A Multimethod Investigation into Nigerian and Ghanaian Young People's Experiences of Care for Common Mental Disorders in Inner London

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University College London

Anthony Isiwele
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Abstract

This study explores the lived experiences of Ghanaian and Nigerian young people in Inner London regarding their care for anxiety and depression. Despite global and national efforts to enhance mental health support, disparities in accessing care persist, especially for Black African communities. The study aims to understand how these young individuals navigate the mental healthcare system and identify their needs and preferences concerning appropriate care.

Interpretative phenomenological analysis (IPA) was used for data from semi-structured interviews with young people, parents, and practitioners. This approach enabled an in-depth exploration of personal narratives and provided a nuanced understanding of their experiences, incorporating intersectionality theory. Additional participatory work through a Research Impact Workshop engaged Ghanaian and Nigerian youth, parents, community leaders, and practitioners. Activities included facilitated discussions, group presentations, and collaborative action plan development, using methods like small group discussions and anonymous contributions with Post-it notes. This approach aimed to ensure all voices were heard, fostering cultural humility and co-creating solutions to improve mental healthcare for Black youth in Inner London.

The findings highlight the inadequacies of existing care models, which often fail to address the cultural and social complexities these young people face. Participants expressed feelings of being misunderstood by practitioners and noted a lack of culturally sensitive approaches in therapy. The study reveals a disconnect between standardised care practices and the lived realities of these communities, emphasising the need for tailored, culturally humble approaches to mental healthcare.

In conclusion, this research emphasises the importance of integrating cultural humility into mental health services to better serve Ghanaian and Nigerian youth. It calls for policy reforms and practice adaptations that reflect the diverse needs of Black youth, aiming to reduce disparities and foster more inclusive mental healthcare practices in Inner London.

Impact statement

In this thesis, I explore the lived experiences of Ghanaian and Nigerian young people navigating care for anxiety and depression in Inner London. This study holds significant potential for application both within academic scholarship and in shaping real-world mental health practices and policies. My research addresses critical gaps in both understanding and practice by centring the unique cultural and systemic factors that influence access to and perceptions of mental healthcare. Impact forms an integral part of this work and is discussed with more nuance in Chapter 6

Within the academic sphere, my research contributes to disciplines such as psychology, social work, and mental health studies by offering a nuanced perspective on culturally relevant care models. Through the use of Interpretative Phenomenological Analysis (IPA) and intersectionality, the study challenges traditional Evidence-Based Practices (EBP) that often overlook intrinsic cultural contexts. This approach enriches the literature on mental health disparities and encourages future research to adopt methods that prioritise participant narratives and the specific cultural realities that shape their experiences. As such, my findings can inform curriculum development in universities, guiding students and researchers toward more inclusive methodologies that better address the needs of marginalised communities.

Beyond the academic realm, the study's insights have direct implications for mental health practitioners and public health professionals. By identifying the barriers that Ghanaian and Nigerian youth face, such as cultural stigma and systemic distrust of mental health services, the research suggests practical strategies for making therapy more accessible and effective. Training programs for therapists can integrate these insights by including modules on cultural humility and understanding the role of intergenerational dynamics in shaping young people's attitudes towards mental health. This can lead to more tailored therapeutic approaches, improving the quality of care for Black African youth in diverse urban settings like London. This was detailed in Section 7.4, operationalising an intersectionality-based cultural humility framework.

Additionally, the study's findings can support the design of community-based mental health initiatives to reduce stigma and enhance service accessibility. Engaging with the lived experiences of young people and their parents, my research emphasises the value of community-led awareness programs. These initiatives could leverage trusted community leaders and faith-based organisations, bridging gaps between formal mental health services and the cultural contexts that influence help-seeking behaviours. Such an approach can enhance trust, increase service uptake, and contribute to better long-term mental health outcomes for young people from these communities.

The implications of this research also extend to the policy level. Policymakers can use the insights to develop strategies that prioritise culturally appropriate care for minoritised youth. By highlighting the unique challenges faced by Ghanaian and Nigerian young people, my study supports the integration of cultural humility into the NHS and community mental health frameworks. This aligns with ongoing national discussions around equity in healthcare, offering concrete recommendations for ensuring that mental health services are truly accessible to all. By addressing gaps in current care models, this research contributes to shaping policies that are sensitive to the needs of immigrant populations and better equipped to tackle disparities in mental health service provision.

In conclusion, the impact of my research is multifaceted, spanning contributions to academic scholarship, improvements in mental healthcare practice, and the development of more inclusive public policies. By placing the voices and experiences of Ghanaian and Nigerian young people at the centre of this study, my research offers a pathway for developing more empathetic and effective approaches to mental healthcare. These contributions have the potential to improve the well-being of marginalised communities in London and beyond, fostering a more inclusive and equitable approach to mental health that can resonate both locally and internationally.

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This thesis is the culmination of a long and transformative journey made possible by the invaluable support, encouragement, and contributions of many individuals and organisations. I wish to express my heartfelt gratitude to all who have contributed to bringing this work to fruition.

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List of Abbreviations

APA: American Psychiatric Association

BASW: British Association of Social Workers.

BBC: British Broadcasting Corporation.

CAMHS: Child and Adolescent Mental Health Services

CBT: Cognitive-Behavioural Therapy

CMD: Common mental disorder

ONS: Office for National Statistics.

CQC: Care Quality Commission

CYP: Children and Young People

DOH: Department of Health

GAD: Generalised Anxiety Disorder

IPA: Interpretative Phenomenological Analysis

NCCMH: National Collaborating Centre for Mental Health

NHS: National Health Service.

NICE: National Institute for Health and Care Excellence

OCD: Obsessive-Compulsive Disorder

PHE: Public Health England

PTSD: post-traumatic stress disorder

UNCRC: United Nations Convention on the Rights of the Child.

Chapter 1: Introduction

In this thesis, I explored the lived experiences of Ghanaian and Nigerian young people in Inner London as they navigate care for anxiety and depression. This research is framed within the broader global concern regarding mental health issues among children and young people (CYP) (Mei et al., 2020; Sobalvarro et al., 2023; WHO, 2021). The UK faces similar challenges, as highlighted by research (Fitzsimons & Villadsen, 2019; NHS Digital, 2023a; The Children's Society, 2023)

In this context, the historical and persistent disparities in mental healthcare for young Black individuals are well-documented (Devonport et al., 2023; Littlewood & Cross, 1980; Rwegellera, 1977). Despite significant international and national efforts to address these disparities—such as the UN Declaration on the Rights of Persons Belonging to National or Ethnic, Religious, and Linguistic Minorities (OHCHR, 1992) and the UK Equality Act 2010—inequalities remain entrenched. For instance, in the year leading up to March 2023, about 2,907 Black African individuals per 100,000 accessed NHS services for mental health, learning disabilities, and autism. This figure is notably lower than the 4,820 per 100,000 reported for White individuals (NHS Digital, 2024). Similarly, in 2014, only 6.5% (97,000) of Black individuals were receiving treatment for mental or emotional health issues during the survey period, compared to 14.5% (6.5 million) of White British individuals who accessed similar care (NHS Digital, 2021).

I am particularly engaged with the ongoing shortcomings of Child and Adolescent Mental Health Services (CAMHS) in effectively serving Black youth. The 2018 Care Quality Commission (CQC, 2018) review highlighted significant gaps in care for Black youth. This is an important revelation, considering that the CQC is the UK's regulatory body responsible for overseeing health and social care services to ensure safety and quality standards. Yet, care inequality remains a significant protracted issue (Bansal et al., 2022; Devonport et al., 2023; Holt, 2022; Kapadia et al., 2022). Additionally, there are established links between poor mental health, youth, and gang violence (BBC, 2018; Greater London Authority, 2017; PHE, 2015).

Although the prolonged inequalities within the mental healthcare system for Black CYP have been historically underexplored (Devonport et al., 2023; Littlewood & Cross, 1980; Rwegellera, 1977), the specific experiences of Ghanaian and Nigerian youth remain particularly overlooked. This neglect persists within the broader context of a significant population (Ghanaian and Nigerian) of minoritised youth (see Section 1.5), whether intentionally or unintentionally. My research seeks to fill this gap by providing an in-depth interpretative phenomenological analysis of how these young people perceive and make sense of their experiences of care for anxiety and depression in Inner London.

1.0. My Position as the Researcher

As a researcher, I am committed to exploring the mental healthcare experiences of young people from Ghanaian and Nigerian backgrounds in Inner London. This commitment stems not only from my academic and professional background but also from my personal experiences as an individual who identifies as a Black immigrant living in the UK. My lived experiences have provided me with a unique perspective that would enrich the research. This insider experience allows me to approach the topic with empathy and a critical understanding of the perceived issues affecting mental health outcomes for Black youth (Bansal et al., 2022; Bhui et al., 2003; 2008).

In my role as a researcher, I embrace a constructivist-interpretivist paradigm, which aligns with my belief that reality is socially constructed and varies across individuals and cultures (Creswell & Poth, 2018; Lincoln & Guba, 1985). This perspective is particularly pertinent

given the focus of my research on the subjective experiences of Ghanaian and Nigerian youths navigating mental healthcare in a socio-cultural context that often marginalises their voices (Nazroo et al., 2020). My methodological choices, such as employing Interpretative Phenomenological Analysis (IPA), reflect my commitment to centring the lived experiences of my participants, ensuring that their narratives are not only heard but deeply understood (Eatough & Smith, 2017; Larkin & Thompson, 2012; J. A. Smith et al., 2022) , discussed in more detail in Section 3.1.

At the same time, I am acutely aware of the potential influence of my own background and biases on the research process and how I dealt with my biases in Section 3.6.4: *'Pre-reflexive Reflexivity and Bracketing'*. However, to provide some context here, I recognise the importance of maintaining reflexivity throughout the research as someone who has navigated similar cultural and social landscapes. I strive to remain transparent about my positionality, acknowledging that my own experiences shape my interpretations. Giorgi (1994, p. 205) argued,

> *For phenomenology, nothing can be accomplished without subjectivity, so its elimination is not the solution. Rather, hozu the subject is present is what matters, and objectivity itself is an achievement of subjectivity. Thus, one could say that in all research one should value the truth, or "what is," or the correct facts or meanings, and so on, but is is equally true that subjectivity is needed to achieve those values. Thus the real issue is how subjectivity should be present and which values should be fostered.*

I am committed to ensuring this research remains grounded in the authentic voices of the young people I study and their parent's and practitioners' perspectives (Larkin et al., 2006).

In summary, my position as both a researcher and an individual is one of deep engagement with the complexities of race, culture, and mental health (Crenshaw, 1989). I approach this work with a dual-lens—both academic and personal—motivated by a desire to contribute to the development of more culturally sensitive mental health support frameworks that genuinely reflect the needs and realities of Ghanaian and Nigerian youths in London (Fernando, 2010; Nazroo et al., 2020).

1.1. Research Significance

The significance of my research lies in its potential to inform both academic and practice understandings of mental healthcare for minority ethnic youth in urban settings. The significance is predicated on the fact that,

> *"The lived experiences of people from ethnic minority groups need to be taken into account to deliver safe and person-centred care that is equal for all. This includes considering how personal experiences of racism and migration affect mental health during assessment and treatment" (National Institute for Health and Care Research (NIHR), 2023)*

By focusing on the lived experiences of Ghanaian and Nigerian young people, my study contributes to the growing body of literature that seeks to decolonise mental health research and practice (Devonport et al., 2023; Littlewood & Cross, 1980; Rwegellera, 1977). This study highlights the need for culturally relevant care and the importance of recognizing the intersectionality of race, culture, and mental health (Crenshaw, 1989).

Furthermore, my research is timely, given the ongoing discussions around mental health disparities and the urgent calls for equity in healthcare provision, reflected in the works of scholars such as Barnett et al. (2019), Marmot (2020), and Rains et al. (2020). The findings of my study will potentially provide valuable insights for policymakers, mental health practitioners, and community organizations working towards more inclusive and effective mental health services (see the published Executive Summary of the recommendations from the Impact Workshop in Appendix A Isiwele, 2024).

1.1.1. Aims and Objectives

The primary aim of this study is to investigate the experiences of Ghanaian and Nigerian young people regarding the care for anxiety and depression in Inner London. To achieve this aim, the research is guided by the following objectives:

1. To investigate the lived experiences of Ghanaians and Nigerians regarding the care for anxiety and depression in Inner London, along with the perspectives of their parents or carers and practitioners on the construct of care model.
2. To ascertain how practitioners utilise models to care for Ghanaians and Nigerians.
3. To understand how Ghanaian and Nigerian views, preferences, and expectations can inform the design of care and practice.

1.1.2. Research Questions

This study is structured around several key research questions:

1. How do young Ghanaian and Nigerian individuals in London make sense of their lived experiences with care for anxiety and depression?
2. How do parents and carers of young Ghanaian and Nigerian individuals interpret and understand their own experiences with anxiety and depression about their child's care?
3. What are the perspectives of practitioners on the available model of care?
4. How can the views and preferences of Ghanaians and Nigerians towards the care for anxiety and depression inform the mental healthcare and practice design?

1.2. Phenomenology Approach to Mental Healthcare

I adopted the phenomenological approach to mental healthcare because it aligns deeply with my belief in the importance of understanding individuals' unique, lived experiences, especially those from marginalised communities (Bansal et al., 2022; Smith et al., 2009). Phenomenology, particularly through Interpretative Phenomenological Analysis (IPA), provides a framework that allows me to delve into the subjective realities of people, capturing the nuances and complexities of their mental health journeys (Eatough & Smith, 2017). IPA is discussed in detail in Section 3.3.

