DRI), do please refer to the DRI Safeguarding policy for further information and procedures. Do please contact the principal investigator for this project, Patrick Nyikavaranda, if you need guidance and clarity.

Email addresses:

Principal Investigator: Patrick Nyikavaranda P.nyikavaranda@bsms.ac.uk or if you cannot contact the principal investigator, please contact his lead supervisor:

Lead Supervisor for Patrick Nyikavaranda: Professor Carrie Llewellyn
C.D.Llewellyn@bsms.ac.uk

4. Interviewer emotional safety and support

If the interviewer hears anything during the interview process that upsets **them** as the researcher, they can make use of the support available from within the organisation that they are aligned to. After each interview, you will have an opportunity to talk after the interview with DRI team members supporting the project, mainly the Projects Coordinator. If you are not aligned with DRI, please do not worry, Patrick Nyikavaranda will be at hand and will offer extra support in the form of his lead supervisor and an agreement with DRI to provide immediate support for you.

These are also some approaches the interviewers may like to take:

Before the interview:

- Ensuring there is time to de-brief or to do something healing after an interview when planning the timing of interviews
- Having something reassuring or healing nearby when doing interviews

During and after the interview:

- Recognising their strengths, remembering our role
- Taking a brief break, being sure to breathe deeply
- Talking to another member of the team after the interview (de-briefing)
- Talking to a friend or other trusted colleague in confidence, without naming or identifying any participants
- Doing something that they find healing or distracting after the interview
- Privately write down how they are feeling after the interview - noting what has been difficult, what might help, etc.

Additional support

As well as being able to share certain concerns with each other and at a team meeting, interviewers could, depending on their needs, discuss how they are finding working on the project with:

The lead on this project, Patrick Nyikavaranda p.nyikavaranda@bsms.ac.uk

For **Diversity Resource International Community Researchers**, Tacye [@email](#)

Interviewers can of course also seek support from a family member, partner, or friend, or from any professional counselling or mental health support they may be receiving.

Whilst the interviewer can share their feelings with a trusted person, it is important that they do not breach confidentiality and anonymity and reveal the actual identities of any participants or any details that could lead to identification.

12/07/22 Patrick Nyikavaranda

Appendix E: Coproduced Presentations and Abstract Examples

Coproduced Abstract for the 38th Annual Conference of the European Health Psychology Society, September 2024

Stigma as a barrier to accessing support among female migrants in Southeast England: Qualitative study

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³ Diversity Resource International, United Kingdom

⁴ ICN Business School, France

Background: While awareness of mental health stigma is increasing, a nuanced understanding of the specific mechanisms by which it impacts female migrants' access to support remains elusive. This study, drawing upon the Health Stigma and Discrimination Framework, aims to address this gap by identifying and analysing the unique stigma experiences of female migrants. By doing so, it seeks to illuminate the factors influencing their willingness to seek and receive mental health support.

Methods: A qualitative approach was employed, involving interviews with 18 female migrants over 18 years old in Southeast England. A community advisory board consisting of 5 female migrants and bilingual advocates informed all stages of the study process from ethical procedures to the interpretation of findings. Thematic analysis was used to identify prevalent stigma patterns that may fuel a reluctance to seek mental health support.

Findings: Participants reported widespread discrimination and ostracisation, both in society and by health professionals. Participants highlighted stigmatising attitudes that they experienced as female migrants. Challenges included prejudice from interpreters which in turn exacerbated the reluctance of female migrants to discuss mental health concerns. A critical finding was the pervasive fear of child removal, significantly hindering the pursuit of mental health support.

Discussion: The study underscores the profound effect of stigma on access to mental health support for female migrants. Findings highlight the need for targeted interventions to reshape societal attitudes, dismantle structural barriers, and alleviate individual concerns. Health psychology research is uniquely placed to inform inclusive and supportive services for female migrants.

KSS Winter Symposium February 2023

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Co-producing Mental Health Interventions With Female Migrants

The design of an effective engagement and research process on a PhD project

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Overview

1. Co-production Team Structure and Collaborators
2. Background
3. Qualitative Study Aims
4. Purpose of The Co-production Group
5. Example Session
6. Reflections on The Co-production Process
7. Some Considerations
8. Next Steps and Where We Are Going
9. Key References

Qualitative Study Aims

Research Question: *What are the experiences and perceptions of female migrants regarding seeking and/or accessing support in primary or community care settings for their mental health in Southeast England?*

Study Aims:

- To gain an understanding of the barriers and facilitators to accessing primary and community care settings in Kent, Surrey and Sussex.
- To use participatory action research practices and co-production/involvement guidelines throughout the study
- To evaluate through personal reflection the effectiveness of employing feminist and community-led participatory action research in a PhD study

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Purpose of The Co-production Group

To co-produce/make key decisions about the research alongside the supervisory team and how it is undertaken at all stages, for example:

- Choosing how the research is undertaken
- Co-designing the interview schedule
- Suggesting the resources to hand to the female migrant participants
- Input to the study protocol
- Promotion and recruiting towards the study
- Co-interviewing
- Analysis
- A reference point for study issues, e.g. gender-specific, analysis-specific and recruitment issues
- Dissemination of study findings

Example Session

Recap of previous session and feedback

Discussion points:

- 1) Payment issues
- 2) Participant demographics and issues arising from recruitment
- 3) Presentation of analysis framework and what is important to consider after analysis
- 4) Expert experiences discussion of supporting female migrants
- 5) Required input in ongoing and future studies
- 6) Any other business

Detailed minutes are taken and a log of all discussion points made is to be shared with the group.

Reflections on The Process

JB: "I find the meetings very interesting, I think we can all go on talking for a long time...."

AW: "It is really very nice talking to you and the other researchers....if there is anything I can do for your research, please feel free to let me know"

ELA: "Working on this project is really enjoyable! I thoroughly enjoy participating in the discussions and gives me a forum to engage in open discussion and share my knowledge. As well as, gaining knowledge from the other members of the team"

PN: "Enlightening, engaging. It has challenged me and made me a better researcher and a more compassionate human"

Some Considerations

1. Do **Consider** and **review** payments for involvement
2. Build a strong **support** structure for team members
3. True involvement must consider differing views and experiences - **facilitation skills** are essential
4. Be **Consistent in communication**, including feedback on every task
5. Be **honest**. When things do not work out. Or when they do
6. Please **Celebrate** every achievement!!!

Next Steps and Where We Are Going

- Co-authoring Qualitative Study papers (separate from thesis)
- Continued Engagement in the next phase of PhD: Study 3: Diagnostic and referral pathway variation between foreign-born women and British-born women accessing mental health services in southeast London
- Providing advice and support on the project including follow-up interviews if time permits
- Provide guidelines and recommendations on female migrant research and support
- Co-authorship of a coproduction process paper

NIHR ARCs national webinar Mental health and social inclusion June 2023

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Barriers and Facilitators to Maintaining Good Mental Health

A qualitative interview study investigating the perceptions and experiences of female migrants

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21 June 2023

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Background

Systematic Review: *Barriers and Facilitators to Seeking and Accessing Mental Health Support in Primary Care and the Community Among Female Migrants in Europe*

Authors: Patrick Nyikavaranda, Marija Pantelic, Christina J Jones, Priyamvada Paudyal, Alice Tunks, Carrie Llewellyn

Methods: The protocol was pre-published on PROSPERO. 6 electronic databases were searched. Thematic analysis was undertaken. A feminist quality appraisal tool was applied.

Results: Barriers: *lack of information, stigma, religious, and cultural practices and beliefs. Lack of consideration of gender-specific needs within the health system.*

Facilitators: *Gender-sensitive services, supportive general practitioners and religious leaders*

Conclusions: The design of mental health research, services, policies, and commissioning of support for migrants must consider **female migrant needs and include them in the processes**. Mental health support services **must be culturally appropriate** and gender-sensitive.

