Nigerian and Ghanaian young people's experiences of care for common mental disorders in inner London: Protocol for a multimethod investigation

Introduction

Since the 1970s, there have been concerns that the mental health system in the UK does not lend itself to the specific needs of Black people [1]–[3]. This may have led to the establishment of the Nafsiyat intercultural therapy centre for ethnic minorities in London in 1983 [4], [5]. Yet in 2018, the Care Quality Commission (CQC), an independent regulator, published its findings from a review in England of Child and Adolescent Mental Health Service (CAMHS) entitled 'Are we Listening?' [6]. This revealed that CAMHS are still not responsive to the specific needs of Black young people and other minorities even in areas with ethnically diverse populations. They "found that commissioners and service planners had failed to engage with … young people, families, and carers to understand their needs and expectations" [6, pp. 37–38]. Direct engagement with ethnic subgroups is a gap in knowledge that this study aims to fill.

Thus, this study aims to engage with a section of two underserved communities, Nigerian and Ghanaian young people (NAGYP), to increase understanding of their care needs for common mental disorders (CMD) in inner London. The study will also engage with their parents or carers, and practitioners to capture their views on CMD and mental healthcare (MHC) models. It starts from the position that MHC needs to be reflective of cultural humility to NAGYP as conceptualised in multi-cultural competencies [7], [8]

This is the first study in the UK to explore NAGYP mental health experiences as part of the push against a one-size fit all approach to MHC [9,10,11]. In the domain of ethnic minorities, Lavis [9], Butt et al [10] and London Assembly [11] highlight the need to pay specific attention to the needs of the different sub-groups and individualisation as paramount. Vostanis et al [12, p. 764] in their work on Indian adolescents in England argued that "rather than a blanket approach being applied to policy and service planning to meet the needs of diverse communities of young people, more specific evidence needs to be gained". This NAGYP study will add to the body of evidence given their population size in the UK.

The 2011 Census analysis for ethnicity (as we wait for the 2021 Census due to be published early 2023 [13]) estimated 312,000 Nigerian-born and 130,000 Ghanaian-born people live in the UK [14]. It also showed around a fifth of the foreign-born population of

England and Wales were born in Africa (17%). Nigeria (n=191,000) and Ghana (n=94,000), both account for up to 89% of the Black/Black British residing in England and Wales [15]. London is the setting of this study with a 2020 population of 9 million [16] and of the non-UK born, London has a Nigerian and Ghanaian population of 135,000 and 63,000 respectively [17]. These population sizes are much larger than those of the Jewish community (n = 7,770) in the City of Salford, Greater Manchester [18], or the Chinese (n = 14,000) in Northeast of England [19], both of which have already been the subject of research on their young people.

Prevalence of common mental disorders (CMDs) varied by ethnicity

The 2014 age-standardised data showed on average Black people are more likely to report a CMD; Black & Black British 23%, Mixed & Other 20%, Asian & Asian British 18%, White British 17%, White Other 14%. [20], [21]. For children and young people, the latest series (2017, 2020, 2021) of mental health surveys sponsored by the Department of Health and Social care did not show CMD prevalence by ethnicity. For all ethnic groups, CMD rates were higher in girls (10.0%) than boys (6.2%) in 5 to 19 year olds [22], [23]. The data for ethnicity was on general mental disorder, among 6 to 23 year olds, White British, mixed or Other, Asian/Asian British and Black/Black British were estimated as 18.9%, 22.5%, 8.4%, and 8.3% respectively [23].

There are a few issues to consider regarding lack of data and its inconsistencies. First, data for CMD prevalence by ethnicity is grossly limited. There is evidence of variation of CMD prevalence and symptoms presentation among ethnic subgroups [24], [25]. The London Assembly [11, p. 5] was unequivocal that nuanced data on ethnic subgroups “simply does not exist”. When the nature and scale of the demand for mental health services is not known, it inhibits policies and service planners’ responses. The Assembly emphasised frustration of funding and commissioning services with little or no knowledge of the demand for those services.

Second, data suggests links between poor mental health, youth and gang violence [26]–[28]. This, often involving young Black people, has led to them being wrongly associated with a tendency to criminality, rather than this being acknowledged as the result of structural inequalities. A practitioner participant in Fitzpatrick et al’s [29, p. 7] study said “when I became a consultant […] I saw Black people …, not being given the more respectable diagnoses but the more derogatory ones, those that carry punishment instead of therapy”.