In my view, mental healthcare needs to go beyond just diagnosing and treating symptoms. It needs to involve understanding the personal meanings that individuals ascribe to their experiences (Schwandt, 1994), the ways in which their cultural, social, and historical contexts influence their mental health (Crenshaw, 1989; Hankivsky et al., 2014), and how

they navigate the often complex healthcare systems (Finlay, 2011). This is especially true for populations like Ghanaian and Nigerian young people in Inner London, who may face additional layers of complexity due to factors like race, immigration status, and cultural background.

By adopting a phenomenological approach, I aim to give voice to these young people's experiences, ensuring that their stories are heard and understood in their own terms (Smith et al., 2009). This approach is participant-centred, emphasising the importance of their perspectives in shaping the understanding of their mental health issues and the care they receive (Husserl, 1970). It is also adaptable, which is crucial when dealing with diverse experiences and conditions that cannot be fully captured by more rigid, quantitative methods (Finlay, 2011)—details of the phenomenology approach in Section 3.3.

In summary, I adopted the phenomenological approach because it honours the lived realities of individuals, which I believe is essential for developing more effective, inclusive, and culturally sensitive mental health interventions (Finlay, 2011).

1.3. Definitions

1.3.1. Common Mental Disorder

Common mental disorder (CMD) is a group of emotional distresses that interfere with daily function and is less disabling than major psychiatric disorders (Bhugra et al., 2019; Goldberg & Huxley, 1992; Stansfeld et al., 2016). It can also be “unexplained somatic symptoms and are the contemporary equivalent of neurotic disorders typically encountered in community and primary care settings” (Risal, 2011, p. 213), usually manifest in

> *different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. Although usually less disabling than major psychiatric disorders, their higher prevalence means the cumulative cost of CMDs to society is great (Stansfeld et al., 2016, p. 2).*

‘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) all come under CMD (NCCMH and NICE, 2011, p. 14), updated 2021.

I started by interrogating care for CMD, but feedback from the Patient Public Involvement (PPI) events I conducted instigated a few changes (See Section 3.6.3). One of the changes is a response to the revelation that the term ‘mental disorder’ in "common mental disorder" was perceived as offensive and stigmatising. Consequently, the terminology was revised to "anxiety and depression" to better resonate with the community. This change aimed to foster a more inclusive and less stigmatising dialogue around mental health, as participants expressed that the original term carried a strong negative connotation. Adjusting the language helped create a safer space for open discussions and encouraged more engagement with the study. As a result, instead of CMD, I have used “Anxiety” and “Depression” throughout this thesis.

1.3.2. Anxiety

Anxiety, as a multifaceted psychological and physiological state, encapsulates a complex interplay of cognitive, emotional, and somatic responses to perceived or actual threats (APA, 2022; Barlow, 2004; Clark & Beck, 2009). It is crucial to distinguish anxiety from fear, as articulated by the American Psychiatric Association, which posits that "fear is the emotional response to real or perceived imminent threat, whereas anxiety is the anticipation of future threat" (APA, 2013, p. 189). This distinction underpins the understanding that anxiety primarily involves a forward-looking apprehension with adverse multidimensional implications for one's health.

Cognitively, anxiety is typified by pervasive worry and anticipatory concerns regarding future events, which often impair concentration, distort perceptions of reality, and exaggerate the sense of danger, thus "interfering with an individual's ability to lead a productive and fulfilling life" (Clark & Beck, 2009a, p. 7). Emotionally, it is associated with feelings of dread, uneasiness, and, in severe cases, panic, with intensities ranging from mild discomfort to

overwhelming terror (Beck et al., 2005). Physiologically, the activation of the sympathetic nervous system during anxiety episodes induces,

> *symptoms such as trembling, shaking, hot and cold spells, heart palpitations, dry mouth, sweating, shortness of breath, chest pain or pressure, and muscle tension (Clark & Beck, 2009, p. 17).*

Sociologically, anxiety transcends individual experiences and can be construed as a social phenomenon. As Horwitz (2013) elucidates, anxiety is not solely an internal psychological state but also a reflection of broader social conditions and cultural expectations. This social construction of anxiety is particularly relevant in the context of modern life, where the increasing demands for individual success, the fragmentation of social bonds, and "having to deal with uncertainty produced through decisions in the modernisation process" have escalated its prevalence (Beck & Beck-Gernsheim, 2002, p. 69).

Although anxiety can serve an adaptive function by preparing individuals to address potential threats, it becomes maladaptive when it is excessive or disproportionate to the actual threat, often leading to anxiety disorders, which are among the most common psychiatric conditions globally (Kessler et al., 2005). Marks (1987) aptly notes that while moderate anxiety is essential for survival, its excess can be paralysing, resulting in significant impairment in daily functioning and quality of life.

In the context of this research, I conceptualise anxiety by grounding it in the lived experiences of Ghanaian and Nigerian youth navigating mental healthcare systems in Inner London. Therefore, this study recognises anxiety not merely through clinical definitions but as a subjective experience profoundly influenced by intersecting factors like race, culture, socioeconomic status, and systemic issues such as racism and discrimination (Crenshaw, 1989; Delgado & Stefancic, 2017). These factors shape how anxiety is perceived, experienced, and expressed in the youth's world in this study. The manifestation of anxiety within this demographic may diverge from traditional Western conceptualisations, reflecting cultural and social realities unique to their identities as Ghanaian or Nigerian youth in London. Hence, this research necessitates an approach that is attuned to these distinct experiences and perspectives. In this study, I conceptualise anxiety as a subjective

experience shaped by the cultural, social, and systemic realities of Ghanaian and Nigerian youth in Inner London, characterised by a perceived helplessness in predicting, controlling, or achieving desired outcomes in significant contexts.

1.3.3. Depression

In this thesis, depression is conceptualised as a multifaceted and chronic mental health disorder characterised by persistent low mood, diminished interest or pleasure in most activities, and a spectrum of cognitive, emotional, and physical symptoms that substantially impair daily functioning (APA, 2013; A. T. Beck & Alford, 2009; WHO, 2023). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), depression, clinically identified as Major Depressive Disorder (MDD), encompasses a constellation of symptoms that must persist for a minimum duration of two weeks to warrant a formal diagnosis (APA, 2013). These symptoms include pervasive feelings of worthlessness or excessive guilt, profound fatigue or loss of energy, significant difficulty concentrating, alterations in weight or appetite, insomnia or hypersomnia, psychomotor agitation or retardation, and recurrent thoughts of death or suicidal ideation (APA, 2013).

The aetiology of depression is complex, involving an interplay of genetic, biological, environmental, and psychological factors. Neurobiological research reveals that the pathophysiology of depression is intricate, implicating multiple “neural” systems, “molecular” pathways, and “cellular mechanisms” (Nestler et al., 2002, p. 18). Notably, hyperactivity of the hypothalamic-pituitary-adrenal (HPA) axis has emerged as “one of the most consistent biological findings” in the study of major depression, though the precise “mechanisms underlying this abnormality are still unclear” (Pariante & Lightman, 2008, p. 464).

From a psychological standpoint, cognitive theories propose that depression is maintained by negative thought patterns, such as distorted beliefs and schemas, leading to a biased interpretation of experiences (Beck, 1967; Sabshin, 1968). Beck (1967) highlights the "negative cognitive triad"—a pessimistic view of the self, world, and future. Behavioural theories add that decreased positive reinforcement and increased negative experiences

contribute to depression (Ingram, 2012). In other words, the likelihood of developing depression correlates with the frequency and quality of positive reinforcement.

Depression is one of the main causes of disability worldwide (WHO, 2023). It frequently co-occurs with other psychiatric conditions, such as anxiety, substance use, and personality disorders, complicating both diagnosis and treatment (APA, 2013; Beck & Alford, 2009). Although pharmacotherapy (Schildkraut, 1965), and cognitive-behavioural therapy (CBT) are effective interventions (Beck, 1967), treatment-resistant depression remains a significant challenge. Rush et al. (2006) report that a significant proportion of patients with depression do not respond to their first antidepressant treatment.

In a sociological context, depression transcends individual psychological dysfunction and is understood as a social phenomenon influenced by structural factors, including socioeconomic status, gender, race, and social relationships (Blane, 2008; Link & Phelan, 1995; Pearlin, 1989). The social stress theory posits that depression may result from chronic stressors associated with social inequalities, such as poverty, unemployment, and discrimination (Pearlin et al., 1981). Pearlin (1989) emphasises that "stress proliferation occurs when a “primary stressor”, such as financial strain, leads to “secondary stressors”, such as relationship conflicts, both of which contribute to the onset of depression" (p. 248).

Thus, my research situates depression within the lived experiences of Ghanaian and Nigerian youth navigating mental healthcare systems in Inner London, recognising the critical role of social conditions and life events in shaping the prevalence and manifestation of depressive symptoms in these populations.

1.3.4. Care and Treatment

In this thesis, I chose to use the term "care" instead of "treatment" because my social work background emphasises the importance of a holistic, person-centred approach. This choice is deeply rooted in the principles of social work, which emphasise the need to view individuals within the context of their environment and relationships (BASW, 2021). I resonate with Fisher and Tronto's (1990, p. 40) definition of care:

> *A species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.*

This definition emphasises the holistic and relational aspects of care, encompassing not just physical maintenance but also the emotional, psychological, and social dimensions of well-being. The term "care" aligns with this broader perspective, while "treatment" often suggests a narrower focus on addressing specific symptoms, typically within a medical model (Engel, 1977; Wilkinson et al., 2024).

The Department of Health and Social Care (2024) statutory guidance emphasises a holistic approach, where "care" involves supporting a person's well-being, dignity, and independence through tailored services and interventions. I find that using "care" is more consistent with the ethical standards that guide this work. It also reflects my commitment to culturally appropriate practice, where practitioners are sensitive to the diverse needs and contexts of diverse clients.

Therefore, in this thesis, I defined care as a holistic, person-centred approach that encompasses not only physical maintenance but also the emotional, psychological, and social dimensions of well-being. It involves supporting an individual's well-being, dignity, and independence through tailored interventions that integrate their environment and relationships, aligning with the broader perspective of care that sustains the complex web of life.

1.3.5. Defining Therapy, Therapeutic Space and Relationship: How I Refer to Therapist and Practitioner

Before I explore how intersectionality in practitioner engagement through cultural humility could be operationalised (Section 7.4.2), I want to clarify that I have used the terms "therapist" and "practitioner" interchangeably in some instances. The interconnectedness of these terms and the concept of the "therapeutic space" and "therapeutic relationship” can extend beyond healthcare settings. Within the framework of cultural humility, these ideas

apply to health professionals and individuals in non-healthcare contexts, such as personal relationships, educational settings, workplaces, and anyone offering services or support to marginalised youth and communities (Tervalon & Murray-García, 1998).

Therapy generally refers to treating psychological, emotional, or behavioural disorders through psychological methods (Rogers, 1951). According to the APA College Dictionary of Psychology (APA, 2016), therapy is characterised by a cooperative relationship between therapist and client, the use of research-based techniques and strategies, defined outcomes based on the client's needs, such as reducing symptoms of distress, enhancing well-being, or improving coping mechanisms. Therapy aims to provide a structured and supportive environment where individuals can explore their feelings, thoughts, and behaviours, ultimately gaining insight and developing strategies to manage their mental health challenges (Rogers, 1951).

A *therapist* is a professional who delivers these therapeutic interventions, offering psychological support through methods such as cognitive-behavioural therapy (BACP, 2023). In contrast, a *practitioner* refers to a broader category of professionals, including therapists and others acknowledged by the children and young people mental health service (CYPMHS) workforce in England and the education setting. It is not limited to, but includes clinical psychologists, psychiatrists, psychotherapists, mental health nurses, social workers, support workers, occupational therapists, family therapists, crisis workers, well-being practitioners and administrative roles (NHS England, 2017; RcPsych, 2018; YoungMinds, 2024). Although their roles may differ, both therapists and practitioners are committed to supporting individuals' mental well-being (see Chapter 2, Section 2.3.3 for their roles. Therefore, I have used these terms interchangeably because both are vital in providing holistic mental healthcare, particularly when integrating cultural humility, which cuts across different settings.

Conceptualising *therapeutic space,* a study that explores the shift to virtual therapeutic spaces during COVID-19, refers to the therapeutic space as the physical or virtual setting for therapy that encompasses various mediums such as consulting rooms, telephone, or online platforms where treatment occurs, with each impacting the therapeutic process differently

(Ingram, 2021). I draw from Michel Foucault's (1986) conceptualisation of space, particularly his discussion of heterotopias, places that exist as counter-sites or "other" spaces relative to everyday life. In other words, specific cultural, institutional, or discursive spaces could exist as "other" contradictory or transformative environments. Therefore, one could interpret a "therapeutic space" as a kind of heterotopia. This space would be distinct from the ordinary world and serve as a setting where relationships, roles, and experiences differ from those in everyday life, often aiming at healing, reflection, or transformation. Foucault's idea of space being both real and mythic could also imply that therapeutic spaces embody a special significance, perhaps as sanctuaries of health and care, where patients can step outside their regular environments and engage in practices of self-recovery. I, therefore, conceptualised the *therapeutic space* as the emotional and relational environment where therapy or mental healthcare takes place. Whether physical, non-physical, virtual, or in abstraction in the sense of dealing with an idea, this space is carefully and intentionally designed to be confidential, non-judgmental, and supportive, allowing clients to feel safe while exploring their mental health concerns. These could be consultation rooms, hospital rooms, in the client's home, on the phone, on an online platform, walking with a client, meeting on a park bench, and written correspondence—all may be therapeutic spaces.