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Co-production Group Need and Purpose

To co-produce/make key decisions about the research alongside the supervisory team and how it is undertaken at all stages, for example:

- *Choosing how the research is undertaken*
- *Co-designing the interview schedule*
- *Suggesting the resources to hand to the female migrant participants*
- *Input to the study protocol*
- *Promotion and recruiting towards the study*
- *Co-interviewing and analysis*
- *A reference point for study issues, e.g., gender-specific, analysis-specific and recruitment issues*
- *Co-dissemination of study findings*

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Experiences and Perceptions of Mental Health and Access to Support of Migrant Females in KSS

Study Team: Patrick Nyikavaranda, Juliet Batista, Anne Wong, Esohe Linda Abumwenre, Anna Wang, Fatima Elkhaldi, Marija Pantelic, Christina J Jones, Carrie D Llewellyn

Study Aims:

- *To gain an understanding of the barriers and facilitators to maintaining good mental health in primary and community care settings in Kent, Surrey and Sussex.*
- *To use participatory action research practices and co-production/involvement guidelines throughout the study*
- *To evaluate through personal reflection the effectiveness of employing feminist and community-led participatory action research in a female migrant mental health study*

BSMS ethics approval has been obtained to conduct this study. Project ID Number: ER/BSMS9K87/1

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Methods

Design: Qualitative study using semi-structured interviews

Setting: Working alongside community-led organisations in Kent, Surrey and Sussex, Southeast England

Participants: 18 adults self-identifying as migrant females (Age range 35 years (24-59), The mean age was 38.83 years (SD = 10.29 years)

Procedure: Interviews were conducted online and in person. Co-production group members co-interviewed participants

Analysis: Reflexive thematic analysis (Braun, V., & Clarke, V. (2006))

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Barriers to accessing support

The infographic consists of seven vertical panels, each with an icon and a text box:

- Language problems:** Language problems including inadequate support for interpretation
- Trust:** Psychological and physical safety, security, and trust
- Waiting Times:** Waiting Times for accessing support
- Stigma:** Stigma, Prejudice, Discrimination, Racism
- Mothers' fears:** Mothers' fears of losing their children
- Women at work:** Work and family limitations - Everything is about the kids, so sometimes I ask myself when is the time for me?
- Menopause:** Female-specific barriers - periods, menopause, female-specific medical conditions

Stigma as a Cross-Cutting Barrier

Sub-Theme	Illustrative Quotes
Fear of losing children due to mental ill-health	<i>If the school is aware that the mom is having a breakdown. The last thing I need [is] for social services to contact me...they don't just come like that because you called them thinking they will help...This is speaking from experience.</i>
Racism and hostility towards female migrants	<i>Being called that angry black woman or being called militant...and the perception that black people don't feel pain as much... Being female already, you know you don't have as much authority as the males</i>
Institutional sanctioning of stigma	<i>I still feel several incidents of racism toward me [because I am] Asian or like maybe just how we look...I have to do more to get the same support</i>
Societal attitudes as a hidden epidemic	<i>There was the stigma of Oh, no, we'll just keep this quiet. Because no one's gonna marry anyone in this family.</i> <i>I think one of the main reasons why I haven't gone to seek any support is because from where I come from, we don't talk about mental health. It's almost like a taboo...You can't have a mental health issue. It's not allowed</i>

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Facilitators to Good Mental Health Support

Individual

Interpersonal

Systems level

My first go-to is probably going for a walk, if I've had a bad day if I've having a bad time, I'm going for a walk

Strengthening Bodies and Minds: The Power of Physical Activity for Female Migrants

Healing Rhythms: Music as a Tool for Self-Care

Spiritual Strength: The Power of Faith and Religious Support

The Ties that Bind: The Role of Social Networks in Well-being

Therapy: Mindful Healing for Female Migrants

Education and work-based support: Empowering Female Migrant's Minds

Virtual Wellness Anywhere: The Benefits of Remote Support and Online Information

Right Help, Right Care: The Significance of Appropriate Support

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Conclusions

Barriers and Facilitators to accessing Mental Health Support

- Participants found numerous barriers to support. These cannot be generalised to the wider society as being female and being a migrant compounded some of these barriers
- Stigma has a very big impact on help-seeking behaviours and support
- Low-cost and often free forms of facilitators to well-being are effective

Recommendations

1. Provide information and education specific to female migrant needs
2. Improving access to school-based and work-based support
3. Adaptive support - culturally curious
4. Consider incorporating informal and group support
5. Involve female migrants in the research, design, and commissioning of support

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Thank You



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KSS Women's Health Research Network September 2023

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From Barriers to Bridges

Health Solutions From Female Migrant Voices in East Sussex

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21 September 2023

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Introduction and context

- New direction on focusing on action and solutions
- Female migrants at the heart of research, policy and implementation
- Today focusing on 18 Female Migrants (Age range 35 years (24-59), The mean age was 38.83 years (SD = 10.29 years)

BSMS Ethics Project ID Number: ER/BSMS9K87/1

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Key Recommendations by Female Migrants

Health literacy = Increased awareness

Adaptive services = Improved accessibility

Social networks = Support networks

Health Literacy

Ability to understand and use information to make decisions about one's health

Problem Statement	Illustrative Quotes	Recommendation [ACE it]
Lack of awareness of the availability of mental health support	"The local authorities should advertise, promote, have leaflets, and tell people what's available because I was not aware that mental health support was available" [Alison]	Advertising more on what is available
Lack of awareness of the specific health challenges associated with menopause	"So maybe females nearing their menopause should be educated more on what to expect. Yeah, when it starts and also once it starts that they should seek help at any point in time when they feel they need to seek help because it can really badly affect them". [Obenewaa]	Creating awareness specifically aimed at female migrants of menopause
Hesitation to seek mental health	"making a migrant woman feel like if there is any stigma attached to asking for that support that there isn't, you know there's no stigma attached to it" [Nadia]	Educating and informing on the impact of stigma

Social Networks

With a little help from my friends (and family and community)

Problem Statement	Illustrative Quotes	Recommendation
Lack of opportunities to connect with others	"They should conduct workshops with other female migrants where we can share our experiences or do activities together. It doesn't even matter their nationality" [Rachele]	Informal support e.g., walking groups, coffee, art
Different cultures may have different interests and needs	have some sort of activity that would attract these women, some sort of activity that works in all different cultures [Elizabeth]	Multi-need, multi-solution environments
The lack of informal support can lead to isolation, stress, and health problems	"And support that is not necessarily so formal it can't be so. Right now, I'm a single mom, so one thing that could be supportive to me is a group or an organisation or some support around single motherhood done in a less formalised way, and I think you will have more women [Gugu]	Creating informal support specific to tackling loneliness, and isolation for single migrant mothers
Emotional and psychological challenges specific to female migrant populations	I used to run an FGM support group for about 12 women of colour. They used to have different activities that they did, but effectively we were talking about FGM, but in a very kind of light-hearted way. People got support, peer support and so on and so forth. So, it's those things that I think would pull people in" [Gugu]	Recognising the interface between mental and physical health and social needs by training peer supporters

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And...So What???

Problems to Recommendations, to Strategy and Policy, to Action, to Better Health and Social Care Outcomes

- Female Migrant health is a Public Health, economic, and societal issue
- How do we translate some of these recommendations into action?

They need you! You need them!