Definition of common mental disorder

The British Psychological Society and The Royal College of Psychiatrists recognise ‘depression’ (including subthreshold disorders) and ‘anxiety’ (including generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) as CMD [30, p. 14]. In some literatures, depression and anxiety disorders are recognised and are often grouped together as 'emotional disorders' as a more restrictive definition of CMD [9], [11], [31], [32]. CMD (common mental disorder) has been chosen as the acronym or term in this protocol to align with the NCCMH and NICE (National Collaborating Centre for Mental Health and National Institute for Health & Clinical Excellence) definition.

Study aim and objectives

The primary aim is to investigate the NAGYP experiences of MHC for CMD in inner London in order to give voice to their views and preferences for service improvement. The study has five key objectives:

1. To identify the care and treatment options available for NAGYP in London living with CMD.
2. To evaluate how culturally appropriate and potentially adaptable is the Positive Practice Guide of Improving Access to Psychological Therapy (PPG-IAPT) for NAGYP Service Users which is the first line of treatment for CMD.
3. To investigate the lived experience of NAGYP of care for CMD in inner London, and the views of their parent/carer on the construct of CMD
4. To ascertain how practitioners employ models in their repertory to care for NAGYP
5. To understand how could NAGYP’ views, preferences and expectations inform care and practice design.