At the core of this therapeutic space is the *therapeutic relationship*, which is the collaborative bond between the therapist or practitioner and the client. This relationship is built on trust, empathy, respect, and mutual understanding, allowing the client to feel safe, supported, and valued (Rogers, 1951). The quality of the therapeutic relationship is often the most significant predictor of positive outcomes in therapy (Wampold, 2015). When working with culturally diverse populations, such as Ghanaian and Nigerian youth, this relationship also needs to be grounded in cultural humility. Practitioners need to engage in humble inquiry, recognising that their clients are the experts of their lived experiences and cultural contexts.

By integrating these concepts, I make the case for using *therapist* and *practitioner* interchangeably in this section. Both roles are integral to creating a therapeutic space that fosters a strong therapeutic relationship. Whether providing direct therapy or broader mental health support, both therapists and practitioners contribute to an environment

where Black young people can address their mental health needs within a framework that respects and honours their cultural identities. This holistic and culturally humble approach is essential for improving mental health services for Ghanaian and Nigerian youth in Inner London.

1.3.6. Ethnic groups, Nationality and Community

In this thesis, I draw upon the terms "ethnic groups," "nationality," and "community" to encompass the identities of the Ghanaian and Nigerian young people participating in my research in Inner London, utilising sociological and anthropological perspectives to explore these concepts. Each term is applied with particular nuance to capture the multifaceted dimensions of identity and belonging that shape the participants' lived experiences.

The term "ethnic groups" is used to refer to participants' shared cultural heritage, including language, religion, and ancestral lineage. This concept captures the influence of cultural practices among Ghanaians and Nigerians on their mental health experiences, especially in the context of navigating healthcare systems that may lack full cultural recognition and sensitivity. This aligns with Anthony D. Smith's definition, where ethnic groups are characterised by a belief in common descent and shared historical memories that underpin social identity and group solidarity (A. D. Smith, 1991). Ethnic identity is typically grounded in shared practices, beliefs, and values that contribute to a sense of collective belonging and continuity over time (Phinney, 1996). Similarly, Nagel (1994, p. 152) notes,

> *Ethnicity is the product of actions undertaken by ethnic groups as they shape and reshape their self-definition and culture; however, ethnicity is also constructed by external social, economic, and political processes and actors as they shape and reshape ethnic categories and definitions.*

Ethnicity is thus seen as both a self-defined concept shaped internally by the group and as a construct influenced by external factors. In the UK, the term “ethnic group" refers to a category used to describe people who share a common cultural background, ancestry, language, history, and, sometimes, religion (The Law Society, 2023). It encompasses the social group a person identifies with based on shared cultural traits and heritage. Ethnic

group classifications are often used in national censuses and other official surveys to understand the demographic composition of the population (ONS, 2021a).

The term "nationality" is employed to recognise the participants' formal membership in the nation-states of Ghana and Nigeria and their lived experiences as members of these national communities within the UK. This study explores how the sense of belonging to their national communities intersects with their experiences of mental healthcare in London, reflecting Benedict Anderson's notion of nationality as an "imagined community"—a construct shaped through shared cultural practices and historical narratives (Anderson, 2016). National identity, therefore, adds another layer to how participants perceive themselves and navigate their place in a multicultural setting like London.

Finally, "community" describes the social unit that Ghanaian and Nigerian young people form within Inner London, characterised by shared values, interests, and the geographic space of their local environment. The analysis touched on how their membership in ethnic and national communities and their interactions with the broader London community influence their mental healthcare experiences. Tönnies' (2001) concept of community emphasises the significance of close-knit, personal relationships and social cohesion, contrasting with society's more formal, impersonal structures. This focus on mutual support and solidarity is central to understanding how these young people engage with each other and with mental health services.

In conclusion, this thesis highlights the nuanced use of "ethnic groups," "nationality," and "community" to describe the identities of Ghanaian and Nigerian young people in Inner London, each offering a distinct lens through which their experiences are understood. "Ethnic groups" centres on shared cultural heritage and practices, shaping their interaction with mental healthcare. "Nationality" adds the dimension of belonging to a broader national context, influencing identity in a diasporic setting. "Community" emphasises the importance of local networks and support systems, shaping their collective experience within Inner London. These interconnected dimensions offer a comprehensive understanding of the participants' identities and their encounters with mental healthcare services.

1.3.7. Culture

In the context of the lived experiences of Ghanaian and Nigerian young people regarding care for anxiety and depression in Inner London, "culture" is a multifaceted concept that extends beyond superficial elements like language, food, and dress. It encompasses deeply rooted values, beliefs, practices, and norms that shape individuals' perceptions and behaviours (G. H. Hofstede, 2001; Triandis, 1996). Culture functions as a dynamic and adaptive system that guides how people interpret their experiences, including mental health and well-being (Bender & Adams, 2021). Hofstede (1984, p. 21) defines it as "the collective programming of the mind that distinguishes the members of one group or category of people from others". This definition emphasises that culture operates at the collective level, shaping shared understandings and guiding social behaviours within a group. It is not only about national or ethnic identity but also involves how these shared patterns influence responses to experiences like mental health:

> *Culture influences action not by providing the ultimate values toward which action is oriented, but by shaping a repertoire or "tool kit" of habits, skills, and styles from which people construct "strategies of action" Swidler (1986, p. 273).*

In Swidler (1986) culture is considered to be the shared symbols, values, and norms that shape the behaviours and practices of a group. In this view, culture is a "toolkit" of symbols and practices that individuals draw upon to navigate their world. This perspective is particularly relevant in understanding the mental health experiences of young people from Ghanaian and Nigerian backgrounds, as their cultural contexts may influence how they express distress, seek help, and understand mental health conditions like anxiety and depression.

Hall's (1989) concept of culture as a "silent language" is also useful here. The emphasis is on the implicit rules and unwritten norms that guide social interactions, shaping individuals' communication and emotional expression. This is significant in mental healthcare, where differences in cultural communication styles between practitioners and clients could lead to misinterpretations or feelings of being misunderstood.

For Ghanaian and Nigerian young people, I assert that culture includes not only traditional values and communal practices but also the lived realities of being in the diaspora, where they need to navigate the expectations of their cultural heritage alongside those of British society. As such, culture is dynamically influenced by factors like migration, generational changes, and social environments. This complexity necessitates a culturally humble approach to mental healthcare, recognising the diverse and evolving cultural contexts that shape each individual's experience. Therefore, in this thesis, I define culture as a dynamic, adaptive system of shared values, beliefs, and practices that shapes individuals' perceptions, behaviours, and responses to their experiences. It encompasses both traditional heritage and the evolving realities of diaspora life, guiding how these young people in Inner London understand and navigate mental health challenges.

1.3.8. The definition of children and young people

The definition of Children and young people (CYP) can vary depending on the context, such as legal, social, and educational settings. However, there are generally accepted definitions provided by key organisations and legal frameworks. For example, the United Nations Convention on the Rights of the Child (UNCRC), Article 1, defines a child as "every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier." International law widely accepts this definition (UNHR, 1989). The World Health Organization (WHO) generally categorises children and young people as follows: Children typically refer to individuals aged 0–9 years; adolescents refer to those aged 10–19 years; and young people refer to individuals aged 10–24 years, which includes both adolescents and young adults (WHO, 2024).

In the UK, the Children Act 1989 defines a "child" as anyone under the age of 18. "Young people" generally refer to those in the transition phase from childhood to adulthood, often considered to be between the ages of 16 and 24. I discussed in detail in Section 2.3.1 the introduction of the term Children and Young People's Mental Health Services (CYPMHS) as a contemporary evolution of Child and Adolescent Mental Health Services (CAMHS) (Kirk-Wade et al., 2024). This terminological shift, driven by the NHS Long-Term Plan (2019, Chapter 3), aims to expand mental health services up to the age of 25, thereby addressing a

demographic previously underserved by CAMHS (DOH and NHS England, 2015). The adoption of CYPMHS signifies a broader and more inclusive approach to mental healthcare (DOH and NHS England, 2015; Grimm et al., 2022; Rainer & Abdinasir, 2023). In this thesis, I defined CYP as those aged between 16 and under 25.

1.4. Why Ghanaians and Nigerians, and Why London

In selecting Ghanaians and Nigerians for this study, I aimed at unbundling Africa in mental health research, and several key considerations guided me. First, the population sizes of these communities. According to the 2021 UK Census, the non-UK-born Nigerian population in England is approximately 270,768, representing 12.9% of the total Black African population of around 2.1 million. The Ghanaian population is about 114,000, making up 5.4% of this demographic. When I focus on London, where this study is centred, the significance of these communities becomes even clearer. The Nigerian community in London numbers around 114,000, accounting for 10.4% of the city's Black African population of about 1.1 million. Similarly, the Ghanaian population in London, estimated at 60,000 to 70,000, represents approximately 5.5% to 6.4% of the Black African demographic. Together, these communities make up around 184,000 individuals, or 16.45%, of those who identify as non-UK-born Ghanaians and Nigerians (ONS, 2021b).

My focus on these communities is further motivated by existing research that reveals variations in the prevalence and presentation of anxiety and depression among different ethnic subgroups (Lavis et al., 2015; Li et al., 2020; Rees et al., 2016). This emphasises the importance of targeted research within specific ethnic groups, as emphasised by Butt et al. (2015), Lavis (2014), and the London Assembly (2015). The London Assembly (2015) pointed out that "nuanced data on ethnic subgroups simply does not exist." This is consistent with the findings of this 2024 research, where practitioner participants said they do not collect nationality data. To the London Assembly, the lack of subgroup data significantly hinders the development of effective policies and the planning of mental health services. According to the Assembly, this absence of detailed data impairs our understanding of the demand for these services and frustrates efforts to adequately fund and commission them (London

Assembly, 2015). Therefore, by focusing on Nigerians and Ghanaians, I aim to fill this gap and provide insights into a significant segment of the Black African population in London.

Given the sise of these populations, I also expect that common mental disorder (CMD) may be more prevalent among Ghanaian and Nigerian youth compared to other minoritised groups in the UK. This expectation is based on research indicating that children and young people from minoritised communities are most susceptible to CMD (Lavis, 2014; Khan, 2016; Rees et al., 2016; Patalay and Fitzsimons, 2017; Turrini et al., 2017). These vulnerabilities are compounded by intersections of race, ethnicity, immigration status, socioeconomic status, culture, and religion—all of which may be compounded by structural discrimination (Collins, 2021; Crenshaw, 1991; Hankivsky & Jordan-Zachery, 2019; Rivas et al., 2022; Showunmi & Tomlin, 2022).

Another reason why I combined Ghanaian and Nigerian youth in this study is due to the homogenous features allowed by my chosen methodology, interpretative phenomenological analysis (IPA).

> *IPA researchers usually try to find a fairly homogeneous sample, for whom the research question will be meaningful. The extent of this 'homogeneity' varies from study to study. Making this decision is partly a practical problem (Which people are in this situation? How easily can they be contacted?), and partly an interpretative problem (In what other ways do these people vary from one another? How much of that variation can be contained within an analysis of this phenomenon?) (Smith et al., 2022, p. 44).*

However, I am mindful of the guidance Smith et al. (2022) provided, who note that both practical and interpretative considerations influence the decision and extent of homogeneity in IPA studies. Practically, I define homogeneity in terms of participants' exposure to the same phenomenon and their accessibility. For this study, homogeneity is understood as the shared experience of being immigrants from West Africa, living in London, and navigating broadly similar social contexts (see Sections 1.3.6 "Ethnic groups," "Nationality," and "Community"). This decision is also influenced by the barriers that young Black people face in seeking mental healthcare, often due to discrimination (Hatch et al., 2016), fear and

distrust of the UK mental health system. The NHS Race and Health Observatory (NRHO) review (Kapadia et al., 2022, p. 11) highlighted that these fears are “clear barriers to seeking help.” So, I perceive they may not want to participate due to fear. Thus, when I refer to homogeneity in this study, it does not imply that Ghanaians and Nigerians are identical in all respects, only to those shared in Sections 1.3.6 & 1.3.7. Rather, combining these two subgroups may enhance the potential for broader participation and richer data. On the interpretative level, I engaged with hermeneutic interpretation to explore how varied the participants are and how much of this variation can be accommodated within the analysis, in line with IPA’s idiographic commitment (Larkin, Watts, and Clifton, 2006; Smith and Osborn, 2008; Smith, Flowers, and Larkin, 2022).

1.5. Structure of the Thesis

Chapter 1: Introduction. This chapter has introduced the research, focusing on the lived experiences of Ghanaian and Nigerian young people in Inner London as they navigate care for anxiety and depression. It has provided the background and context, highlighting the significance of the study within the broader discourse on mental health disparities among Black youth. The chapter outlines the research aims, objectives, and questions. It also introduces the phenomenological approach used in the study and provides definitions of key terms and concepts. The chapter concludes with this overview of the thesis structure, guiding the reader through the subsequent chapters.