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Thank You

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Services are not always welcoming or accessible	"It would be a good idea to have a mental health clinic where they can talk about how they feel, and they are given the time and opportunity to talk with someone who will listen to them and support them. This will encourage them to open and share what they are feeling" (Francesca).	A welcoming first point of contact
Working long hours vs. accessing support	I work 12-hour shifts for two days and then after that, I just want to rest, but I want something I can access easily. That works around the times that I work, really" (Elizabeth).	24-hour/365 days of the year support? Local hubs?
Cultural and language barriers create hesitancy	"And the language... if someone went and then they could explain to whoever is helping them, especially if you don't have the words in your own language, but the person helping you understands what you're saying. Then you feel confident that they know exactly what you mean" (Obenwaa).	Culturally-aware-culturally-curious-culturally-appropriate
Family and caring commitments	"So, in order to encourage them to use or seek for mental health service, first of all, I think it's to establish more Schemes for taking care of their family so that they could have time for or space to seek help" (Liberty).	Support for female migrants with childcare when they have health appointments.

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**Society for Academic and Primary Care (SAPC) South East Regional Conference
25.01.2024**

NIHR Applied Research Collaboration Kent, Surrey and Sussex Brighton and Sussex Medical School

Navigating Uncertain Shores

Female Migrant Perceptions and Experiences of Mental Health Support in General Practitioner Settings

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Published in the *Journal of Migration Health* 2024

NIHR Applied Research Collaboration Kent, Surrey and Sussex

Background: Experiences and Perceptions of Mental Health and Access to Support of Migrant Females in KSS

Study Team: Patrick Nyikavaranda, Juliet Batista, Anne Wong, Colette Linda Alcorn, Anna Maria, Fatima Elkhadi, Marija Pavlovic, Christine J Jones, Corrie D Deweylin

Study Aims:

- To gain an understanding of the perceptions and experiences of female migrants in primary and community care settings in Kent, Surrey and Sussex.
- To use participatory action research practices and co-production/engagement guidelines throughout the study.

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Methods

Design: Qualitative study using semi-structured interviews

Setting: Working alongside female community researchers and community-led organisations in Kent, Surrey and Sussex, Southeast England

Participants: 18 adults self-identifying as migrant females (Age range 35 years (24-59). The mean age was 38.83 years (SD = 10.29 years)

Procedure: Interviews were conducted online and in person. Co-production group members co-interviewed participants

Analysis: Reflexive thematic analysis (Braun, V., & Clarke, V. (2006))

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Accessibility and Communication Hurdles

- Limited access, long wait times, reliance on phone consultations
- Lack of face-to-face interaction hampering communication and understanding
- Language barriers and GP attitudes impacting engagement and support

"I think sometimes it would be good to be able to go to the GP and see and be able to talk to the GP. Will decide what to do. Instead of just a telephone appointment, I would have to go to the GP and see the GP because I do not see the point of telephone consultations sometimes"

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Knowledge Gaps and Dismissive Attitudes

- Perceived lack of GP knowledge about mental health and support options.
- Limited awareness of alternative and complementary support.
- Negative GP attitudes and cultural insensitivity contributing to poor outcomes.

"Being called that angry black women is being called militant...and the perception that black people don't feel pain as much... Being female already, you know you don't have as much authority as like males"

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Struggles with Access and Referral Systems

- Female migrants are often unaware of mental health support beyond the GP.
- Lack of knowledge about access and referral pathways, even for legal migrants.
- Complex referral pathways

"I don't know for how I could get to the specialist or even free counsellor or a mental health professional, even when I'm basically ill I can't really get hold of GP, so I don't think the GP can refer me to anywhere else"

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The Value of Positive Relationships and Continuity

- Importance of trust, familiarity, and safe spaces for disclosure.
- Positive experiences with proactive GPs facilitating access to support.
- The need for continuity and familiarity in GP-patient relationships.

"I know my GP quite well...and I feel comfortable telling her about my mental health or physical health problems or whatever"

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A Call for Proactive Engagement and Transparency

- Active inquiry about mental health alongside physical health concerns.
- Culturally sensitive training for GP surgery staff improving communication and understanding.
- Proactive mental health screening protocols for female migrants

"If they notice that some of their patients are living with long-term physical conditions that could cause stress and depression, they should bring it up..."

Recommendations and Conclusion

- Proactive mental health screening protocols
- Increased access to face-to-face consultations and alternative communication channels
- Strengthened referral pathways and resource provision.

The potential for better mental health outcomes through improved access, communication, and support will save money, save time and save lives.

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Thank You

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Appendix F: Example Risk Assessment Form

Risk Assessment Form

Name of the risk assessor	<i>Patrick Nyikavaranda</i>	What School or Department are you in?	Brighton and Sussex Medical School	Authoriser's signature	<i>X</i>
Assessment title	<i>Interviewing people onsite for PhD project</i>	Date of assessment	X	Location of the activity	
Description of the work area or activity being assessed	<p><i>As part of a PhD project, the researcher is going to be undertaking face-to-face interviews with individuals. Although it is envisaged that most interviews will take place virtually, there may be cases where it may be required for this to be in person. Where it is in person, university facilities may be used to conduct the one-on-one interviews. Alternatively, some interviews may involve the lead researcher setting up the Dictaphone in the room and leaving a researcher and an interviewee to the interviews. Apart from a university-owned Dictaphone, no other equipment will be needed. The proposed dates are over the course of X.</i></p>				

What is the hazard?	People affected and how they might be harmed	Measures in place to control the risk	Risk Rating			Additional controls required and by whom	New Risk Rating		
			S	L	R		S	L	R
<i>What could cause harm</i>	<i>This could include students, staff, visitors, or other groups.</i>	<i>These should be safety measures you have already planned</i>				<i>Only fill this out if additional controls are required</i>			
COVID-19	Staff, visitors	Alcohol gel, hygiene and cleaning wipes	2	2	2	Researcher to ensure interviews are conducted in rooms with proper ventilation and allow space between interviewer and interviewee if conducting interviews indoors.	1	1	1

Severity					
	1 Minor	2 Moderate	3 Significant	4 Serious	5 Major
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost certain	5	10	15	20	25

Hazard severity

1 – Minor	Capable of causing minor injury which would not require first aid treatment but may result in temporary health conditions (e.g. temporary skin rashes etc.).
2 – Moderate	Capable of causing minor injury which would allow the individual to continue after first aid treatment on site or at a local surgery. The duration of the stoppage/treatment is such that the normal activities are not seriously interrupted.
3 - Significant	Capable of causing injury or disease likely to result in an individual being unfit for work for one or more days.
4 - Serious	Capable of causing serious injury or terminal/chronic disease to an individual

5 - Major	Capable of causing death or multiple serious injury and/or possible destruction of property. Such a hazard would include a major event such as an explosion, toxic release, building collapse etc. It may cause death and injury both on and off site and would be the subject of a major incident report.
-----------	--

Likelihood of occurrence

1 – Rare	An incident is possible but only under freak conditions should there be a possibility of an accident or illness.
2 – Unlikely	If other factors were present, this incident or illness might occur, but the probability is low (e.g. storing items above shoulder level, worn carpet etc.).
3 – Possible	The incident may happen if additional factors precipitate it, but it is most unlikely to occur without them. The additional factor is more than a casual slip or nudge and would require an additional action or event to trigger it (e.g. leaving a vehicle with the engine running, obstructing an access/egress route, failing to replace a defective light, obstructing emergency equipment etc.).
4 – Likely	The effects of vibration, weather, inexperience, physical state, or human carelessness would precipitate an incident, but which is unlikely to happen without this additional factor (e.g. ladder not secured, temporary electrical supply, makeshift arrangements, medical condition etc.).
5 – Almost Certain	If the activity/condition continues as it is, there is almost a 100% certainty that an incident will happen (e.g. broken stair or ladder rung, exposed electrical conductor, unstable stack of materials etc.).

Appendix G: Kent Resources for Participants

This list has been compiled with the help of female migrants

Your GP

Often the quickest way to access support. Your GP is not just there for your physical health but for your mental health. You can call your GP surgery to make an appointment if you become concerned about your mental health. The GP may talk with you about accessing further support.

Integrated Access to Psychological Services (IAPT)

If you live in England and are aged 18 or over, you can access NHS psychological therapies (IAPT) services. Use the website to find the right service for you. You can also ask your GP to refer you.