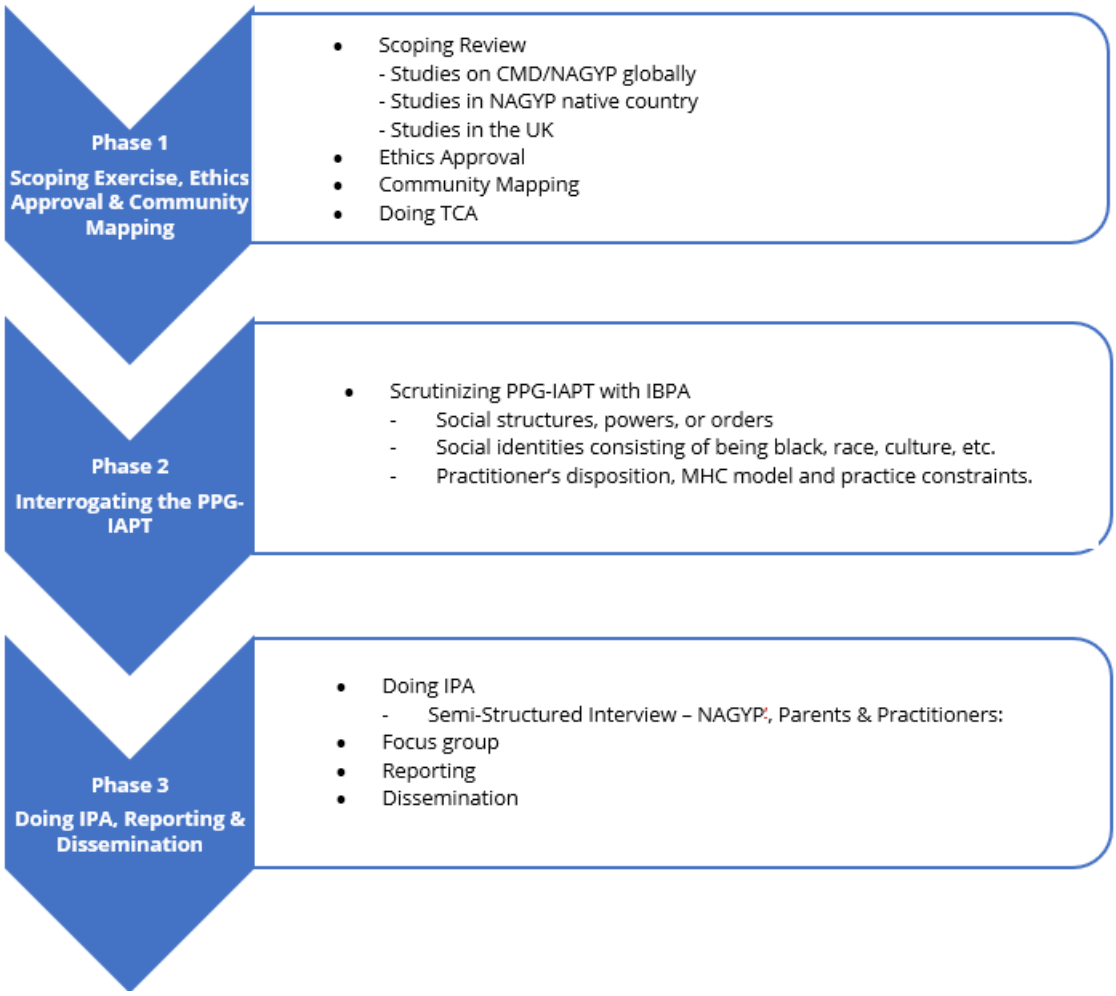
Methods

Combining Thematic Content Analysis (TCA), Interpretative Phenomenological Analysis (IPA) and Intersectionality-Based Policy Analysis (IBPA).

This study has chosen three contemporary complementary methodologies to achieve the research objectives at different phases. This choice stems from the consideration of CMD as a phenomenon and its impact on NAGYP social worlds. These philosophical underpinnings reflect the personal and professional background of the lead researcher as a Black man, a social worker and the sensitive nature of the phenomenon, both in terms of cultural stigmatisation [11], [25] and institutional mistrust [37] that characterises NAGYP’s reality.

While Thematic Content Analysis (TCA) will focus on NAGYP's lived experiences in terms of what CMD as a phenomenon "looks like", Interpretative Phenomenological Analysis (IPA) [39] will focus on how it "feels like" [38, p. 430]. In context, TCA will culminate in "deeper-level analysis relating to power and communities" [38, p. 430]; on the other hand, IPA will "give voice" to and "make sense" [40, p. 102] of NAGYP's own accounts. In addition, Intersectionality-Based Policy Analysis (IBPA) [41] will focus on intersectional issues, particularly on how NAGYP social identities related to race, culture, religion, status, etc., and dispositions intersect with shared social structures and context [42], [43]. IBPA will be used to scrutinize the PPG-IAPT for NAGYP constituents in order to expose those assumptions that characterise policy formulation without robust direct engagement with those for which the policies are actually meant [44], [45]. The study will be undertaken in three comprehensive phases, see figure 1.

Figure 1: NAGYP London research design



Phase 1: Scoping exercise and Community Mapping

Scoping exercise

In the UK and in England in particular, there is a body of work on CMD in relation to ethnic minority children and young people [29], e.g. [46]–[50]. However, little is known about Blacks/Africans specifically [25], e.g. [51], [52] and very little or nothing is known of the individual or combination of this study's subgroups (Nigerian and Ghanaian), geographical location (London) and their relationship with the phenomenon (CMD). Thus, this phase will review literatures which examine elements of NAGYP and Black Africans with experience of CMD. Boote and Beile [53, p. 7] suggest that for topics about which little or nothing has been written the reviewer may need to "broaden the search" to explore related topics. Therefore, the principles of a scoping review will be employed to "determine the scope or coverage" [54, p. 2]. Cooper [55, p. 110] argues that "coverage" is the most distinct element

of literature reviewing. Thus, the coverage will include NADYP native lands, and UK studies, though with a particular focus on London as being the primary geo-socio-political context of this study. Relevant themes will be critically analysed and will inform further phases of this study.

Studies on the CMD construct related to NAGYP domain globally: the rationale, understanding the impact of CMD on Black African young people at a global level will be important to place our UK findings in context. Attention will be given to the location and social context from which samples were drawn.

Studies in NAGYP native countries: relevant studies undertaken in Nigeria and Ghana will be synthesised. Findings from NAGYP homelands will increase understanding of the perceptions of NAGYP, general disposition and what they make of CMD. This is crucial because when people migrate, they do so with the health perceptions, cultural and religious beliefs developed within their country of origin.

Studies in the UK: in the UK, since health is a devolved matter across the constituent countries, relevant literatures will have national spread across England, Scotland, Wales, and Northern Ireland. However, the literature from England, specifically London where possible, will have primacy in informing further stages. London is the primary social, political, and environmental context of this study where the researcher will engage in multimethod research activities with NAGYP, parents or carers, and practitioners.