Chapter 2: Literature Review. The literature review explores existing research across various fields, including social work, sociology, and psychology, related to the mental health experiences of Black youth, specifically focusing on Ghanaian and Nigerian populations in the UK. It discusses the theoretical frameworks of Intersectionality and Critical Race Theory (CRT), which underpin the study’s analysis of systemic racism and cultural dynamics affecting mental healthcare. The chapter reviews statutory frameworks governing mental health services in England, evaluates current mental health policies, and critically examines the availability and effectiveness of care for Black youth. The review concluded by identifying gaps in the field and articulating this study's rationale.

Chapter 3: Methodology. This chapter details the research design and methodological approach, emphasizing the use of Interpretative Phenomenological Analysis (IPA) to explore participants' subjective experiences. It discusses the philosophical underpinnings, including the constructivist-interpretivism paradigm, and provides a rationale for selecting qualitative methods. The chapter explains the sampling strategy, the recruitment of participants, and the data collection methods, including semi-structured interviews. It also addresses ethical considerations, such as informed consent and data confidentiality, and discusses strategies for ensuring research validity and quality, such as reflexivity and bracketing.

Chapter 4: Analysis. This chapter describes the analytical process using IPA, providing a detailed account of how the data was interpreted. It outlines the steps taken in the analysis, such as memoing, exploratory noting, and the development of experiential statements. The analysis process includes identifying Personal Experiential Themes (PETs) and Group Experiential Themes (GETs), using the hermeneutic circle to deepen understanding of participants' narratives. This chapter showcases how individual and shared experiences are interpreted, leading to the identification of key themes that form the basis for the findings.

Chapter 5: Findings. The findings chapter presents the key themes that emerged from the analysis of participants' experiences. It reveals challenges faced by Ghanaian and Nigerian young people in accessing mental healthcare, such as cultural stigma, systemic barriers, and issues with cultural compatibility in therapy. The chapter also reveals participants' coping mechanisms, including the role of family expectations, community support, and faith. It provides insights into how these young people perceive and navigate London's mental healthcare system, offering a rich understanding of their lived experiences.

Chapter 6: Research Impact Workshop. In this chapter, I discuss the Research Impact Workshop conducted to share the study's findings with key participants, including youth, parents, and practitioners. The workshop aimed to disseminate research insights and foster dialogue on integrating cultural humility into mental health practices. It details the workshop's structure, including presentations, discussions, and collaborative development of action plans. The chapter highlights the feedback received from participants, emphasising

the need for systemic improvements in mental health services for Black youth in London and outlining the potential practical implications of the research.

Chapter 7: Discussion. The discussion chapter contextualises the findings within the theoretical frameworks of Intersectionality, CRT and cultural humility, exploring how these perspectives help interpret the lived experiences of Ghanaian and Nigerian young people. It revisits the key themes, such as systemic barriers and traditional Evidence-Based Practice (EBP) limitations. The chapter also addresses the interplay between family dynamics, trauma, and resilience, offering recommendations for policy and practice to improve culturally sensitive care. It highlights the importance of adapting mental health models to better serve the needs of these communities, proposing strategies for enhancing accessibility and reducing stigma.

Chapter 8: Conclusion. The final chapter recaps the key outcomes of the study, emphasising its contributions to understanding the mental healthcare experiences of Ghanaian and Nigerian youth in Inner London. It discusses the broader significance of the findings, highlighting the need for culturally adapted mental health interventions and systemic reforms. The chapter also addresses the study's strengths and limitations and suggests directions for future research, such as further exploration of cultural influences on mental healthcare. It concludes by highlighting the study's potential impact on improving mental health services for Black youth, advocating for a more inclusive approach in the UK’s mental health landscape.

Chapter 2: Literature Review

2.1. Introduction

In this chapter, I critically analyse and synthesise existing research, providing a comprehensive overview of the current knowledge, theories, and gaps in the field. It positions the new study within the academic context, identifies research gaps, and justifies the study's significance (Hart, 2018; Ridley, 2012). The reviews encompass several fields across social work, sociology, education, and psychology. I begin by elaborating on the theoretical foundations underpinning this research. Ridley (2012) emphasises that the literature review in a thesis needs to establish a theoretical framework for the research and highlight essential concepts and theories that guide the study. I first discuss intersectionality theory, a critical framework elucidating the intricate interplay of social identities in shaping mental health outcomes (Bowleg, 2012; Collins, 2021). Intersectionality provides a nuanced understanding of the intersecting effects of culture, race, gender, socioeconomic status, and other identities (Crenshaw, 1989). Additionally, I integrate Critical Race Theory (CRT) to critically analyse how systemic racism and discrimination permeate mental healthcare systems and impact well-being (Bell, 1992; Crenshaw et al., 1995).

I then review the statutory frameworks governing mental health services for children and young people in England. Understanding these regulatory landscapes is crucial, as they shape the context in which my research population seeks care. From the perspective of Black children and young people, I evaluate recent policy documents, including the NHS Long-Term Plan, to assess their impact on mental health services for Black youth.

Next, I provide an overview of existing studies on the mental healthcare experiences of Black African children and young people, focusing on anxiety and depression. This section highlights the prevalence and patterns of these mental health issues globally and within the UK context, and I discuss cultural factors influencing mental health experiences. Drawing on international and national research, I present a flavour of the challenges faced by this demographic.

Finally, I critically evaluate available mental healthcare services and initiatives targeting Black African youth, particularly Ghanaians and Nigerians in Inner London, including community-led initiatives, culturally adapted interventions, and current policy effectiveness in addressing mental health disparities. This literature review aims to establish a robust foundation for my empirical investigation, offering a nuanced understanding of the theoretical, cultural, and systemic factors shaping these young people's mental healthcare experiences. The chapter culminated by synthesising the key themes explored, ultimately revealing critical gaps in the existing body of knowledge and establishing the rationale for undertaking this study.

2.2. Theoretical Framework

This research is grounded in three primary theoretical frameworks: Interpretative Phenomenological Analysis (IPA) (I have discussed IPA in Section 3.3), Intersectionality and Critical Race Theory.

2.2.1. Intersectionality Theory

Intersectionality theory, first introduced by Kimberlé Crenshaw (1989), has emerged as an essential framework for understanding the intricate and multifaceted nature of social identities and their effects on various life aspects, including mental health. Patricia Hill Collins and Sirma Bilge (2016) have significantly contributed to expanding the concept as a critical framework across various fields. Intersectionality theory asserts that social identities such as race, gender, class, sexuality, and disability intersect to create unique experiences of oppression and privilege (Collins, 2021; Crenshaw, 1991; Hankivsky & Jordan-Zachery, 2019; Winker & Degele, 2011).

In the field of mental health, researchers such as Lisa Bowleg (Bowleg, 2012) highlight the significance of intersectionality in public health and mental health studies. Bowleg's research foregrounds the impact of race, gender, and sexuality on health outcomes, promoting intersectionality as an essential analytical framework for examining health disparities. Different intersecting identities would significantly influence Black children and young people's mental health outcomes as they encounter multiple, simultaneous sources of stress and discrimination.

The intersectional perspective challenges the reductionist approach of examining single identity factors in isolation. For example, Watson (1913) focuses solely on observable behaviour, Skinner (1938) focuses on observable behaviour and environmental stimuli, and Schildkraut's (1965) monoamine hypothesis of depression suggests that a deficiency in neurotransmitters such as serotonin and norepinephrine leads to depression. Although Schildkraut's model has been instrumental in the development of antidepressant medications, it oversimplifies the intricate and multifaceted causes of depression. The latter is what intersectionality aims to elucidate in my study.

Hankivsky et al. (2014, 2019), in their design of Intersectionality-Based Policy Analysis (IBPA), captured the uniqueness and expanding frontiers of the intersectional approach in the following tenets that human existence and experiences (1) cannot be defined with a single characteristic, (2) cannot be entirely understood by prioritising a single or combination of factors or by a recognised pattern, (3) that social categories, such as race, gender, class, etc., are all a product of social constructivism and are dynamic, (4) social locations cannot be separated from constituted social processes. Constituted social processes refer to the dynamic and interactive nature of social categories, which are not fixed or isolated. These categories are formed and shaped by ongoing social processes and power structures influenced by historical and contemporary contexts. (5) The promotion of social justice and equity should be of utmost importance. Collins (2021, pp. 2–3) took the debate further in her work, 'Intersectionality, Black Youth, and Political Activism,' relating it to the construct of ideology referring to intersectionality as "a framework for bringing together the ideas and actions of many groups that have been excluded from or misrepresented within Western disciplines and national knowledge traditions".

Therefore, intersectionality provides a more holistic approach, capturing the interplay between various factors contributing to mental health. This comprehensive understanding is essential for developing effective interventions and policies (Bowleg, 2012), paving the way for more nuanced and effective treatment and policy measures.Furthermore, it might uncover mental health disparities that might be overlooked in single-axis frameworks.

Despite its strengths, intersectionality theory faces significant limitations. A primary criticism is its complexity. Operationalising intersectional frameworks in empirical research is challenging due to the vast number of possible identity combinations and interactions (McCall, 2005). Another issue I paid attention to is Cole's (2009) concerns that while intersectionality aims to highlight unique experiences, there is a possibility of creating new stereotypes or assumptions about certain identity groups if care is not taken. The solution might include recognising the fine line between identifying patterns and overgeneralising findings. This means that I will ensure that the individuality within identity groups is respected.

In summary, intersectionality theory offers me a useful framework for understanding the intricate and interconnected factors influencing Black youth mental health to inform more effective, inclusive interventions, focusing on Ghanaians and Nigerian youth in London. While it presents challenges, such as methodological complexity and potentially stereotyping another group's identity, innovations, collaboration, and critical reflection can address these issues.

2.2.2. Critical Race Theory

Derrick Bell, Kimberlé Crenshaw, Richard Delgado, and others developed Critical Race Theory (CRT) as a framework to examine and challenge how race and racism influence social, legal, and political structures in the United States (Bell, 1992; Crenshaw et al., 1995). CRT is a vital framework for analysing the mental health experiences of Black youth (Cokley, 2021; Stoll et al., 2022), particularly those of Ghanaian and Nigerian descent in London. CRT asserts that racism is not just the result of individual prejudice but is entrenched within the institutions and structures of society (Bell, 1992). By incorporating CRT into my research, I can offer an

understanding of how systemic racism and discrimination influence the mental health of these young people, shaping their experiences with depression and anxiety.

It illuminates how racial dynamics and socio-political context may contribute to affecting the mental health of young Ghanaians and Nigerians, including the legacy of colonialism and the pervasive nature of racial inequality in the UK. For instance, research conducted by King's College London and University College London uses Critical Race Theory (CRT) to explore how institutional and personal factors, including racism, influence Black students' mental health. Key recommendations include decolonising mental health services (Stoll et al., 2022). Decolonising mental health services involves challenging Western-centric approaches, integrating diverse cultural perspectives, and prioritising community-led practices to address historical power imbalances and systemic inequities (Burgess & Choudary, 2021; Rivas & Goff, 2020). Focusing on systemic issues in my study context, CRT will reveal how institutional racism in education and mental health services contributes to mental health disparities.

Furthermore, CRT can clarify how experiences of racism and discrimination in schools impact the self-esteem and psychological well-being of Ghanaian and Nigerian youth. These experiences can lead to feelings of alienation and stress, major contributors to mental health issues like depression and anxiety (Carter, 2007). Additionally, it offers a framework to analyze how cultural stigma surrounding mental health within these communities interacts with external racial pressures to worsen mental health challenges.

However, CRT has its shortfalls in mental health research. One primary limitation is its strong focus on structural and institutional factors, which can sometimes overshadow individual psychological experiences and personal agency. In other words, it can tend to emphasise external oppression over internal coping mechanisms, potentially overlooking the resilience and adaptive strategies (T. N. Brown, 2003) that Ghanaian and Nigerian youth employ to manage their mental health. Another limitation is that CRT's emphasis on race might not fully consider other intersecting identities and factors such as gender, socioeconomic status, and immigration status. Although intersectionality, an extension of CRT, attempts to address

this by considering multiple identities simultaneously, CRT often prioritises racial analysis over other dimensions (Crenshaw, 1989).

To address these limitations, I integrate CRT with IPA and intersectionality. By using a blended framework, I can provide a more comprehensive understanding of how systemic racism and individual experiences intersect to influence the mental health of young Ghanaian and Nigerian immigrants in London.

In sum, these concerted approaches not only acknowledge the pervasive impact of structural racism but also recognise the agency and resilience of these youth in navigating their mental health challenges.

2.3. Statutory Frameworks of Children and Young People Mental Health Services in England

2.3.1. An Overview of Child and Adolescent Mental Health Services

The House of Commons Library Research Briefing, published on January 26, 2024, titled "Children and Young People's Mental Health: Policy and Services (England)," introduces the term Children and Young People's Mental Health Services (CYPMHS) as a contemporary evolution of Child and Adolescent Mental Health Services (CAMHS) (Kirk-Wade et al., 2024). This terminological shift, driven by the NHS Long-Term Plan (2019, Chapter 3), aims to expand mental health services up to the age of 25, thereby addressing a demographic previously underserved by CAMHS (DOH and NHS England, 2015). The adoption of CYPMHS signifies a broader and more inclusive approach to mental healthcare (DOH and NHS England, 2015; Grimm et al., 2022; Rainer & Abdinasir, 2023).