<https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/>

Hub of Hope

An easy-to-use online database listing many mental health support organisations and has a list of support organisations for females in your area.

<https://hubofhope.co.uk/>

CalmZone

Campaign Against Living Miserably

<https://www.thecalmzone.net/help/get-help/>

SANE

Online Mental Health Support Forum

http://www.sane.org.uk/what_we_do/support/supportforum/support_rooms/

MIND (also has local Mind branches)

You can get support online and get tips of looking after yourself

<https://www.mind.org.uk/information-support/tips-for-everyday-living/online-mental-health/online-mental-health-tools/>

Samaritans

Call free any time, from any phone, on 116 123

Contact a Samaritan: If you need someone to talk to, they listen & won't judge or tell you what to do.

<https://www.samaritans.org/how-we-can-help/contact-samaritan/>

Saneline

They provide emotional support and information: **0300 304 7000. Open 4.30pm – 10.30pm every day.**

Kent

Mental Health Matters/ Live Well Kent is a helpline to contact if you are feeling low, anxious or stressed and that talking to another person might help, or if you are in extreme emotional distress and feel there is nowhere else to turn.

Tel: 0800 107 0160

Website: <https://www.mhm.org.uk/helpline-webchat>

Kent and Medway Safe Havens offer out-of-hours mental health support to anyone aged 16+ in the Kent area in one of their four crisis cafes. Please visit their website to see the one closest to you.

Website: <https://www.mhm.org.uk/kent-safe-havens>

Kent Mental Health and Wellbeing Hub is a resourceful website to direct you to the right support for your wellbeing including activities and strategies for your mental health.

Website: <https://www.kentandmedwayccg.nhs.uk/mental-wellbeing-information-hub>

Porchlight offer free support with mental health and wellbeing for people anywhere in Kent. You may be struggling with depression, low mood, stress, money issues or housing and need someone who can help then do get in touch with them.

Helpline: 0800 567 7699

Website: <https://www.porchlight.org.uk/information-support/list-of-support-services>

Kent: Insight IAPT.

Call: 0300 555 5555

Email: kent@insighthealthcare.org

For self-referral: <https://insight.limbic.ai/>

North Kent Women's Aid is a charity offering support for victims of domestic abuse. They also offer support for young people between the ages of 16 to 24 experiencing homelessness.

Telephone: 01322 384792

Address: 753, Dartford, DA1 1FY

Domestic Abuse Volunteer Support Services (DAVSS) is an award winning community based charity supporting any victims (aged 16 and above) of domestic abuse, who are living in West Kent.

Address: PO Box, Tunbridge Wells TN2 9TB

Phone: 01892 570538

Website: <https://www.davss.org.uk/>

If you wish to contact the researchers about the study, please email p.nyikavaranda@bsms.ac.uk

Appendix H: Surrey Resources for Participants

This list has been compiled with the help of female migrants

Your GP

Often the quickest way to access support. Your GP is not just there for your physical health but for your mental health. You can call your GP surgery to make an appointment if you become concerned about your mental health. The GP may talk with you about accessing further support.

Integrated Access to Psychological Services (IAPT)

If you live in England and are aged 18 or over, you can access NHS psychological therapies (IAPT) services. Use the website to find the right service for you. You can also ask your GP to refer you.

<https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/>

Hub of Hope

An easy-to-use online database listing many mental health support organisations and has a list of support organisations for females in your area.

<https://hubofhope.co.uk/>

CalmZone

Campaign Against Living Miserably

<https://www.thecalmzone.net/help/get-help/>

SANE

Online Mental Health Support Forum

http://www.sane.org.uk/what_we_do/support/supportforum/support_rooms/

MIND (also has local Mind branches)

You can get support online online and get tips of looking after yourself

<https://www.mind.org.uk/information-support/tips-for-everyday-living/online-mental-health/online-mental-health-tools/>

Samaritans

Call free any time, from any phone, on 116 123

Contact a Samaritan: If you need someone to talk to, they listen & won't judge or tell you what to do.

<https://www.samaritans.org/how-we-can-help/contact-samaritan/>

Saneline

They provide emotional support and information: **0300 304 7000. Open 4.30pm – 10.30pm every day.**

Surrey

Surrey and Borders Mental Health Crisis helpline is a mental health crisis helpline for people in emotional distress or experiencing suicidal thoughts and in need of support. Open 24 hours a day, 365 days a year.

Telephone: 0800 915 4644

More information at www.sabp.nhs.uk/help

Healthy Surrey can help you lead a healthier life, whether you want to be more active, drink less alcohol, stop smoking, and more.

Website and how to find resources: <https://www.healthysurrey.org.uk/>

The Women's Support Centre Surrey provides practical and emotional support to women. They are based in Woking but support women across Surrey.

Telephone: 01483 726621

Email: Admin.WomensSupportCentre@woking.gov.uk

Your Sanctuary is a local charity that provides a range of services which offer emotional and practical support to people and their children who are experiencing or have experienced domestic abuse.

Contact person: Katerina Turitto

Email address: admin@yoursanctuary.org.uk

Telephone: 01483 776822

Website: Error! Hyperlink reference not valid.

East Surrey Domestic Abuse Services Support for individuals experiencing Domestic Abuse and Violence, Help and Outreach in *East Surrey*.

Phone: 01737 771350

Website: <https://www.esdas.org.uk/>

NW Surrey Safe Haven provides support in person or virtually for anyone experiencing a mental health crisis or their carers. The virtual Safe Haven offers crisis support virtually. To access the service, please use the link: <https://nhs.uk/sabp/safe-haven-woking>

Address: 30 Goldsworth Rd, Woking GU21 6JT

Mental Health Crisis Helpline: 0800 915 4644

SMS texting for people with speech or hearing difficulties: 07717 989 024

If you wish to contact the researchers about the study, please email p.nyikavaranda@bsms.ac.uk

Appendix I: Sussex Resources for Participants

This list has been compiled with the help of female migrants

Your GP

Often the quickest way to access support. Your GP is not just there for your physical health but for your mental health. You can call your GP surgery to make an appointment if you become concerned about your mental health. The GP may talk with you about accessing further support.

Integrated Access to Psychological Services (IAPT)

If you live in England and are aged 18 or over, you can access NHS psychological therapies (IAPT) services. Use the website to find the right service for you. You can also ask your GP to refer you.

<https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/>

Hub of Hope

An easy-to-use online database listing many mental health support organisations and has a list of support organisations for females in your area.

<https://hubofhope.co.uk/>

CalmZone

Campaign Against Living Miserably

<https://www.thecalmzone.net/help/get-help/>

SANE

Online Mental Health Support Forum

http://www.sane.org.uk/what_we_do/support/supportforum/support_rooms/

MIND (also has local Mind branches)

You can get support online and get tips of looking after yourself

<https://www.mind.org.uk/information-support/tips-for-everyday-living/online-mental-health/online-mental-health-tools/>

Samaritans

Call free any time, from any phone, on 116 123

Contact a Samaritan: If you need someone to talk to, they listen & won't judge or tell you what to do.

<https://www.samaritans.org/how-we-can-help/contact-samaritan/>

Saneline

They provide emotional support and information: **0300 304 7000. Open 4.30pm – 10.30pm every day.**

Sussex

The Sussex Mental Healthline offers a 24/7 telephone service offering listening support, advice, information and signposting to anyone experiencing difficulties with their mental health.

Telephone: 0800 0309 500

Website: <https://www.sussexpartnership.nhs.uk/sussex-mental-healthline>

The Links Project is a multi-agency support and advice project for asylum seekers, refugees and new migrant communities living in East Sussex.

- Contact Marc Turczanski (Project Coordinator) on 01424 444 010, 07752 495 508 or marc@hastingsvoluntaryaction.org.uk.
- Website: <https://hastingsvoluntaryaction.org.uk/project/links-project>

Seaview is an open access wellbeing centre in St Leonards. It helps to improve the lives of people who are marginalised for a variety of reasons, and who often have mental health difficulties. Open 7 days a week over the winter.