The selected databases and libraries include: IBSS - International Bibliography of the Social Sciences; ASSIA – Applied Social Sciences Index and Abstract; Web of Science; SCOPUS; UCL (University College London) Explore; Google Scholar; and Academic Search Complete (via London Senate House Library). These databases host a rich variety of social science peer reviewed literatures with international coverage. In addition, studies will be added through snowballing from the included studies reference lists [56].

Ethics Approval

Ethical approval has been granted by the UCL Institute of Education Research Ethics Committee with reference number: Z6364106/2022/02/28 (health research) from 3rd May 2022. We are waiting approval from National Health Service (NHS) Health Research Authority (HRA) Ethics Committee.

Community Mapping

Rigorous community mapping will be undertaken in these inner London boroughs: Camden, Greenwich, Hackney, Hammersmith and Fulham, Islington, Kensington and Chelsea,

Lambeth, Lewisham, Southwark, Tower Hamlets, Wandsworth, Bexley, and Westminster. These have been chosen from amongst the total 32 boroughs of London because they host large numbers of the NAGYP population [57]. There are five objectives in community mapping within London boroughs: (1) To identify community-based organisations delivering specific MHC services to NAGYP/ Black Africans or minoritized groups within them. (2) To ensure voluntary and statutory organisations with departments with such services are included within them. (3) To attend a representative sample of meetings where relevant care is being discussed or delivered. (4) To conduct an informal interview with a representative sample of practitioners. (5) Doing TCA with Framework approach.

The objective is to investigate the ways and the extent to which MHC and elements of models are actually adapted by practitioners to meet the specific mental health needs of NAGYP. Contacts will be made directly with these departments or teams. Permission will be sought to attend and observe selected meetings, at least one from each borough, where care plans are discussed, and workshops or sessions where care is delivered in action. The ones deemed appropriate will be attended with due regard to full ethical and governance requirements. If permission is not granted, data from the relevant service websites would be analysed instead. Some practitioners (n = 20-25) will also be invited for an informal interview at this stage.

Informal Interviews

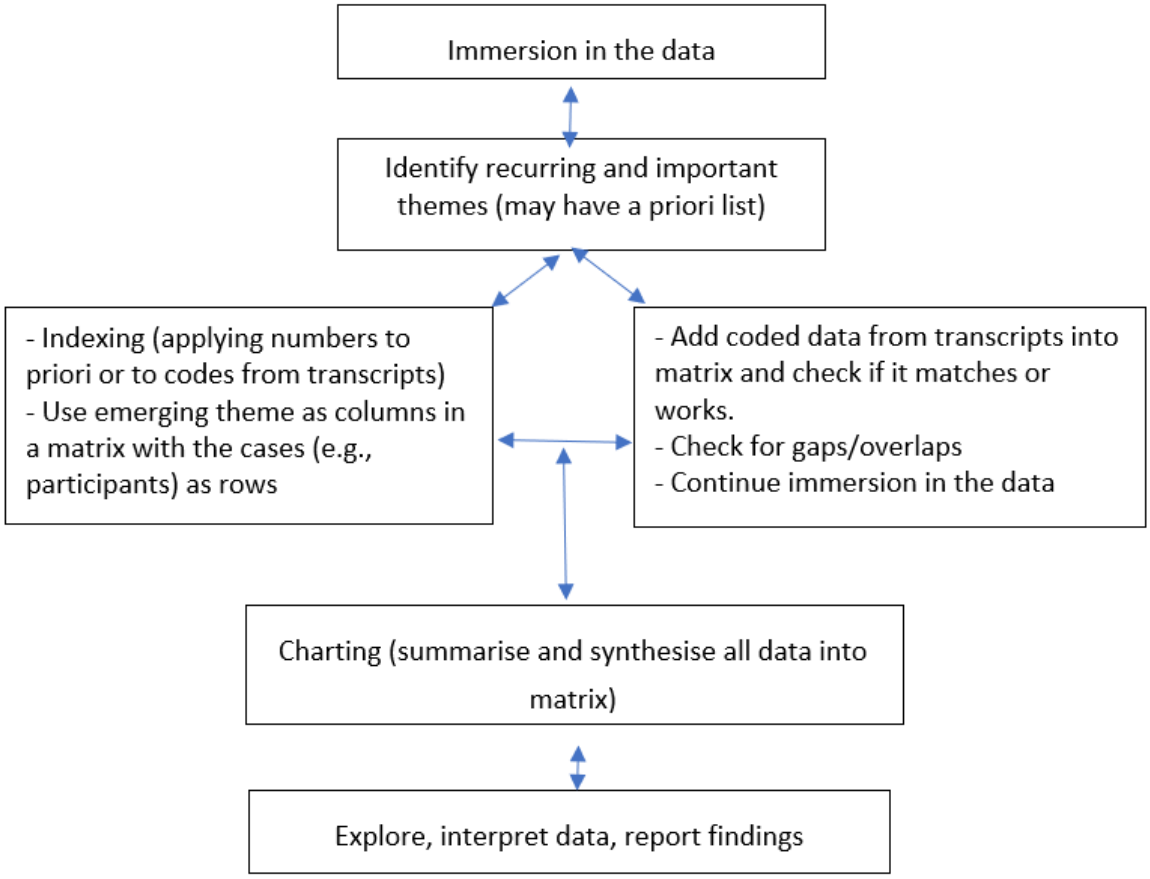
Various spontaneous unscheduled interviews will be undertaken with practitioners after meetings or observed sessions either to clarify or to better understand certain approaches or practices. These informal interviews are meant to complement what the researcher observes, as ethnographic interviews [58]. This has the potential of validating what is discussed in meetings, adding to authenticity of the data. The interview content will be written in a field note book as soon as possible as it may not have been recorded due to the spontaneous nature of the interview [58]. Informants may provide different amounts of information depending on what the researcher need to know. To manage bias, the information collected will be incorporated as field note data rather than as interview data.