CYPMHS is strategically designed to enhance the continuity and accessibility of services for young adults, mitigating the common fragmentation experienced during the transition to adult services (Grimm et al., 2022; Rainer & Abdinasir, 2023). Empirical evidence supports this transition from CAMHS to CYPMHS. The MILESTONE study, for example, conducted across eight European countries, examines the transition from CAMHS to Adult Mental Health Services (AMHS) and introduces a "Managed Transition" service to improve poorly

managed transitions, offering valuable insights into enhancing transition practices and outcomes for young people (Health Research Authority, 2015; Singh et al., 2017). Their transitions are characterised by Mental health Services underestimation of the anxiety of CAMHS leavers (Dunn, 2017), lack of continuity of care (Hendrickx et al., 2020) and lack of patients and parents/carers involvement (Adamopoulos & Samuel, 2021).

The impetus for this transformation lies in recognising that the mental health challenges faced by young people often extend beyond adolescence, necessitating a smoother transition to adult services. Hence, I am looking at ages 16-25. The 2015 "Future in Mind" report published by the Department of Health (DOH) and NHS England catalysed this change by advocating for a holistic, integrated model of mental health services (DOH and NHS England, 2015). The report promotes collaboration across the health, education, and social care sectors. This approach signifies a departure from the traditional CAMHS Tier 1, 2, 3, and 4 structure, see Table 1. Fonagy et al. (2014) support this integrated approach, arguing that the tiered system is too rigid and fails to adequately address the complex needs of children and young people. In this thesis, I have used the terms CYPMHS and CAMHS interchangeably. In addition to NHS CAMHS, various other services tailored to local needs and commissioning arrangements are available in local areas (ACAMH, 2023). These services are provided by local authorities, the private sector, schools, charities, and community paediatrics, including preventive, early intervention, and specialist services (ACAMH, 2023; Parish et al., 2020).

Furthermore, a report titled "Children's Mental Health Services 2021-2022" by the Children's Commissioner (2023) for England highlights that most CAMHS are provided in outpatient and community settings, with limited inpatient beds. The report highlighted that “the data leave out a group of children who are admitted to hospital, but no appropriate bed is found” (p. 26). A claim that had been made in other government reports, for example, in the 2016 "Lightning Review: Access to Child and Adolescent Mental Health Services" (Children’s Commissioner, 2016) and in the “Review of children and young people’s mental health services” (CQC, 2017).

As a strategic governmental response, the National Institute for Health and Care Excellence (NICE, 2021) and the NHS Long Term Plan (2019, para. 3.25) highlight the commitment to

> *invest in expanding access to community-based mental health services to meet the needs of more children and young people. By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams.*

This initiative emphasises early intervention, and in October 2023, the UK government announced nearly £5 million for early mental health support hubs targeting children and young people. These hubs, offering drop-in centres without referrals or appointments, provide counselling, psychological therapies, and specialist advice to prevent the escalation of mental health conditions (DHSC, 2023a).

A range of studies have been published that focus on issues aligned with early support. For instance, Ford et al. (2021), in "The Role of Schools in Early Adolescents' Mental Health: Findings From the MYRIAD Study," found that positive school climates significantly improve mental health. Fonagy et al. (2014) work had demonstrated that parental involvement and school-based programs are effective in "What works for whom?". The Evidence-Based Practice Unit (EBPU) at University College London (UCL) and the Anna Freud National Centre for Children and Families (AFNCCF), in partnership with Public Health England (PHE), developed a toolkit to measure and monitor children and young people's mental well-being in schools and colleges (Deighton et al., 2017) last review by AFNCCF and PHE (AFNCCF, 2023) in May 2023. Additionally, recent research from the University of Oxford (2024) shows that an online program enabling parents to use Cognitive Behavioural Therapy (CBT) techniques to treat their child's anxiety is as effective as conventional talking therapies.

However, critiques of community-based services, school initiatives, and early intervention in CAMHS raise several concerns. Critics argue that the evidence supporting the effectiveness of early interventions and school-based mental health initiatives is not always robust, with many programs lacking rigorous evaluation and long-term benefits not well-documented (Clarke et al., 2021; Lai et al., 2022). Implementation challenges, such as insufficient

resources, trained personnel, and infrastructure, also hinder the effectiveness of these programs (Richter et al., 2022). Also noted are concerns about consistency and quality across different regions and schools, which leads to inequalities in service provision by practitioners (Clarke et al., 2021; Richter et al., 2022) who address numerable mental health issues.

CAMHS professionals in England address a wide range of emotional, behavioural, and psychiatric problems in children and adolescents, including depression and anxiety, eating disorders, self-harm and suicidal thoughts, obsessive-compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), autism spectrum disorders (ASD), psychosis, bipolar disorder, schizophrenia, trauma and post-traumatic stress disorder (PTSD), and conduct disorders (NHS England, 2017; RcPsych, 2018; YoungMinds, 2024).

The CAMHS workforce in England comprises a diverse range of professionals, each playing a vital role in supporting the mental health of children and young people (NHS England, 2017; RcPsych, 2018; YoungMinds, 2024). Key roles include those in table 1:

Table 1: CAMHS Workforce and their Roles

Practitioners	Roles
Clinical Psychologists	Trained to work with children experiencing emotional, social, and behavioural distress
Psychiatrists	Medically trained doctors specialising in mental health conditions
Psychotherapists	Treat emotional and behavioural problems that are resistant to other treatments.
Mental Health Nurses	Provide care and support to children and their families
Social Workers	Train to uphold the rights of children, young people and their families
Support Workers	Offer practical assistance and help young people achieve their goals

Occupational Therapists	Work to improve children's physical, psychological, and social well-being.
Family Therapists	Engage the whole family in the therapeutic process
Crisis Workers	Support young people experiencing severe difficulties, such as suicidal thoughts and self-harm
Wellbeing Practitioners	Use CBT techniques to help with low mood and anxiety
Administrative Roles	Ensure the smooth operation of CYPMHS services

2.3.2. The Structure of CAMHS: Tier Model

The CAMHS tier model is a framework used in the UK to structure services for children and young people's mental health, ranging from universal services to highly specialised care. The tiers (illustrated in Table 2) are designed to ensure that children receive the appropriate level of support according to their needs (ACAMH, 2023; NHS Hertfordshire Partnership, 2024).

Table 2: The Structure of CAMHS: Tier Model. Adapted from NHS Health Advisory Service (1995) and ACAMH (2023).

Tiers	What they offer
Tier 1	**Universal Services** • **Description**: Basic support and advice provided by professionals who are not mental health specialists but have some training in mental health issues. • **Providers**: General Practitioners (GPs), school nurses, teachers, social workers, youth workers. • **Services**: General advice, initial identification of mental health issues, basic support, and signposting to other services.
Tier 2	**Targeted Services** • **Description**: Targeted interventions provided by professionals with more specialised training in mental health.

	• **Providers**: Primary mental health workers, educational psychologists, counselors. • **Services**: Assessment, brief therapy, and support for mild to moderate mental health issues.
Tier 3	**Specialist Services** • **Description**: Specialist services for children with more complex and severe mental health needs. • **Providers**: Multidisciplinary teams, including child psychiatrists, clinical psychologists, psychotherapists, and psychiatric nurses. • **Services**: Comprehensive assessment, specialist therapy, and treatment plans.
Tier 4	**Highly Specialist Services** • **Description**: Highly specialised care for children with the most severe, complex, and persistent mental health problems. • **Providers**: Inpatient units, specialised outpatient teams, and intensive treatment programs. • **Services**: Inpatient care, intensive outpatient services, specialised units for conditions such as eating disorders.

The Tier model of CAMHS was conceptualised in the early 1990s and formally articulated in 1995 by the Health Advisory Service in their document, "Together We Stand: The Commissioning, Role and Management of Child and Adolescent Mental Health Services" (NHS Health Advisory Service, 1995). The publication established a comprehensive framework for organising mental health services for UK children and adolescents, delineating four service provision tiers to ensure a structured and integrated approach to mental healthcare.

However, there has been a significant transformative initiative from the central government. Beyond the October 2023 announcement of nearly £5 million in funding for early support hubs for children and young people aged 11-25, which do not require referrals for specialist support (DHSC, 2023a), as partly discussed above. The government has launched substantial initiatives to reform mental health services. In 2021, as part of the Levelling Up policy, the government announced a £500 million investment “over three years to transform ‘Start for Life’ and family help services in half of the council areas across England”. This initiative aims

to “fund a network of Family Hubs, Start for Life services, perinatal mental health support, breastfeeding services, and parenting programs (HM Treasury, 2021, p. 68). This initiative is predicated on the evidence that the first 1,001 days of a child’s life have a significant impact on their health, well-being, and opportunities throughout their life course (HM Government, 2021; Parent-Infant Foundation, 2015)

This overview of CAMH/CYPMHS sets the context for my thesis, and next I review recent research on CAMHS through the lens of Black CYP, wherein I evaluated the service in Section 2.3.3.

2.3.3. Today Mental Health Policy Through The Lens Of Black Children And Young People

On April 12, 2022, the government initiated a discussion paper and a call for evidence to develop a new comprehensive, cross-governmental ten-year plan focused on mental health and wellbeing in England (DHSC, 2022). This Plan sought public input on how to improve mental health and prevent suicide across the population. Of particular relevance to my research is the response to a question in the results published on May 17, 2023, which asked, "How can we improve the general population’s wellbeing?" The main themes highlighted were the necessity for the "provision of culturally appropriate services" and "support for disadvantaged communities" to ensure equitable mental healthcare (DHSC, 2023b).

In January 2023, the Government Action on Major Conditions and Diseases announced plans to release a Major Conditions Strategy that integrates mental health with physical health conditions instead of developing a separate mental health strategy (UK Parliament, 2023). This comprehensive approach aims to address mental health within the broader context of overall health. However, mental health charities, including the Mental Health Foundation, Mind, and Rethink Mental Illness, expressed their disappointment with this decision. They argued that a dedicated mental health plan is urgently needed to address the specific challenges and support required for mental health issues (Mental Health Foundation, 2023).

This debate is particularly pertinent to my research, as these mental health charities have a history of providing tailored services for Black children and young people, including those of Ghanaian and Nigerian descent. Their services focus on addressing the unique challenges faced by these communities, promoting culturally sensitive support, and working to reduce mental health disparities. For example, the Mental Health Foundation (2020) collaborates with organisations like Black Thrive to deliver programs aimed at young Black men. Mind (2024a) offers specific resources and support tailored to Black communities, while Rethink Mental Illness (2024) focuses on advocacy and inclusive services to ensure equitable mental healthcare for Black youth.

Prior to the publication of the Major Conditions Strategy, the DHSC (2023c) produced a comprehensive document on May 17, 2023, titled “Call for evidence outcome: Mental health and wellbeing plan: a discussion paper.” Chapter 4, para. 7 noted:

> *We are changing legislation, investing in the inpatient estate, and piloting culturally appropriate advocacy for people of all ethnic backgrounds and communities, in particular for black men who were more than 4 times more likely to be detained under the Mental Health Act in 2020 to 2021 than their white counterparts.*

This resonates with existing reports, highlighting a trust deficit between my research population and mental health services. For instance, on May 26, 2023, NHS Digital (2023b) reported that Black individuals were nearly five times more likely than White individuals to be detained under the Mental Health Act (MHA) 1983, with 342 detentions per 100,000 Black people compared to 72 per 100,000 White people. Supporting this, research by Mind (2024b) and a report by ITV News on January 13, 2021 by Younger (2021), noted that Black individuals face higher levels of coercion and are more frequently subjected to restrictive interventions such as restraint or involuntary medication.

These current realities align with a systematic review and meta-analysis of 71 quantitative studies published in "The Lancet Psychiatry" in 2019, which highlighted that Black Caribbean and Black African individuals were significantly more likely to be compulsorily admitted to hospital compared to their White counterparts under the MHA 1983 (Barnett et al., 2019).

This disproportionate application of the MHA has been reported for decades, particularly in London (Bhui et al., 1998; S. Davies et al., 1996), the location of my study. Although my research does not focus on detention, the political landscape and its impact on my study population are highly relevant.

The criticism by the three charities I highlighted above of the DHSC's approach to integrating mental health within the broader context of overall health, rather than developing a separate mental health policy, is validated by the “Policy Paper - Major Conditions Strategy: case for change and our strategic framework” published on August 24, 2023 (DHSC, 2023d) informed by the DHSC (2022) call, discussed above. Yet, this policy framework does not explicitly mention Black people or culturally appropriate care despite these groups being most affected by mental health issues (Barnett et al., 2019).

The lack of explicit policies addressing significant social issues indicates policymakers' commitment deficiency or complacency. Wiseman (1979) emphasises that the absence of explicit policies on significant social issues shows insufficient commitment to effectively tackle these problems. Additionally, a study on public policy and advocacy highlights that the exclusion of significant social concerns from policy discussions can hinder the development of effective solutions, thereby reflecting poorly on the policymakers' commitment to addressing these issues (Jurns, 2019). Moreover, another study highlights that inaction or neglect in policymaking can occur due to a range of factors, including organisational biases and the marginalisation of certain issues. This neglect can often be intentional or strategic, reflecting deeper systemic issues within policy frameworks and the prioritisation processes of policymakers (McConnell & ’t Hart, 2019)

The Major Conditions Strategy outlines the intended expansion of Mental Health Support Teams in schools and colleges, aiming to reach at least 50% of students in England by 2025. It also highlights the implementation of the “Start for Life Program” (DfE et al., 2023). Start for Life Program seeks to strengthen parent-infant relationships and reduce the likelihood of adverse childhood experiences (HM Government, 2022). This is crucial as it highlights the importance of early intervention.