- Phone: 01424 717 981
- Email: admin@seaviewproject.org.uk
- Website: <https://www.seaviewproject.co.uk/>

Staying Well Space (Brighton and East Sussex) is an out-of-hours mental health crisis prevention service

Brighton: Opening hours: Weekdays - 5.30pm to 10.30pm, Weekends - 3.30pm to 10.30pm

Telephone (Freephone): 0800 023 6475, choose option #3

Email: stayingwell.brighton@southdown.org

Address: Preston Park Recovery Centre, 18 Preston Park Avenue, Brighton, BN1 6HL

Eastbourne: Opening hours: Weekdays - 4pm to 10.30pm, Weekends - 3pm to 10.30pm

Telephone (Freephone): 0800 023 6475, choose option #1

Email: stayingwell.eastbourne@southdown.org

Address: Eastbourne Wellbeing Centre, 8 Saffrons Road, Eastbourne, BN21 1DG

Hastings (St Leonards-On-Sea): Opening hours: Weekdays - 4pm to 10.30pm, Weekends - 3pm to 10.30pm

Telephone (Freephone): 0800 023 6475, choose option #2

Email: stayingwell.hastings@southdown.org

Address: St Leonards-On-Sea Wellbeing Centre, Carisbrooke House, Stockleigh Road, Hastings, TN38 0JP

Brighton Women's Centre help women from all backgrounds, facing all kinds of issues, to live happier lives. Women dealing with bereavement or trauma, women who have been through homelessness or the criminal justice system, survivors of abuse or discrimination – are all welcome.

Open Monday-Friday: 9am–5pm

Address: 22 Richmond Pl, Brighton BN2 9NA

Phone: 01273 698036

If you wish to contact the researchers about the study, please email p.nyikavaranda@bsms.ac.uk

Appendix J: Research Governance Approval Letter

BSMS Research Governance & Ethics Committee (RGEC)
Interim Chair: Dr Peter West-Oram
Interim Deputy Chair: Ceri Butler
Senior Research Ethics and Integrity Officer: Caroline Brooks
Tel: 01273 641470 c.e.brooks@bsms.ac.uk
Applications and general enquiries: rgec@bsms.ac.uk



Brighton and Sussex Medical School
Medical Teaching Building
University of Sussex
Falmer
Brighton
BN1 9PX

26th July 2022

Patrick Nyikavaranda (Doctoral Student)
Department of Primary Care and Public Health
Brighton and Sussex Medical School

Dear Patrick,

Full Study Title: Co-producing stigma-proof mental health interventions with and for newcomers (asylum seekers, refugees and migrants) in Southeast England

RGEC Ref No. : ER/BSMS9K87/1

Many thanks for your re-submitted application for project ER/BSMS9K87/1, "Co-producing stigma-proof mental health interventions with and for newcomers (asylum seekers, refugees and migrants) in Southeast England."

The Medical School's Research Governance and Ethics Committee (RGEC) Sub-Panel have now had an opportunity to review the application and are happy that the Sub-Panel's requests have been fully addressed. Thank you very much for addressing each of our requests in such detail.

Concerning the issue surrounding research participants who may receive welfare benefits, we think that slightly more neutral wording may be needed for the Participant Information Sheets. However, this is solely intended for the further enhancement of the participant-facing documents and the Sub-Panel does not require receipt of the updated documentation.

We suggest slightly amending the current wording (below):

"If you are concerned that taking part in the study will affect your financial circumstances, for example benefits or for tax purposes, please ask the researcher for a letter to take to the Jobcentre which explains that your taking part in the research does not constitute paid work."

We suggest revising this to:

"If you receive benefits, please be aware of the possibility of research participant payments affecting any benefits to which you would otherwise be entitled so that you can make an informed decision about whether or not to participate. The research team is happy to provide a brief letter explaining the research and the remuneration involved that can be used in interactions with government agencies (e.g., Job Centre Plus). Please ask the researcher if you would like such a letter."

The study has now been granted research ethics and governance approval from the Medical School and in the meantime, we wish you every success with your project.

Yours sincerely

A handwritten signature in black ink, appearing to be the initials "MO" or similar, written in a cursive style.

Appendix K: BSMS Research Governance Certificate



BSMS Research Governance Ethics Committee

Certificate of Approval	
Reference Number	ER/BSMS9K87/1
Title Of Project	Co-producing stigma-proof mental health interventions with and for newcomers (asylum seekers, refugees and migrants) in Southeast England
Principal Investigator (PI):	Patrick Nyikavaranda
Student	Patrick Nyikavaranda
Collaborators	Prof Carrie Llewellyn (Supervisor); Dr Priya Paudyal (Supervisor); Dr Marija Pantelic (Supervisor); Dr Chrissie Jones (Supervisor) University of Surrey; Carolyn Baguma (Community Researcher) Diversity Resource International; Li Wang (Community Researcher) Diversity Resource International; Juliet Bastista (Community Researcher) Diversity Resource International; Chi Ling Chan (Community Researcher) Diversity Resource International; Alejandra Gonzalez (Community Researcher) Diversity Resource International; Mebrak Ghebreweldi (Diversity Resource International).
Date Of Approval	26-Jul-2022
Approval Expiry Date	31-Jan-2023
RGEC Chair	Caroline Brooks
Name of Authorised Signatory	Dr Peter West-Oram
Date	26-Jul-2022
<p>The Brighton and Sussex Medical School Research Governance and Ethics Committee (RGEC) has assessed your application and granted Ethical and Research Governance Approval to proceed with the above named project.</p> <p>Approval is granted on the following basis:</p> <p>Duration of Approval</p> <p>Approval covers the period stated above. Research must commence within 12 months of the certificate start date; any delay beyond 12 months and this certificate of approval will lapse necessitating renewed review of the project.</p> <p>Project Amendments</p> <p>Any substantial changes or minor amendments to the project following issue of the certificate of approval should be submitted to the Research Governance and Ethics Committee for review and authorisation prior to implementation. Please submit your application for an amendment to the Committee (via rgec@bsms.ac.uk) using the Request for an Amendment Form.</p> <p>Reporting Adverse and Unexpected Events</p> <p>Any incidents occurring during the project's lifespan presenting ethical and safety implications must be reported immediately to the Chair of the Research Governance and Ethics Committee. In the event of an adverse (undesirable or unintended) and unexpected event occurring during the project, research must be stopped immediately and events reported to the Chair of the Research Governance and Ethics Committee within 24 hours of its occurrence.</p> <p>Monitoring</p> <p>The Medical School has a duty to ensure all its research is conducted in accordance with the University of Sussex's Code of Practice for Research and Research Governance and Ethical Review Framework. In order to ensure compliance auditing may be undertaken annually and /or periodic monitoring of a percentage of approved research studies. If your project is selected you will be given 4 weeks' notice to prepare all study documentation for inspection.</p> <p>Notification of End of Study</p> <p>Please notify the Research Governance and Ethics Committee once the study has completed. It is also your responsibility to inform the Committee in the event of early termination of the project or if the work is not completed.</p>	

Appendix L: Gatekeeper's Letter



Gatekeeper / Agency Information sheet

Title of Study: **Co-producing stigma-proof mental health interventions with and for newcomers (asylum seekers, refugees, and migrants) in Southeast England.**

I am writing to ask the assistance in encouraging some of the female migrants you support to be interviewed for a research study as part of a PhD project.

Before deciding if you should offer your support, please take the time to read a brief description of the project, my needs for your support and what I may offer in return as a form of thank you. Please feel free to ask me any questions to gain a better understanding.