Doing Thematic Content Analysis with Framework approach

The qualitative data generated in this phase will be analysed using the framework approach. Framework matrices (called charts) enable the analysis of data from a wide variety of sources such as, from websites, pdfs, audio or video recordings, blog posts, field notes, memos and including transcripts generated from the informal interviews. The approach allows all data to be collected before analysis begins. Data will be imported into NVivo

where it will be summarised in charts, according to pre-determined themes [60]. The reporting for TCA is normally written in a descriptive list, as ‘careers’ or journeys through time or place, or as a typology. For this study, it will be written in a descriptive list format to ensure findings are communicated in a concrete manner (rather than more conceptually) that makes sense to the wider audiences [38]. The process is illustrated in Figure 2.

Figure 2: Stages of the Framework approach [38]



Phase 2: Interrogating the Positive Practice Guide of Improving Access to Psychological Therapy (PPG-IAPT) for Blacks and ethnic minorities

IBPA will be used to scrutinise the PPG-IAPT as the main MHC national policy and other organisational internal policy and procedures for NAGYP and its constituents with CMD. IBPA is an "equity-promoting public policy analysis" framework [41, p. 136] which will be used to perform a multi-levelled intersectionality analysis. The analysis will emphasize the simultaneous interplay and triangulation between:

1. The social structures of institutions, powers, or orders on one strand
2. Social identities consisting of being black race, culture, religion etc. as the second strand
3. Practitioner's disposition, MHC model and practice constraints as the third strand.

The aim is to ascertain the PPG-IAPT and its related policy of its cultural adaptiveness and appropriateness to the specific needs of NAGYP Service Users. The two core components of IBPA will be utilised

a. A set of guiding principles (see Figure 3) and
b. A list of 12 overarching questions (see Table 1) [41] with a set of sub-questions [66].

The design is for the principles to be used with the questions (including with the sub-questions) simultaneously. Each of the questions will be asked and answered in a manner that would depict explicit intersectionality informed analysis. The aim is to draw attention to those assumptions that characterise policy formulation without robust direct engagement with those the policies are met for [44], [45].

Figure 3: Guiding principles of IBPA [41]