In examining these policies and their implications, it becomes clear that the statutory landscape governing mental health services is deeply intertwined with the lived experiences of Black children and young people. The evidence of disproportionate detention rates and coercive practices, coupled with the lack of culturally appropriate care, highlights significant challenges within the current framework. These issues are directly relevant to my research, as they shape the context in which Ghanaian and Nigerian young people navigate mental health services in London. Understanding this landscape is essential for interpreting their experiences and developing recommendations that address the specific needs and challenges these communities face.

2.3.4. NHS Long-Term Plan (2019): What is in it for Black Children And Young People?

The NHS Long-Term Plan aims to ensure a sustainable, high-quality NHS for the future by improving care, increasing efficiency, and incorporating patient and staff experiences (NHS, 2019). The Plan upholds the 2016 Five Year Forward View for Mental Health, which aims to improve mental healthcare and support across the NHS (2016). The NHS Long Term Plan (NHS, 2019, para. 3.25) says

> *By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams. Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it.*

The Plan aims to improve the quality of mental health services for CYP by investing in staff training and development and introducing new and innovative models of care. These underpins the concerted efforts by the DHSC, DfE and NHS Transforming Children and Young People's Mental Health Implementation Program (DFE, 2024). The initiatives provided senior mental health lead training grants for eligible schools and colleges, which spent £20.0m grant funds from 11 October 2021 to 31 March 2024 (DFE, 2024). In paragraph 3.27, the NHS Long-Term Plan provided "a single point of access through NHS 111, all children and young

people experiencing crisis will be able to access crisis care 24 hours a day, seven days a week". However, this has not been meant as shown in Section 2.3.3 above.

For Black CYP, the NHS Long Term Plan also sets out a number of specific commitments, including investing in culturally appropriate mental health services for black children and young people, improving the representation of black people in the mental health workforce, and tackling the stigma associated with mental health in black communities (NHS, 2019). While the NHS Long-Term Plan acknowledges the need to tackle these inequalities, there is a lack of research specifically evaluating the impact of its implementation on Black children and young people's mental health

2.3.5. Other Key Policy Initiatives in Recent History

In this section, in addition to those discussed above, I will briefly highlight other key policy documents from the past decade that have significantly influenced the development of mental health policies relevant to my research on Black African children and young people. I believe there has not been a lack of policy statements, but actionable political will might be lacking.

The Coalition Government's 2011 strategy, No Health without Mental Health, marked a pivotal moment in mental health policy by addressing disparities in mental health outcomes across various demographics (HMG/DH, 2011). This document acknowledges the disproportionate rates of mental health issues among Black and Minority Ethnic (BME) groups, highlighting that "migrant groups and their children are at two to eight times greater risk of psychosis" (p. 59). This statistic highlights the critical necessity for culturally sensitive and targeted mental health interventions tailored specifically to the needs of Black African children and young people (CYP). By emphasising these disparities, the strategy sets a precedent for subsequent policies aimed at bridging the mental health equity gap.

Subsequent to this, the 2014 publication by the Department of Health, Closing the Gap: Priorities for Essential Change in Mental Health, further elaborated on the urgent need to enhance mental health services for CYP, particularly those from minoritised communities, sponsored by Social Care, Local Government and Care Partnership Directorate, London, UK

(2014). This document not only reiterates the importance of addressing inequalities but also advocates for collaborative efforts with community leaders to promote psychological therapies within these groups. The directive that "appropriate support should be offered from the outset" for young Black men (p. 29) highlights a targeted approach to mental healthcare, reinforcing the necessity for immediate and culturally relevant supportive systems.

In March 2015, the Future in Mind report from the Taskforce delineated a comprehensive strategy for transforming mental health services for children and young people by 2020 (NHS England and DOH, 2015). This report is particularly notable for its emphasis on early intervention and cultural sensitivity, aiming to create a supportive environment that encourages resilience and timely access to mental health services. The commitment to non-stigmatising, inclusive services is articulated clearly: "We must make it much easier for a child or young person to seek help and support in non-stigmatised settings" (NHS England and DOH, 2015, p. 4). This objective aligns closely with the needs of Black African youth, advocating for an approach that minimises barriers to accessing mental healthcare.

The government's 2018 response to the 2017 consultation on Transforming Children and Young People's Mental Health Provision: A Green Paper and Next Steps further solidifies the commitment to culturally competent mental health services (DHSC and DoE, 2018). This document stresses the importance of creating inclusive environments and providing tailored support for Black or minority ethnic children. It emphasises the need for staff training, stigma reduction, and early intervention, with a particular focus on enhancing awareness and accessibility during non-term periods to address specific cultural challenges (DHSC and DoE, 2018). This response represents a holistic approach to mental healthcare, integrating cultural competence into the broader framework of mental health provision.

Through the review of these policy documents, it becomes evident that there is a progressive recognition and response to the unique mental health needs of Black African children and young people. These policies collectively advocate for early intervention, culturally sensitive services, and collaborative community engagement, setting a robust foundation for future advancements in mental healthcare for this demographic.

2.3.6. The Evaluation of Mental Health Services Through the Lens of Black Children and Young People

I have looked at the evolution of mental health services as it affects Black CYP, and I now evaluate mental health services through the lens of Black children and young people, who are my research population.

On 29 February 2023, the National Audit Office (NAO) (2023) released a report examining the progress in improving mental health services in England. The NAO independently oversees public spending for Parliament, helping hold the government accountable and advising public bodies to improve services. The report evaluates the execution of commitments outlined in (1) the Five Year Forward View for Mental Health, which aims to improve mental healthcare and support across the NHS (2016), (2) the "Stepping forward to 2020/21: The mental health workforce plan for England" (NHS, 2017), which outlines a roadmap and details additional staff needed to achieve the Five Year Forward View's transformation. (3) and the NHS Long-Term Plan (NHS, 2019) discussed in Section 2.3.4..

The report discusses the rise in mental health disorders among children and young people between 2017 and 2022, particularly after the COVID-19 pandemic. It also details the NHS's efforts to expand mental health services for this group, including setting access targets and investing in new care models. However, the report also highlights challenges such as missed targets, long waiting times, and concerns about the overall quality of care. It emphasises the need for better data collection and monitoring to understand the variations in access and outcomes for different groups of children and young people.

I found it curious that the report does not explicitly focus on Black children and young people's mental health, being the most affected by mental health issues (Bansal et al., 2022; CQC, 2018; Holt, 2022; Kapadia et al., 2022). It discusses mental health inequalities more broadly, noting that people from minority ethnic groups tend to have lower treatment rates, poorer satisfaction with services, and worse recovery rates in talking therapies compared to the White British population. The finding regarding “poorer experiences accessing or using services” for Black CYP is no longer a novel finding due to its historical (Acharyya et al., 1989; Littlewood & Cross, 1980; Rwegellera, 1980) and contemporary occurrences (Bansal et al.,

2022; CQC, 2018; Holt, 2022; Kapadia et al., 2022; National Audit Office, 2023), which are not decreasing.

Still in 2023, on 12 September, the House of Commons Education Committee (2023) in their Seventh Report of Session 2022–23 entitled “Persistent absence and support for disadvantaged pupils” discusses the rise in mental health challenges among CYPs since the pandemic and the negative impact this has had on school attendance. It highlights the long waiting lists for Child and Adolescent Mental Health Services as a barrier to accessing support. However, the report does not specifically mention Black children and young people's mental health. It references research from Mind (2021a, p. 6) a mental health charity, which found that racism in secondary school can be a factor affecting the mental health and school attendance of Black children and young people. However, the report does not delve deeper into this issue or provide specific recommendations for addressing the unique mental health needs of Black CYP.

Mind’s (2021a), mixed-methods inquiry into mental health and secondary education in England entitled "Not Making the Grade: Why Our Approach to Mental Health at Secondary School is Failing Young People" focuses on the mental health challenges faced by Black children and young people in England. The research, conducted from September 2020 to April 2021, utilised surveys and interviews involving 1,271 young people, 313 parents, and 987 school staff, as well as interviews and focus groups with 74 racially minoritised young people aged 14-21. Findings indicate significant mental health impacts on school participation and performance, exacerbated by racism and inadequate mental health support, leading to punitive disciplinary measures rather than supportive interventions. This highlights the need for more robust mental healthcare for Black secondary school children, which will attract funding.

2.4. Experiences of Ghanaian and Nigerian Youth in Inner London for Depression and Anxiety Care

2.4.1. Introduction

As I navigate the research landscape, it becomes evident that specific studies exclusively focusing on this demographic and their experiences of mental healthcare in London, or even more broadly in the UK and globally, are virtually non-existent. The closest approximations available are studies on Black African children and young people (CYP). However, even within this broader category, research remains limited compared to the more extensive body of work on ethnic minority groups or youth in general. Most existing studies are predominantly conducted in the US, necessitating a broadening of my search parameters beyond local and national boundaries to include international perspectives.

Given this context, I have deliberately excluded studies that reference Black CYP without specifying African descent or relevant experiences. Within the UK, the body of work on anxiety and depression, also known as CMD in ethnic minority CYP, is sparse (e.g. Bhui & Bhugra, 2002, 2018; Edbrooke-Childs et al., 2016; Edbrooke-Childs & Patalay, 2019; Fitzpatrick et al., 2014; Moffat et al., 2009). Similarly, research specifically addressing CMD in Black/African populations is scant (e.g. Ababio, 2019; Banks, 2020; Rwegellera, 1980). Even less is known about the specific subgroups of interest in this study – Ghanaian and Nigerian youth in Inner London – and their relationship with CMD/ anxiety and depression.

Therefore, my literature review will encompass studies examining various elements of the Ghanaian and Nigerian young people's experience and the broader Black African experience of anxiety and depression. Following Boote and Beile (2005, p. 7), who advocate for the need to “broaden the search” in under-researched areas, I employed a rapid scoping review method (Cochrane, 2024; Tricco et al., 2018). This approach ensures comprehensive coverage beyond the present purview, incorporating international and UK-based studies. Samples were drawn from Australia, Bermuda, Ghana, Nigeria, Northern Ireland, Swaziland, the United Kingdom, and the United States, and there were no restrictions on years of study. Cooper (1988, p. 110) argues that “coverage” is the most distinct element of literature

reviewing. Given the historical and structural inequalities that underpin mental healthcare disparities (Craig, 2007; Weigert, 2015), it is crucial to situate these experiences within a broader scholarly and historical context. Finally, I adopted the intersectionality approach to their experiences, which is defined by multiple factors, including social locations that cannot be separated from constituted social processes and structures shaped by power, time and place, as well as bringing together the ideas and actions of this demographic that is potentially excluded from or misrepresented within Western disciplines and national knowledge traditions (Collins, 2021; Crenshaw, 1991; Hankivsky & Jordan-Zachery, 2019; Winker & Degele, 2011).

2.4.2. Global Context

I explore the global prevalence and patterns of anxiety and depression among Black African youth, which highlights the significant mental health challenges this demographic faces due to socioeconomic, racial, and geographical factors.

Global Prevalence and Patterns of Depression and Anxiety in Black African Youth

Evidence of the global **prevalence** and patterns of depression and anxiety among Black African youth is limited regarding studies that highlight the extensive mental health challenges faced by this demographic. Planey et al. (2019) systematic review in the US shows that nearly half of African American respondents had experienced a mental health disorder by the age of eighteen. The elevated suicide rates among Black children aged 5-12, nearly twice that of their white peers, starkly illustrate the gravity of the situation. Chakawa's (2023) primary study expanded it in exploring mental health in a rural Black Belt County in the Southeastern United States, finding clinically significant mental health needs in 13 children. A notable 7.69% had anxiety and depression, with another 7.69% experiencing a combination of ADHD, oppositional-defiant disorder/conduct disorder (ODD/CD), and anxiety/depression. This prevalence of mental health disorders is reiterated in Murry et al. (2011), who identified a 19.4% prevalence rate among African American children in poverty in rural Georgia.

The role of Black churches across the United States in promoting mental health, as explored by Hays (2015), emphasises a community-based approach to mental health. Despite this, African Americans experience more severe and persistent depressive episodes compared to whites, often presenting more depressive symptoms in primary care settings. This suggests that community support, while crucial, may not fully mitigate the impact of pervasive psychosocial stressors.

Comparing rural and urban contexts in the USA, Murry et al. (2011) in rural Georgia found higher prevalence rates of mental health disorders among rural African American children, a finding supported by Ndomahina (2020) in Texas, who identified significant mental health challenges among African immigrants, including PTSD, major depression, and generalised anxiety disorder. This highlights the compounded effect of geographical and socio-economic factors on mental health. In urban settings, Williams (2015) observed significant proportions of African American children meeting diagnostic criteria for mental disorders in schools, highlighting a potential systemic issue of underidentification and under-service in mental healthcare. Breland-Noble et al. (2015) further illustrate this, noting high levels of impairment and distress due to depressive illnesses in the Southeastern United States, compounded by barriers such as stigma and mistrust of providers.

Smith et al. (2020) emphasise the pervasive impact of racial stressors on mental health, identifying elevated rates of depression and anxiety among African Americans due to chronic exposure to racial microaggressions in States such as Utah and Illinois. This is consistent with Majors et al. (2020), who stress the significant impact of poor social and emotional skills, trauma, and educational challenges on mental health across diverse contexts, including the United States, the United Kingdom, Nigeria, and Bermuda.