WHO I AM AND WHAT THIS STUDY IS ABOUT

My name is Patrick Nyikavaranda, and I am conducting research on the experiences of female migrants who have had a need for mental health support. I am keen to understand anything that stands in the way of seeking or receiving support. I am also keen to know what may have helped or what should be done to ensure female migrants get the support they need when they need it. My study is based mainly in Kent, Surrey, and Sussex. X, a Community Researcher with Diversity Resource International is a co-researcher on the qualitative aspects of the study.

WHAT I NEED YOUR ASSISTANCE WITH

I would be grateful if you could disseminate information about the study to your contacts, specifically female migrants. X would require permission from you to contact any of the female migrants she may have encountered during her employment with you. Please be assured the contact will only be once and not be for any other purposes beyond your knowledge.

WHAT TAKING PART IN THE RESEARCH WILL INVOLVE?

Participation in the interviews will be voluntary and the individuals being interviewed can request to stop the interview without any fear of consequences. The interviews will normally last 45 minutes to one hour and all interviews will be conducted online, Unless it is not

possible to do so, then they will be held in a public setting but one that offers privacy. All potential interviewees will contact me or X to express an interest in the study so this will not be your responsibility but ours beyond you granting Juliet permission to contact them inquiring if they would like to participate in the study.

WHO WILL HAVE ACCESS TO DATA FROM THE RESEARCH?

As all data will be stored in the University of Brighton cloud database, this ensures that all information is confidentially stored and only I or my lead supervisor will have access to a password-secure folder. No one else is expected to have access to the folder. The only time confidentiality will be broken is if someone is at risk of harm as a result of what has been disclosed. If this is the case, I would inform the person who has been interviewed before taking any action to break confidentiality.

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

The results of the study will form a basis for my PhD thesis. I hope to also publish the results so that other researchers, funders, and providers may be aware of some of the challenges and opportunities when providing or funding services for female migrants. I would fully acknowledge the role you would have played in any publications should you wish this to be so.

I am willing to voluntarily offer mental awareness workshops to staff and the people you support. I am also willing to share localised support information which may be helpful to you and your clients.

WHO SHOULD YOU CONTACT FOR FURTHER INFORMATION?

Name of Researcher: Patrick Nyikavaranda

Contact email of lead researcher: p.nyikavaranda@bsms.ac.uk

Department: Primary Care and Public Health

School: Brighton and Sussex Medical School

Name of PhD Lead Supervisor: Professor Carrie Llewellyn

Contact email of PhD Lead Supervisor: C.D.Llewellyn@bsms.ac.uk

Department: Primary Care and Public Health

School: Brighton and Sussex Medical School

Thank you

Appendix M: Study Advert

**Are you a Female Migrant, seeking asylum or a Refugee?
Would you like to share your experiences?**

We are looking for female migrants, including females seeking asylum and Refugees 18 years and above, living in Kent, Surrey and Sussex to share experiences of their mental health

We are seeking to inform better support for female migrant mental health as part of a PhD project

**The interviews will be conducted online and will last about 60 minutes
We will offer a £25 Thank You shopping voucher**



To find out more, please contact: Patrick Nyikavaranda
Email: P.Nyikavaranda@bsms.ac.uk

The PhD project is funded by the National Institute for Health and Care Research ARC Kent Surrey and Sussex. Diversity Resource International is a Community Research Partner on the project.

BSMS ethics approval has been obtained to conduct this study. Project ID Number: ER/BSMS9K87/1

Appendix N: Participant Information Sheet



PARTICIPANT INFORMATION SHEET

Co-producing stigma-proof mental health interventions with and for newcomers (asylum seekers, refugees and migrants) in Southeast England

Research Team: Patrick Nyikavaranda, Carrie Llewellyn, Marija Pantelic, Priyamvada Paudyal, and Christina J Jones

Invitation Paragraph

You are being invited to take part in a research study. Please take time to read the following information carefully and discuss it with others if you wish. Before you decide whether to take part, it is important for you to understand why the project is being done and what it will involve. Please ask if there is anything that is unclear, or if you would like more information. Take time to decide whether you wish to take part in the study. Thank you for reading this.

1. What is the purpose of the study?

This study is part of a PhD project aiming to improve the mental health and support for migrants in Southeast England. The PhD project has a focus on female migrants, including refugees, and those seeking asylum.

We are carrying out a study to better understand the experiences or perceptions of female migrants around mental health support in the community. They may have accessed support, considered accessing support, or may have not accessed support due to barriers. Research elsewhere has shown that female migrants, including refugees and those that are seeking asylum, are likely to have higher mental health needs but often do not get the support best for them.

The aim of the study is to explore the views and experiences of females who identify themselves as migrants concerning their mental health needs, and to look at what may stop or encourage them to seek support for their mental health. We also want to hear their thoughts on what would be the best way of supporting fellow female migrants.

This will help develop any recommendations or ways of working to better support female migrants.

Why have I been invited to participate?

We would like to interview female migrants who have experience of being supported in the community for their mental health or who have had mental health difficulties but have not been supported. We are not interviewing people who want to talk of experiences of being supported in a hospital ward although this may be important to them.

2. Do I have to take part?

It is up to you to decide whether to take part in the study. If you decide not to take part, it will not affect any support you receive. If you decide to take part, you will be asked to give consent verbally to take part in the study. You can withdraw at any time without giving a reason and without it affecting any support you receive. If you decide to withdraw you will be asked what you wish to happen to the data you have provided up to that point. However, if you decide to withdraw at a point that is two weeks or more after the interview, your data will already have been transcribed (that means the content of the interview will have been typed out) and anonymised, and we will not be able to withdraw it at that point. If you receive benefits, please be aware of the possibility of research participant payments affecting any benefits to which you would otherwise be entitled so that you can make an informed decision about whether or not to participate. The research team is happy to provide a brief letter explaining the research and the remuneration involved that can be used in interactions with government agencies (e.g., Job Centre Plus). Please ask the researcher if you would like such a letter.

3. What will happen to me if I take part?

If you are interested in taking part, you will be invited to have a telephone call or video call with a researcher to talk through this Participant Information Sheet. You will have the opportunity to ask questions before deciding to take part. We will provide as much time as you need for this: it typically takes about 15 minutes. If you agree to take part, you will be asked to give consent by having each statement on the consent form read out to you and asking you to verbally say if you agree with the statements. Even if you had your video on during the consent process, the record of your informed consent will be saved as an audio file. Following this, you will take part in an interview (a conversation with a researcher). During the interview you will be asked several broad questions. The interviews will be primarily carried out either via Zoom online video or Microsoft Teams via a freephone number or online video. The telephone or online interview will last up to one hour, but you are welcome to take breaks if you wish or to stop at any point. If in person, you will be re-imbursed for your travel costs of the interview location.

Each interview will usually be carried out by the primary researcher, who is male. However, if you would rather prefer a female interviewer, this can be arranged. It is up to you to decide who you want to be interviewed by. Then the lead researcher will only receive your consent and let you be interviewed by the female researcher.

The questions will be about your experience of looking for help for your mental health and the help you received or did not receive for your mental health within primary care (general practice) or the community. We will also ask people what may have stopped them from asking for help for their mental health. We are also seeking to understand what you think may help others to get help for their mental health.

The interview will be audio recorded, or video-recorded, if you decide to have your camera on during an interview on an online video call. The video recording will be changed into a sound file before the interviews are transcribed. When the researchers transcribe this recording, they will anonymise your personal information so that no one will be able to link it back to you.

To thank you for your time in the study you will receive a £25 Love2shop e-voucher for use with multiple shops for taking part in the interview and another one if you decide to take part in a follow-up interview. If you agree to a face-to-face interview that requires travelling to the agreed interviewing location, we will reimburse the cost of your travel.

4. What are the possible benefits of taking part?

Whilst there are no direct benefits for you in taking part in this study apart from the £25 voucher you will receive, it is hoped the study may help further our understanding of what may be needed when developing mental health support for other female migrants.