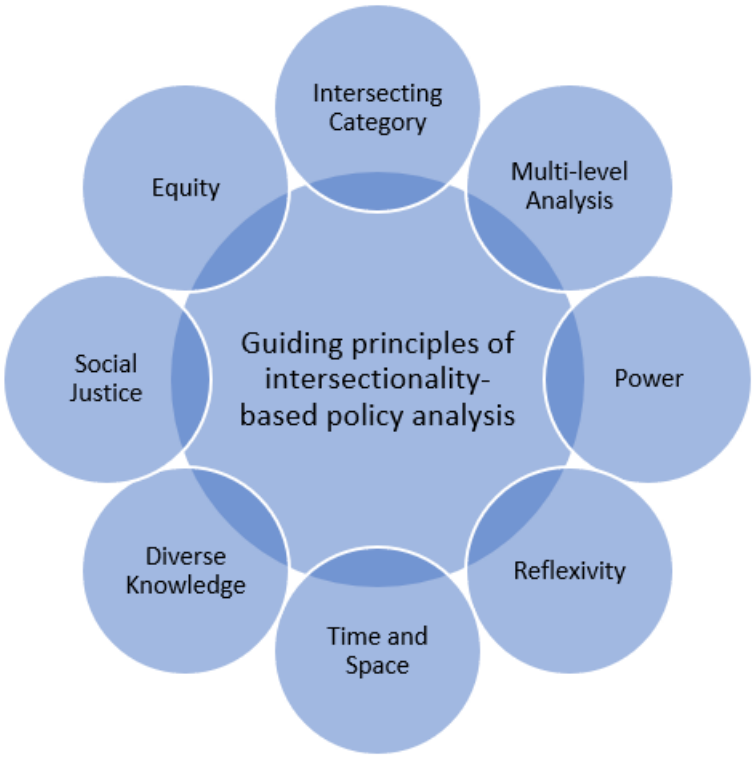


Table 1: Descriptive and transformative questions of IBPA adapted from Hankivsky [41]

Overarching Questions
Descriptive Questions 1. What knowledge, values, and experiences do you bring to this area of policy analysis? 2. What is the policy 'problem' under consideration? 3. How have representations of the 'problem' come about? 4. How are groups differentially affected by this representation of the 'problem'? 5. What are the current policy responses to the 'problem'? Transformative Questions 6. What inequities actually exist in relation to the problem? 7. Where and how can interventions be made to improve the problem? 8. What are feasible short-, medium- and long-term solutions? 9. How will proposed policy responses reduce inequities? 10. How will implementation and uptake be assured? 11. How will you know if inequities have been reduced? 12. How has the process of engaging in an intersectionality-based policy analysis transformed: - Your thinking about relations and structures of power and inequity? - The ways you and others engage in policy development, implementation and evaluation? - Broader conceptualizations, relations and effects of power asymmetry in the everyday world?

The 12 questions are divided into two categories, the first 5 are termed 'descriptive'. This will expose the critical background information about the problem in the PPG-IAPT and

its related policies for ethnic minorities. This phase will pay particular attention to how those problems the policy is meant to ameliorate are identified, (de)constructed, and then addressed. For example, only 1 Nigerian and no Ghanaian was involved in the focus group in the formulation of the PPG-IAPT. This will bring to light the assumptions as well as the inequities or privileges, if there are any, that inundate the policy position. The remaining 7 questions are termed 'transformative'. These are intended to help identify alternative policy responses or proffer suitable solutions that could provoke social and structural change. Phase 1 will play a fundamental role in this. The overarching goal of IBPA is to reduce inequities, if not completely eradicate them, and ultimately to promote equity and social justice [41].

Hankivsky et al [41, p. 138] argued that "simplicity and flexibility are key features of the Framework" All the 12 questions may not be relevant in this study. For this study, some of the question may be prioritised and given more consideration than others due to context and approaches to implementation adopted by individuals or teams. What is critical is that the questions are rooted in key intersectionality principles subsumed in structure and politics [43]. The combined effect of these categories of questions on the PPG-IAPT for minoritized groups as a national policy position and its related policies and procedures peculiar to individual organisations would transform the ways its associated problems and processes are understood.

Phase 3: Engaging with NAGYP, Parents and Practitioners

This is the core of the study and provides, through semi-structured interviews, an in-depth understanding of the lived experiences of NAGYP on the MHC received for CMD. Their parents and practitioners' views are a key part of this. The focus of this is to use IPA to "give voice" and "make sense" [40, p. 102] of NAGYP's experiences in their own words, terms and accounts without affiliation to any existing theory or concepts [39].