Juzang (2020) highlights the profound impact of poverty, violence, and systemic racism on mental health in cities like Philadelphia, Chicago, Washington, D.C., and Baltimore, drawing attention to the intersectional nature of these stressors. Dorahy et al. (2000) illustrate cross-cultural differences, finding higher depression scores among Nigerian and Swazi students compared to their Australian, Ghanaian, and Northern Irish counterparts.

Analysing the **patterns** of depression and anxiety, Chakawa (2023) identified that among children with clinically significant needs, a significant portion had multiple co-occurring conditions. This complexity is echoed by Murry et al. (2011), who found externalising behaviours and attention deficit disorder to be common alongside depression. The findings of Planey et al. (2019) and Hays (2015) demonstrate that Black youth experience higher rates of behavioural and conduct disorders and more severe depressive episodes compared to other racial groups. These patterns are influenced by economic deprivation, violent neighbourhoods, and racial discrimination (Ndomahina, 2020; W. Smith et al., 2020).

Williams (2015) and Breland-Noble et al. (2015) note significant disparities in mental health service utilisation among African American children, often due to underdiagnosis and misdiagnosis, further complicated by stigma and mistrust. The cumulative effects of racial microaggressions, as discussed by Smith et al. (2020), create a potential pervasive environment of heightened stress and vigilance, contributing to chronic anxiety and feelings of isolation.

Majors et al. (2020) and Juzang (2020) explore the compounded stressors faced by Black youth, including poverty, family instability, community violence, and negative school experiences. These factors contribute to higher rates of academic disidentification and emotional distress, with common coping mechanisms including substance abuse and violence. However, resilience and positive coping strategies, such as creativity and goal setting, are also evident among some youth, indicating the potential for targeted interventions to support mental health in these communities.

Cultural Factors Influencing Mental Health Experiences of Black African CYP Globally

I identified a complex interplay of cultural and systemic factors that profoundly influence their mental health outcomes. Religion and spirituality serve dual roles as both facilitators and barriers. While they provide significant social support and a sense of community, they also perpetuate stigma and encourage self-reliance, which hinders professional help-seeking (Planey et al., 2019). This duality highlights the need for culturally sensitive approaches that respect religious coping mechanisms while promoting conventional mental health services. Consequently, the role of faith-based networks and the Black Church cannot be understated,

as they are pivotal in the help-seeking pathways for these communities. They provide trusted, culturally congruent support, yet their emphasis on religious solutions can sometimes overshadow the benefits of professional mental health interventions (Breland-Noble et al., 2015) . This dynamic necessitates collaboration between mental health professionals and religious leaders to bridge the gap and enhance treatment accessibility (Planey et al., 2019).

Moreover, community and neighbourhood characteristics, such as socioeconomic status and family structure, significantly impact mental health experiences. These factors not only affect individual well-being but also influence the perceptions and referrals by teachers and other community members (J. H. Williams, 2015). The intersectionality of these factors underpins the importance of a holistic approach that addresses both individual and environmental influences.

Stigma and mistrust of clinicians, particularly those from different racial backgrounds, are prevalent within these communities. This mistrust is rooted in historical trauma, systemic racism, and ongoing racial discrimination, which collectively shape negative perceptions of mainstream healthcare systems (W. Smith et al., 2020). Furthermore, cultural beliefs that valorise resilience and independent problem-solving exacerbate these issues, discouraging individuals from seeking necessary support (Chakawa, 2023; K. Hays, 2015).

In summary, by acknowledging and navigating the intricate web of cultural factors, healthcare providers can better support these individuals in overcoming barriers and accessing effective mental healthcare.

2.4.3. UK Context

This section examines the prevalence, cultural influences, and service experiences related to mental health among Black African children and young people (CYP) in the UK. The research reveals significant regional disparities in mental health prevalence, with notable findings from cities like Birmingham, Bristol, and Prescot. Socioeconomic factors play a critical role in mental health vulnerability, with children from poorer households disproportionately affected. Cultural factors, such as stigma and reliance on traditional healers, further

complicate mental health experiences. Additionally, the review shows the potential inadequacy and cultural insensitivity of existing mental health services, emphasising the urgent need for culturally appropriate care tailored to the unique needs of Black African CYP.

Prevalence of Depression and Anxiety among Black African CYP in England

The prevalence of depression and anxiety among Black African CYP in England is evident in the literature. For example, Butt et al. (2015) reveal regional disparities through consultations in Birmingham, Bristol, and Prescot. Their findings show that 9.2% of Black children aged 5-16 had a mental disorder, slightly less than the 10.1% reported for White children, with a notable prevalence of conduct disorder among Black boys. Lavis (2014) reported the same. Both studies were conducted by Mental Health Providers Forum and Race Equality Foundation. The London Assembly (2015) adds that approximately 111,000 children and young people in London, across all ethnicities, suffer from clinically significant mental health problems, including conduct disorder, anxiety, depression, and ADHD.

The Centre for Mental Health (2020) emphasises the socioeconomic dimensions of these disparities, indicating that children from the poorest households, which disproportionately include Black African children, are four times more likely to experience severe mental health issues by age 11 compared to their wealthier peers. This socioeconomic factor is pivotal in understanding the heightened vulnerability within these communities. Bignall et al. (2019) further substantiate these findings by highlighting that Black African and African Caribbean communities in the UK exhibit higher rates of depression compared to White communities. This aligns with Bansal et al. (2022), who highlight significant ethnic inequalities in mental healthcare, noting that ethnic minority groups often face undiagnosed and untreated mental illnesses and are more likely to access services through crisis pathways rather than primary care. Bansal et al. (2022) findings of undiagnosed and untreated mental illnesses are consistent with Williams (2015) and Breland-Noble et al. (2015) and are more likely to access services through crisis pathways rather than primary care is consistent with Hays (2015) Black church study, studies in the United States.

Li et al. (2020) illuminate the mental health concerns within minoritised communities in the Hammersmith and Fulham boroughs in London, where anxiety or stress affects 91% and

depression 84% of these populations, highlighting the pressing mental health challenges among Black African CYP. Meanwhile, the Southwark Health and Social Care Scrutiny Commission (SHSCSC, 2021) findings suggest that younger Black Africans report lower levels of mental ill health compared to older Black adults, who face higher risks of severe mental illness.

Cultural Factors That May Influence Black African CYP Mental Health Experiences in England

As I explore the mental health experiences of Black African CYP, I recognise that cultural factors play a significant role. Reluctance to seek mental health support often stems from stigma and cultural misunderstandings prevalent within the African Diaspora (Li et al., 2020). This reluctance is further complicated by the frequent misdiagnosis of schizophrenia and underdiagnosis of anxiety and depression among Black individuals, leading to inadequate treatment (Francis et al., 2002; SHSCSC, 2021). Cultural differences in understanding and expressing mental health issues, along with a historical mistrust of statutory services, make these challenges even more complex (Butt et al., 2015; Centre for Mental Health, 2020). Moreover, reliance on faith and traditional healers, combined with perceptions of mental illness as a consequence of life events or witchcraft, often delays formal mental healthcare (Bignall et al., 2019).

Additionally, factors like racism, migration stress, complex trauma, and social marginalization profoundly affect mental health and service use among Black African youth (Bansal et al., 2022). Discrimination, socioeconomic disadvantage, family breakdown, and exposure to gang culture further diminish resilience and exacerbate mental health problems within these communities (Butt et al., 2015; P. Lavis, 2014). Hatch et al.'s (2016) study found that discrimination significantly impacts mental health, particularly depressive episodes, in South East London's diverse population, where Black and recent migrants were most affected. While Centre for Mental Health (2020) found systemic racism and discrimination intensify mental health issues, particularly post-traumatic stress disorder (PTSD) and schizophrenia, among African and Caribbean communities.

Mental Healthcare and Service Experiences of African Children and Young People in England

The mental healthcare and service experiences of African children and young people suggest that there is a pervasive sense of inadequacy and cultural insensitivity within existing mental health services (Bignall et al., 2019; Butt et al., 2015). Participants repeatedly emphasised the Eurocentric nature of available services, rendering them unsuitable for many users. As one respondent in Butt et al.'s (2015, p. 9) study aptly noted, "available services are very Eurocentric and unsuitable for many of our clients". This sentiment is profoundly echoed in the enduring "'circles of fear' between Black communities and mental health services" (Centre for Mental Health, 2002, p. para 2), a phenomenon described nearly two decades ago by Keating and colleagues. Despite the passage of time, there is no significant evidence of improvement in these relationships; rather, the fear and mistrust have become more entrenched (Centre for Mental Health, 2020).

A lack of respect and understanding for religious and faith beliefs by health practitioners further exacerbates the problem. Participants in a study by Bignall et al. (2019) expressed their doubts about the efficacy of Western medicine in addressing mental illnesses perceived to be caused by magic or possession. This dissonance highlights a critical gap in culturally sensitive care.

The need for empathetic, unbiased, and culturally aware treatment is a recurrent theme. The synthesis of participant experiences indicates that systemic oppression and deeply entrenched biases are particularly pronounced for Black ethnic groups (Bansal et al., 2022). This systemic racism creates an environment of fear, with some African communities fearing that involvement with mental health services could result in their death (Lavis, 2014). One particularly upsetting account illustrated the stigma associated with mental health services: "People do not even want to associate themselves with statutory organisations, psychiatric hospitals" (London Assembly, 2015, p. 11). This stigma, combined with a history of exclusion and professional neglect, compounds the reluctance to seek help. A service provider lamented, "by the time they come through the criminal justice system [...] they've probably

been excluded from school, they've probably been let down by professionals as they see it" (Li et al., 2020, p. 16).

Moreover, young Black men face heightened mental health challenges but are particularly reluctant to access services due to stigma and cultural barriers (SHSCSC, 2021). Their experiences with mental health services are often seen as degrading and alienating, mirroring the oppressive dimensions of other institutions in their lives (Francis et al., 2002). This analysis shows the urgent need for culturally sensitive, respectful, and empathetic mental health services tailored to the unique needs of Black African children and young people.

2.4.4. Available Care for Anxiety and Depression Accessed by Africans in England

Examination of the literature on service provision for mental healthcare for African heritage populations suggests that culturally appropriate services are essential (Bansal et al., 2022). It is important to note that the mental healthcare services identified in this review are not exhaustive. The literature suggests that Black African communities often turn to community-led initiatives due to mistrust of formal services (Bansal et al., 2022; Butt et al., 2015; Li et al., 2020). The Motherhood Group and Black Thrive exemplify efforts in providing perinatal support and addressing mental health inequalities (Centre for Mental Health, 2020). These initiatives are vital in bridging the gap created by underutilised formal services. Organisations such as Sahara, Bolton Council of Mosques, and Leeds Gypsy and Traveller Exchange provide holistic models and community support, emphasising user involvement in shaping and delivering services (Butt et al., 2015). In Bignall et al.'s (2019) study, disparities exist in the types of mental health services accessed by Black African communities. These groups often underutilise community and specialist mental health services compared to their white counterparts due to cultural and linguistic barriers and systemic mistrust. Formal services are perceived as inadequate and discriminatory, prompting reliance on third-sector support (Bansal et al., 2022).

Improving access includes initiatives like Right Here Newham's Boxing Project and Off the Record in Croydon, which employ Black and Minority Ethnic Community Development Workers to enhance mental health services (Lavis, 2014). Projects such as the South London

and Maudsley NHS Foundation Trust's training of faith leaders to promote mental health awareness illustrate integrated service models aimed at improving access (London Assembly, 2015). Digital health platforms and community-based advocacy play significant roles. Services like the Anti-Tribalism Movement's campaigns, Auntie's digital platform for BAME communities, and Black Minds Matter UK are crucial in connecting individuals with black therapists and reducing stigma (Li et al., 2020). The underrepresentation of Black youth in CAMHS highlights the necessity of initiatives like The Nest, which offer accessible support through self-help and group sessions (SHSCSC, 2021).

Overall, despite efforts to provide culturally appropriate care, mainstream services often lack sensitivity and appropriateness, leading to underutilisation by Black African communities. This highlights the ongoing need for culturally relevant and accessible mental health services (Francis et al., 2002). I will use the following section to discuss the primary evidence-based care for anxiety and depression in the UK, Improving Access to Psychological Therapy (IAPT)

2.4.5. The Introduction and Evolution of IAPT for Minoritised Groups

I discuss the evolution of the Positive Practice Guide for Improving Access to Psychological Therapy (PPG-IAPT) for Black, Asian, and Minority Ethnic communities. The NHS IAPT, now called NHS Talking Therapies for Anxiety and Depression (NHS England, 2024), published its Manual in March 2024 (NHS Talking Therapies, 2024). The NHS Talking Therapies manual integrates new guidelines to address these populations' distinct mental health needs. This manual stresses the importance of culturally sensitive methodologies that ensure "therapy delivery models may need to be adapted to improve access, retention rates, and outcomes for ethnic minority communities" (p. 116). This adaptation necessitates considering patients' cultural, spiritual, and value-based perspectives. This involves the utilisation of family genograms to comprehend migration histories and acculturation levels, thereby tailoring interventions more effectively.