5. Are there any possible disadvantages or risks of taking part?

It is possible that you may find some of the interview questions upsetting, as we will be talking about your experiences of the times you were having mental health problems. At the end of the interview the researcher will talk briefly to you to find out how you are following your interview and tell you about resources from organisations that offer support, or other ways to obtain support. The researcher will offer you a phone call a few days later to see how you are following the interview if you would like one.

What about confidentiality?

Audio-recordings of your consent to take part in the study and your interviews will be separately and securely stored in the protected university online system. During the interview the interviewer will not use your full name to protect your identity. The audio recording will be transcribed by the lead researcher. We will then remove anything that may identify you in the transcripts, to further protect your identity. Digital and computer sound files will be destroyed within one month of the interviews being transcribed. The transcripts will be stored on the academic institution's computer as a password protected document and will be accessible by the lead researcher only. If the researchers would like to use a direct quote from you in a publication, they will not use your actual name, or they may use the participant number. We will retain a sound file recording of you giving consent to take part in the interview securely, in line with the University of Sussex's data protection guidelines.

Limits of Confidentiality

Please note that confidentiality will be maintained as far as it is possible, unless during our conversation the researcher hears anything which makes them worried that someone might be in danger of harm. Where there is a possibility of harm, the researcher will have to inform relevant agencies of this, for example anyone you may have stated is responsible for your care, or the emergency services where a life may be in danger, but they will tell you that they are going to do this. The concerns will be speedily and sensitively dealt with.

6. What will happen if I don't want to carry on with the study?

You can withdraw at any time without giving a reason and without it affecting any support you receive. If you decide to withdraw you will be asked what you wish to happen to the data, you have provided up to that point. However, if you decide to withdraw at a point that is two weeks or more after the interview, your data will already have been transcribed and anonymised, and we will not be able to withdraw it at that point.

7. What should I do if I want to take part?

If you would like to take part then please email Patrick Nyikavaranda, Email: p.nyikavaranda@bsms.ac.uk

8. What will happen to the results of the research study?

The results will be used as part of a PhD project and will be published so that researchers, those funding mental health services and people supporting female migrants will have a better understanding of some of the challenges and what works in supporting them.

We hope eventually this research will also make it easier for female migrants to access the support they need when they need it. We can send you a copy of the report if you would like to give us your preferred contact details to do so on the Consent Form.

9. Who is organising and funding the research?

The research is being carried out by a PhD researcher from the department of Primary Care and Public Health at Brighton and Sussex Medical School (BSMS). The PhD project is being funded by the National Institute of Health Research (NIHR) and the Kent, Surrey, and Sussex Applied Research Collaboration (KSS ARC).

10. Who has approved this study?

The research has been approved by the Brighton and Sussex Medical School Research Governance and Ethics Committee (RGEC). The ethical review application number of the study is ER/BSMS9K87/1.

11. Who is responsible if something goes wrong? /What if there is a problem?

If you have any concerns about any aspect of this study or about the way you have been approached or treated during the study, or how your information is handled during the study you should contact the lead researcher who will do their best to answer your questions. Contact details are provided below.

If you wish to make a complaint or have any further concerns please email the Lead supervisor of the PhD researcher, Professor Carrie Llewellyn: C.D.Llewellyn@bsms.ac.uk .

Alternatively, you may wish to contact the University of Sussex Research Governance Office via: rgoffice@sussex.ac.uk .

12. Contact for further information?

If you would like to find out more about any aspects of this study, please contact the lead researcher, Patrick Nyikavaranda, Email: p.nyikavaranda@bsms.ac.uk

13. Insurance

The Universities of Brighton and Sussex have insurance in place to cover their legal liabilities in respect of this study.

Thank you for taking the time to read this information sheet and for considering taking part in this research study.

Appendix O: Consent Form



Title of Project: Co-producing stigma-proof mental health interventions with and for newcomers (asylum seekers, refugees and migrants) in Southeast England

Research Team: Patrick Nyikavaranda, Carrie Llewellyn, Marija Pantelic, Priyamvada Paudyal, and Christina J Jones

This study has been approved by the BSMS Research Governance and Ethics Committee (RGEC) Ref no: ER/BSMS9K87/1

Thank you for considering taking part in this research. The researcher should have included an information sheet which gives information about this study. If you have any questions, please ask the researcher so that you are happy taking part in the study. You will be given a copy of this form and of the participant information for you to keep and refer to at any time.

By ticking or initialling in the tick box you are consenting to the information given in the sentence. If you do not tick or initial any part of a tick box, you understand that you are not consenting to this aspect of the statement and may be deemed ineligible for the study.

		Tick Box or Initial	
		Yes	No

1.	I consent to being interviewed by the researcher.		
2.	I agree to allowing the interview to be filmed / audio recorded. If I choose to keep my camera on, only the audio will be used for transcription of our discussion.		
3.	I agree to making myself available for a further interview should it be required.		
4.	I consent to the use of anonymised quotes in publications from the research.		
5.	In exceptional circumstances, where a disclosure is made regarding your safety or that of others, the researcher will be legally required to pass this information onto an appropriate individual or agency.		
6.	I understand that any information I provide is confidential, and that no information that I disclose will lead to the identification of any individual in the reports on the project, either by the researcher or by any other party.		
7.	I have read, or it has been read out to me, the information sheet, had the opportunity to ask questions and I understand the principles, procedures and possible risks involved.		
8.	I consent to the processing of my personal information and data for the purposes of this research study. I understand that such information will be treated as confidential and handled in accordance with data protection legislation.		
9.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project, nor do I have to give reasons for this. This does not affect my rights or care that I have.		
10.	I consent to my data being deposited in a UK Data Archive for re-use in future research and analysis related to this project. I understand that it will be fully anonymised before deposit.		
11.	I am happy for the Primary Researcher (male) to be present during my interview which may be conducted by a female researcher		
12.	I agree to take part in the above Brighton and Sussex Medical School (BSMS) research project.		
13.	I would like to be sent a summary of the study findings when they have been published.		

	By email (<i>this may be some time away so give an email which will remain valid</i>) Or Postal Address Or by community organisation:		
--	--	--	--

Date:

Signature:

Contact email of lead researcher: p.nyikavaranda@bsms.ac.uk

Thank you

Appendix P: About You

About You

This form is part of academic research being carried for a PhD project. It is aiming to understand the mental health needs of female migrants living in Kent, Surrey, and Sussex.

The information will be kept anonymous and confidential and used only for informational purposes of the project to get an understanding of the different people that took place in the study. Please do not write your name on this form.

1. Gender

Female	
Trans or non-gender conforming	

2. How old are you? (your age will not be included in the report but helps us to know which age range participants are in)

3. What is your highest educational qualification?.....

4. Ethnicity (you do not have to answer if you do not want to)

What is your ethnicity? (e.g., I am Chinese Asian)

.....

What is your first language? (e.g., Hindi)

.....

What is your religion? (e.g., I am Hindu)

.....

What is your country of origin? (e.g., I come from Tanzania)

.....

5. Who do you live with? (*Please circle all that apply*)

Parent/s/grandparent/s/brother/s/sister/s/friend/s/partner/with children or alone

6. How long have you been living in the UK?

7. How long have you been living in Kent, Surrey, Sussex? (To delete as appropriate for each region)

.....

8. Sexuality

Are you?

Heterosexual	
Lesbian /gay	
Bisexual/ pansexual	
Prefer not to say	

9. In your own words, what difficulties, if any, do you have with your mental health?

The information gained from this piece of research will be useful for the services to be aware of when trying to help, by providing mental health support, for female migrants

Thank you for completing this form.