Semi-structured interviews

A. Semi-Structured Interview – NAGYP:

25 - 30 NAGYP participants of age range 16 – 25 years old will be identified and recruited from the Phase 1 exercise. In addition, participants will be recruited through local gatekeepers such as notable voices, faith and community leaders, local associations, and voluntary service providers within the community. The interview will explore themes related to the following topic:

- Meaning and perception of CMD
- Experience during therapy

- Views, preferences, and expectations
- Anything particularly helpful in MHC?
- What to stop, start or continue

B. Semi-Structured Interview – NAGYP Parents or Carers:

This is aimed at capturing about n = 15 - 20 NAGYP parents' views and perceptions of CMD and MHC constructs. Topics will aim to enable the following:

- Reducing the negative connotations and harmful superstitions of CMD that characterise NAGYP communities
- A more liberal understanding of CMD
- Improving access to early intervention or professional help.

Parents and carers will be interviewed because the meaning they attach to CMD discourses, negative or positive, are often passed on to their young people due to the strong family ties that exist between Black parents, children and young adults resulting from their cultural dispositions of the family unit [67], [68].

C. Semi-Structured Interview – NAGYP Practitioners:

The interviews will be designed to elicit practitioner's practical knowledge of MHC models. They are aimed at practitioners in the selected London areas who have delivered MHC to NAGYP. Up to 15 - 20 participants will be identified from phase 1. One practitioner will be included in an embedded pilot. The knowledge generated from this research activity would be used to categorise the different practitioners' understandings of MHC models relating to the services they provide for NAGYP as well as the options available within and across disciplines. The dimensions of the categorisation will be substantiated in the domain of MHC models in existing literatures as currently understood. However, their preference for modification or for new MHC models for NAGYP will be benchmarked against the medical and social models of disability [69] and Eurocentric and Afrocentric MHC. The interview topic guide is:

- The most prevalent CMD diagnosis of NAGYP service users
- Own experience as a therapist supporting NAGYP
- Professional training received in response to meeting the needs of NAGYP or Black young people in general.
- Perception of the suitable model of intervention.
- Effective ways of integrating the model with the PPG-IAPT.
- Challenges and key determinants of success in providing MHC to NAGYP
- Potential examples of positive practice.

- The future of MHC for NAGYP

Doing the Interpretative Phenomenological Analysis (IPA)

This phase will culminate in the IPA protocol. The most recent changes for the terminology of IPA will be adopted in the analysis. For example, the usual emergent themes and superordinate themes will be called experiential statements and Personal Experiential Themes (PET) respectively [70], [71]. The following steps in Table 2 will be adhered to.

Table 2: Steps in doing IPA adapted from Smith et al [71]

Steps in doing IPA	
Step 1	Starting with the first case: reading and re-reading, be immersed in the transcript. This is to make sure the respondent becomes the focus of the analysis. Similar to TCA.
Step 2	Exploratory noting: disentangling semantic content, language and conceptual comments with an open mind, noting everything of interest and developing avowedly interpretative statement relating to context. This will be reviewed with my supervisor.
Step 3	Constructing experiential statements: the process of consolidating and crystallizing the exploratory notes. This process represents one manifestation of the hermeneutic circle, that is, 'the me' and the lived experiences of the participant in collaborative (co-creating) efforts. Tied within local instances in the transcript.
Step 4	Searching for connections across experiential statements: clusters of statements can be organised through different possibilities, employing flexibility.
Step 5	Naming the Personal Experiential Themes (PETs), consolidating and organizing them in a table. Not tied within local instances but within the transcript as a whole.
Step 6	Continuing the individual analysis of other cases: the same steps 1 - 5 will be repeated for other cases in their own terms and individuality, in keeping with IPA's idiographic commitment

Step 7	Working with Personal Experiential Themes to develop Group Experiential Themes (GET) across cases: drawing links between each PET to create GET.

Focus group

Paying greater attention to the views and preferences of NAGYP towards CMD and MHC to inform care and practice design, focus groups will be used to engage with NAGYP. Participants will be recruited through the established contacts from Phase 2 and 4. Seven to ten NAGYP participants of age range 16 – 25 years old will be involved in the focus group discussion. The topic guide will be informed by the data collected so far; two sessions are anticipated. The activities will be documented and analysed using standards for handling data of multiple voices [72], [73]. The focus groups will explore: the experiences of the MHC; the experiences that play a significant role in recovery; what worked well; and what to stop, keep or continue.

Results

The study has been approved by UCL Institute of Education Research Ethics Committee Z6364106/2022/02/28 (health research) and recruitment has begun in the 13 inner boroughs of London. Data collection through semi-structured interviews and focus groups is expected to be finalised by early 2024 and the study published by early 2025.

Discussion

The aim of this study is to investigate NAGYP lived experiences of care for CMD in inner London. The study anticipates identifying the care and treatment options available, the cultural appropriateness of the PPG-IAPT for NAGYP service users, which is the first line of treatment, as well as parents' views and practitioners' dispositions on models of care. We hope the outcomes of this study will contribute to providing a response to the London Assembly recognition of mental disorder as a peculiar problem being faced by young Londoners, particularly from minority ethnic sub-groups. The Assembly acknowledged how this could negatively impact their wellbeing and economic capacities [12]; some impacts may lead to antisocial behaviours and fatality [26], [27]. We also expect the findings to be consistent with the recommendations in the joint Green Paper published by the DHSC (Department of Health & Social Care) and DFE (Department for Education) [78]. The Green Paper captured the views and expectations of 65 respondents from Black or minority ethnic background, LGBT+, and/or having a disability, all were under the age of 25 years. Their expectations were unequivocal, including to create a welcoming environment, train the

CAMHS workforce to gain cultural competence skills, provide bespoke MHC, improve service awareness, and provide out of term time support [78]. These expectations highlighted in the Green paper have not yet been met; a report published in February 2022 by the NHS Race and Health Observatory body found evidence of ethnic inequalities in every area reviewed [79].

The NHS Race and Health Observatory is an independent expert body given the responsibility of examining health inequalities experienced by minority ethnic groups in England of which NAGYP are a major constituent. Their main findings in a review revealed that Black peoples' fear and distrust of mental health services forms "clear barriers to seeking help" [79, p. 11]. Thus, a key strength of this study is in the bottom-up and transparent methodological choices. For example, TCA interrogates NAGYP's lived experiences of what CMD as a phenomenon looks like, and how it feels like, IPA allows idiographic account in participants' own words and terms to allow the very essence of the phenomenon to reveal itself in its primordial form [40], [80]. Then, NAGYP social identity and context is explored within the precepts of IBPA.

The main potential limitation- whilst also a richness - is that qualitative methods are focused mainly on participants' experiences [82], [84] and aim to access participants' social world. As such, IPA researchers, Smith et al [80] acknowledges, might strongly influence the interpretation of the respondent's world. According to Larkin et al [40], the wide range in interpretative frameworks available for IPA constitutes a practical problem. Cromby & Nightingale [85] noted that the part of the participant world the researcher would want to make real or relative may be typically dependent on choices shaped by the researcher's "moral, political or pragmatical precepts" (p. 8) in the stead of epistemological choice. Larkin et al [40, p. 108] puts it succinctly that "we can never fully escape the 'preconceptions' that our world brings with it", thus, transparency is key. Therefore, Larkin and Thompson [86] and Smith et al [72] recommended that a meticulous detailed, organised, plausible and transparent account of the analytical process must be kept. This study will do so.

With respect to the overarching aim of this pragmatic study which centres on equitable MHC, Article 1 of the 1992 United Nations' Minorities Declaration expects the State to protect a minority's existence [87]. In the UK, the Equality Act [88] places statutory duty on public sectors and wider society to promote racial equality, including in MHC. The process to improving this research population's MHC may positively impact on them, friends and associates, and their involvement in street and knife crimes in the future; might combat stigma, reduce the negative connotations and harmful superstitions of mental health

related issues that characterises these communities; and might contribute to a more liberal understanding that could elicit accessing early intervention or seek professional help. The findings of this study are expected to be published in 2025.

Acknowledgements:

Isiwele, A. had the original idea and is the key contributor. I would like to acknowledge the supervisory role by Rivas, C. and Stokes, G, on the project.

Data Availability

The datasets collected and analysed in the duration of this study will be made available from the corresponding author on reasonable request.

Conflicts of Interest: None declared

Abbreviations

CAMHS: Child and Adolescent Mental Health Service
CMD: common mental disorders
CQC: Care Quality Commission
DHSC: Department of Health and Social care
IBPA: Intersectionality-Based Policy Analysis
IPA: Interpretative Phenomenological Analysis
MHC: mental healthcare
NCCMH: National Collaborating Centre for Mental Health
NICE: National Institute for Health & Clinical Excellence)
NAGYP: Nigerians and Ghanaians young people
PPG-IAPT: Practice Guide of Improving Access to Psychological Therapy
TCA: Thematic Content Analysis
UCL: University College London

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