Appendix Q: Letter to Jobcentre

Payment for public involvement for those in receipt of welfare benefits

Department of Primary Care and Public Health
Watson Building, Room 318
Brighton and Sussex Medical School
Brighton,
BN1 9PH

22 June 2022

To Jobcentre Plus

Mr/Ms/Mrs **xxxxxxxxxxxxxxxx** has been requested to assist Brighton and Sussex Medical School with service user involvement. We wish to ensure that the purpose of service user involvement is understood and is not mistaken for work.

What is Brighton and Sussex Medical School and the National Institute for Health Research?

Brighton and Sussex Medical School is a school which is part of the Universities of Brighton and Sussex. As well as taught programmes, the school is involved in research, some of which are funded by the National Institute for Health Research (NIHR). The NIHR is the nation's largest funder of health and care research and provides the people, facilities and technology that enables research to thrive. Working in partnership with the NHS, universities, local government, other research funders, patients, and the public, NIHR delivers and enables world-class research that transforms people's lives, promotes

economic growth and advances science. NIHR's mission is to improve the health and wealth of the nation through research. NIHR is primarily funded by the Department of Health and Social Care, but also receives UK Aid funding to support research for people in low- and middle-income countries.

What is service user involvement

People who can offer a service user perspective because of their personal experiences of using health and/or social care services are requested to assist in our work.

At NIHR, when using the term 'public' we include patients, potential patients, carers, and people who use health and social care services.

DWP have a full description of service users that applies to all benefits and can be found in Advice for Decision Makers Chapter H3: paragraph 3161.

The difference between service user involvement and work

Involvement in research activities should not be mistaken as capacity for work, and recruitment for service user involvement should not be confused with recruitment for employment. People are recruited because of their personal experiences of using health and social care services.

Service user involvement activities:

- are intermittent and people can withdraw at any time
- vary in length and in frequency, and usually last for a few hours (or less) in any one week
- are individual activities and do not imply future involvement
- may include attendance of quarterly or annual meetings
- may include contributing to intermittent meetings or telephone conferences
- may include helping to prepare for meetings, telephone conferences or events
- may include some follow-up activities after meetings or events

Any payment that is offered for service user involvement is intended to cover preparation, attendance and appropriate follow-up activities.

Support provided

Organisations provide support measures that are appropriate for each individual, so that members of the public can attend and contribute to our meetings and events. Some people who we involve may be in receipt of benefits for mobility or care needs. Involvement in activities should not be interpreted as a reduction in the care or mobility needs of service users involved.

Support for care or mobility needs is offered as required by the service user and may cover preparation, travel to and from a venue, and contributions both during and after the activity. For example, support may include provision of childcare, or provision of a personal assistant or a support worker.

Payment for service user involvement

Good practice guidance for service user involvement in research recommends that members of the public should be offered payment for activities such as attending meetings and events, and that reasonable out-of-pocket expenses should be covered. Please note that:

- as involvement activities are often arranged on an ad hoc basis, organisations often pay service users monthly in arrears
- to assist service users who receive welfare benefits which have earnings limits or disregards, organisations offer involvement on a voluntary basis, or at a lesser amount, if requested

- as the payment period may be over a month or more, we anticipate that Jobcentre Plus will treat these payments as averaged over the payment period. See DMG Chapter 48 paras 4080-81 and for a cycle of work para 48094.
- the Department for Work and Pensions legislation exempts ‘service users and carers’ from the application of notional earnings and treats reimbursed expenses for service user involvement as ignored (see ADM Chapter H3, paras 3160 and 3241)
- service users can withdraw from involvement activities at any time to attend ‘employment-related’ activities
- the Department for Work and Pensions legislation for persons who receive Employment and Support Allowance on exempt work now allows earnings at the higher level of Permitted work without time limit (see Memo DMG 7/17)

Please do not hesitate to contact me if you require further information.

Patrick Nyikavaranda

p.nyikavaranda@bsms.ac.uk

Appendix R: Initial results of multivariate linear regression analysis with bootstrapping

Appendix R Table provides a comprehensive summary of the linear regression analysis, including coefficients, standard errors, t-values, p-values, confidence intervals, and bootstrap estimates for each predictor variable.

Appendix R Table: Detailed results of multivariate linear regression with bootstrapping

Predictor Variable	B	SE	t	p-value	95% CI for B	Bootstrap Bias	Bootstrap SE
(Constant)	12.627	0.206	61.348	<.001	[12.223, 13.062]	0.001	0.210
Binary Country of Origin	-0.238	0.265	-0.897	.370	[-0.795, 0.258]	0.001	0.274
Ethnicity (Ref: White)							
- Black	-0.170	0.050	-3.389	<.001	[-0.258, -0.072]	0.002	0.050
- Asian	0.079	0.063	1.566	.211	[-0.045, 0.203]	0.002	0.063
- Mixed or Multiple	0.079	0.063	1.566	.211	[-0.045, 0.203]	0.002	0.063
- Other	0.196	0.081	2.422	.015	[0.037, 0.355]	-0.001	0.079
Migration and Ethnicity Interaction	0.159	0.076	2.080	.038	[0.010, 0.308]	-0.001	0.079
Diagnosis Category (Ref: Common)	0.020	0.073	0.278	.781	[-0.122, 0.162]	-0.001	0.077
Living Arrangements (Ref: Alone)							
- With Partner	-0.013	0.016	-0.791	.429	[-0.045, 0.019]	-0.001	0.016

Missing Values Analysis

Univariate Statistics

	N	Mean	Std. Deviation	Missing		No. of Extremes ^a Low
				Count	Percent	
Age_Group	59824	3.53	3.113	0	.0	0
Log_HoNOS	33233	2.3199	.58253	26591	44.4	1675
MHA_sectioned	59824			0	.0	
Binary_Country_of_Origin	59824			0	.0	
ethnicity_recoded	57444			2380	4.0	
Diagnosis_Category	35894			23930	40.0	
Lives_With_Cat_Num	59824			0	.0	
emergency_referral	59824			0	.0	

Univariate Statistics

No. of
Extremes

High

Age_Group	31
Log_HoNOS	57
MHA_sectioned	
Binary_Country_of_Origin	
ethnicity_recoded	
Diagnosis_Category	
Lives_With_Cat_Num	
emergency_referral	

a. Number of cases outside the range (Mean - 2*SD, Mean + 2*SD).

Summary of Estimated Means

	Age_Gro up	Log_HoN OS
All Values	3.53	2.3199
EM	3.05	2.3730

Summary of Estimated Standard Deviations

	Age_Gro up	Log_HoN OS
All Values	3.113	.58253
EM	2.486	.56067

EM Estimated Statistics

EM Means^a

Age_Gro up	Log_HoN OS
3.05	2.3730

a. Little's MCAR test:
Chi-Square =
686.417, DF = 1, Sig.
= .000

EM Covariances^a

	Age_Gro up	Log_HoN OS
Age_Group	6.179	

Log_HoNO S	.061	.31435
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a. Little's MCAR test: Chi-Square = 686.417, DF = 1, Sig. = .000

EM Correlations^a

	Age_Group up	Log_HoN OS
Age_Group	1	
Log_HoNO S	.044	1

a. Little's MCAR test: Chi-Square = 686.417, DF = 1, Sig. = .000

Transforming HoNOS scores and robust testing

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Log_HoNO S	33233	55.6%	26591	44.4%	59824	100.0%

Descriptives

		Statistic	Std. Error
Log_HoNO S	Mean	2.3199	.00320
	95% Confidence Interval for Mean	Lower Bound	2.3136
		Upper Bound	2.3261
	5% Trimmed Mean	2.3564	
	Median	2.3979	

Variance	.339	
Std. Deviation	.58253	
Minimum	.00	
Maximum	3.76	
Range	3.76	
Interquartile Range	.63	
Skewness	-1.078	.013
Kurtosis	1.924	.027

Tests of Normality

Kolmogorov-Smirnov^a

	Statistic	df	Sig.
Log_HoNO	.104	33233	<.001
S			

a. Lilliefors Significance Correction