The NHS IAPT, introduced in 2008 and recommended by the National Institute for Health and Care Excellence (NICE) as a first-line treatment for common mental disorders (CMD), has garnered national and international acclaim for its evidence-based approaches (NICE, 2022.

Alongside the policies and evidence discussed in Section 2.3, by 2019, IAPT incorporated provisions for ethnic minorities, including religious inclinations (A. Beck et al., 2019). This evolution is reflected in the collaborative efforts by The Synergi Collaborative Centre, which aims to culturally adapt psychological interventions based on the UK's IAPT experiences, involving partnerships between institutions in the UK and Canada (Bhui et al., 2020). Furthermore, Bartham (2019) advocated for Canadian mental health policy and service designers to build on the UK's achievements in expanding psychotherapy access. He highlighted the considerable variation in IAPT's impact across “districts and population groups” (p. 64). However, such variation is negligible for Ghanaian and Nigerian populations in England, leading to this study's formulation of research question 4.

Despite the notable progress of IAPT, the persistence of ethnic disparities highlights the need for ongoing efforts to enhance cultural humility and reduce systemic barriers within mental health services. The 2023 review by the National Collaborating Centre for Mental Health (NCCMH) highlighted ongoing ethnic inequalities within IAPT services (NCCMH, 2023). This review uncovered disparities in access, engagement, and treatment outcomes, particularly among Black African children and young people. Key findings indicated that individuals from Black African backgrounds “were less likely to self-refer” and “more likely to decline mental health assessments” compared to White British groups (NCCMH, 2023, p. 56). They also experienced poorer treatment outcomes, attributed to factors such as increased symptom severity at initial assessment and socio-economic challenges like higher deprivation and unemployment. Additionally, cultural and religious insensitivity among providers adversely affected treatment experiences. Systemic barriers, including longer wait times for assessments and treatments, disproportionately impacted Black African individuals, emphasising the urgent need for culturally sensitive care and community engagement strategies. This aligns with Brown et al.’s (2014) findings about a decade ago in South East London, where the self-referral route had not fully addressed the inequity issue, particularly for younger people who did not access services through primary care routes.

2.5. Conclusions from the Literature Review

The literature review highlights several critical insights into the mental healthcare experiences, though not specific to but relatable to Ghanaian and Nigerian young people in Inner London. I began by engaging with the theoretical underpinnings of this study. First, IPA, which I discussed in Section 3.3, "allows idiographic accounts in participants' own words and terms to allow the very essence of the phenomenon to reveal itself in its primordial form" (Isiwele et al., 2022, p. 7). The intersectionality framework is pivotal for understanding how race, gender, socioeconomic status, and other identities collectively shape mental health outcomes. This approach challenges the reductionist models that have historically dominated mental healthcare, such as the monoamine hypothesis of depression, which often fails to account for the complex lived experiences of Black youth. Critical Race Theory (CRT) further illustrates how systemic racism and institutional biases permeate the mental health sector, contributing to the underdiagnosis, misdiagnosis, and coercive treatment of Black youth. The ongoing disparities in access to mental health services and their disproportionate detention under the Mental Health Act (MHA) 1983 highlight this systemic inequity. Furthermore, the review uncovers cultural barriers, such as stigma and reliance on religious frameworks, which delay professional mental health intervention among these communities. Although community-led initiatives offer some support, formal services remain culturally inadequate, contributing to a widespread mistrust of statutory healthcare services.

From a policy perspective, while the NHS Long-Term Plan and other key policy initiatives signal a commitment to improving mental health services for young people, the literature reveals a persistent gap in addressing the specific needs of Black youth, particularly those of African descent. Despite efforts to expand community-based and culturally sensitive mental health services, the underrepresentation of Ghanaian and Nigerian youth in mental health settings remains a challenge. The review concluded that existing mental healthcare models and policies, although well-intended, are not sufficiently tailored to meet the unique cultural and systemic needs of these populations and diverse youths.

2.6. Rationale for the Study

The rationale for this study stems from the need to bridge the gap between mental health services and the lived experiences of Ghanaian and Nigerian young people in Inner London. While the literature on Black African children and young people's mental health is growing, there is limited research on this demographic in the UK. This gap is compounded by the inadequacy of current mental health services to provide culturally appropriate care for anxiety and depression among these youth.

The literature highlights the importance of culturally sensitive, inclusive care models that integrate an understanding of systemic racism, intersectionality, and community-based approaches. Despite some promising policy frameworks, such as the NHS Long-Term Plan, significant disparities in mental healthcare access and outcomes persist for Black youth. These disparities are exacerbated by cultural stigma, mistrust of mental health services, and the failure of formal systems to engage meaningfully with community networks.

By focusing on the lived experiences of Ghanaian and Nigerian young people, this study aims to inform service improvement efforts, contribute to enhancing cultural appropriateness in therapy models like IAPT, and contribute to the growing body of research on mental healthcare equity. This study is particularly timely, given the increasing recognition of the need for culturally adapted mental health interventions and policies that are inclusive of Black African communities in the UK. Therefore, the research question formulated for this study stems from the following aim:

> To investigate the lived experiences of young Ghanaian and Nigerian individuals in Inner London as they navigate care for anxiety and depression. The study seeks to explore how these youths, along with their parents and practitioners, perceive and experience mental healthcare.

Chapter 3: Methodology

3.0. Overview

In this section, I discuss my paradigm position, enriched by intersectionality, critical race theory (CRT), and the social model of mental health. A qualitative approach, specifically Interpretative Phenomenological Analysis (IPA), is chosen for its ability to capture detailed narratives and the participants' subjective realities (Smith et al., 2009). I discuss the procedures and processes for conducting this study, including participant recruitment and the rigorous ethical considerations involved. The chapter concludes by explaining how validity and quality were maintained, emphasising depth, contextual sensitivity, and reflexivity.

3.1. Paradigm Position

This research is framed within a constructivist-interpretivist paradigm, underpinned by a relativist ontology and an interpretivist epistemology. These foundational stances are enriched by intersectionality, critical race theory (CRT) (discussed in Section 2.2), and the social model of mental health, providing a comprehensive framework for examining the complex interplay of cultural, social, and individual factors influencing mental healthcare experiences.

3.1.1. Ontological Stance

Ontology, as a philosophical discipline, explores the nature of being, existence, and reality, examining entities, their categorization, and interrelationships to address fundamental questions regarding the world's structure and the nature of its constituents (Hofweber, 2011; Loux & Crisp, 2017). In the research context, ontology pertains to a researcher's beliefs about the nature of reality, particularly social reality. (Crotty, 1998; Guba & Lincoln, 1994)

I align myself with a relativist ontology rather than a realist one. Realists assert that social phenomena exist objectively and can be scientifically studied and understood (Bhaskar, 2008). In contrast, I take a relativist or constructivist stance, positing that reality is socially constructed and varies across individuals and cultures. From my perspective, knowledge is subjective and context-dependent, allowing for the coexistence of multiple realities (Guba & Lincoln, 1994). This relativist perspective is particularly pertinent in my research as I examine the lived experiences of Ghanaian and Nigerian youths regarding the care for anxiety and depression in Inner London, where personal and cultural narratives distinctly influence individual understandings and experiences of mental health and care.

I acknowledge the critique that ontological relativism might undermine the pursuit of objective knowledge, potentially leading to fragmented truths and an inability to establish universal principles (Baghramian & Carter, 2022; Bhaskar, 1975). Critics argue that if reality is entirely subjective, findings may lack generalizability and fail to effectively inform broader policy and practice (Bhaskar, 1975). Moreover, this stance could result in relativistic fallacies, where all perspectives are considered equally valid, potentially obscuring the identification of systemic issues and power imbalances (Sayer, 2000). However, my research is qualitative and does not seek objectivity or replicability. Instead, I aim for “a subjective one, wherein readers and writers might find commonality in their constructive processes” (Stahl & King, 2020, p. 26).

3.1.1. Epistemological Stance

Epistemologically, I align with interpretivism, which emphasises understanding individuals' meanings and interpretations of their experiences and social phenomena (Schwandt, 1994). I share the several presets and attributes of the interpretivism positioning, including seeing reality as socially constructed through individual meanings and interpretations as expressed in Schütz's (1967) work, the Phenomenology of the Social World. It emphasises understanding human behaviour within its cultural, historical, and social context (Geertz, 1973) by utilising interviews, observations, and case studies to gain in-depth insights into experiences (Denzin & Lincoln, 2011). As well as hermeneutics, which is focused on interpreting the meaning of texts, actions, and social practices (Gadamer, 2003), underpinned by the researcher's role to co-construct knowledge with participants influenced by the research process (Guba & Lincoln, 1994).

The constructivist-interpretivist paradigm is essential for understanding the nuanced and multifaceted experiences of young Ghanaians and Nigerians dealing with anxiety and depression. Through interpretative phenomenological analysis (IPA), I seek to explore these individuals' personal and unique experiences, recognizing that their realities are shaped by their cultural backgrounds, social contexts, and individual perceptions (Smith, Flowers, & Larkin, 2009).

3.1.2. Rationale for qualitative

I chose to adopt a qualitative methodology and not quantitative or mixed methods for several key reasons. These reasons are rooted in the nature of the research questions, the theoretical frameworks guiding the study, and the need for a perceived in-depth understanding of complex, subjective experiences.

First, the nature of the research questions, quantitative methods are designed to test hypotheses and measure variables numerically, which may not capture the depth and nuance required for my research questions. My study aims to explore the intricate and subjective experiences of young people from Ghanaian and Nigerian backgrounds, focusing on their interactions with mental healthcare systems underpinned by the cultural

appropriateness of these systems. These questions necessitate a qualitative approach that allows for possibly rich, detailed narratives rather than numerical data (Creswell & Creswell, 2023).

Second, the underpinning theoretical frameworks such as intersectionality and critical race theory demand a deep exploration of how different social identities and systemic factors intersect to shape individuals' experiences (Crenshaw, 1989; Delgado, 2023). These frameworks are best examined through qualitative methods, which can provide a comprehensive understanding of the social, cultural, and historical contexts that may influence mental health and well-being. Quantitative methods, which often focus on generalizability and statistical significance, may not adequately address these complex, context-dependent interactions (Hill Collins & Bilge, 2016).

Third, for potential depth of understanding, qualitative research is invaluable for obtaining a profound and comprehensive understanding of participants' perspectives. Methods such as in-depth interviews and focus groups allow for the collection of perceived rich, detailed data that reflect the complexities of participants' lived experiences (Patton, 2015). While useful for measuring prevalence and correlations, quantitative methods may not capture the subjective realities and personal meanings crucial to my study (Smith et al., 2009).

Fourth, the methodological considerations, Interpretative Phenomenological Analysis (IPA), which is the chosen methodology for this study, align well with qualitative research paradigms. IPA focuses on understanding how individuals make sense of their personal and social worlds, emphasizing detailed examinations of personal lived experiences (Smith et al., 2022). Mixed methods, which combine qualitative and quantitative approaches, may dilute the depth and specificity that IPA seeks to achieve. Furthermore, the integration of both methods can complicate the research design and analysis, potentially diverting focus from the rich qualitative insights (Creswell & Plano Clark, 2018).

Fifth, practical considerations in conducting mixed methods research may require additional resources, time, and expertise in both qualitative and quantitative methodologies (Teddlie & Tashakkori, 2009). Given the specific aims of my research, prioritising qualitative methods

ensures that I can deeply engage with the data and provide meaningful, context-rich insights without the added complexity and resource demands of integrating quantitative methods.

In summary, the decision not to adopt quantitative or mixed methods in my research is driven by the need for a deep, nuanced understanding of complex human experiences, the theoretical frameworks guiding the study, and the methodological alignment with IPA. This approach ensures that the rich, subjective realities of Ghanaian and Nigerian young people are adequately explored, providing valuable insights that can inform and improve mental healthcare practices.

3.2. Consideration of Methodological Approaches

In exploring the lived experiences of Ghanaian and Nigerian young people regarding their care for anxiety and depression in Inner London, I carefully evaluated multiple methodologies before concluding that IPA was the most fitting. While considering IPA, I also reviewed Grounded Theory, Narrative Inquiry, Ethnography, Case Study, and Discourse Analysis, each offering distinct advantages. However, they presented limitations I could not ignore when aligned with my research's overarching goal of deep understanding of nuanced experiences.

3.2.1. Grounded Theory

Grounded Theory (GT) is highly effective in generating theory from data systematically gathered and analysed (Glaser & Strauss, 1967). This methodology emphasises the development of a theoretical framework grounded in the participants' lived experiences. However, GT focuses on generating a new theory rather than exploring and interpreting specific lived experiences. Given my research objectives, the aim is not to generate a new theory but to deeply understand the nuanced experiences of anxiety and depression care among Ghanaian and Nigerian youths within the context of Inner London's socio-cultural dynamics. IPA's emphasis on the depth of individual experiences aligns more closely with my research goals (Smith et al., 2009).

3.2.2. Narrative Inquiry

Narrative Inquiry involves collecting and interpreting personal stories to understand how individuals make sense of their experiences (Clandinin & Connelly, 2000). This approach is invaluable for capturing the richness of personal narratives and the meaning-making processes. However, Narrative Inquiry can sometimes emphasise the storytelling aspect over the interpretative depth (Riessman, 2008), which is required to explore the intersectionality and critical race aspects deeply embedded in the participants' experiences. My focus is on how these young people interpret and make sense of their mental healthcare experiences, which demands a methodological approach that prioritises interpretative analysis over narrative construction.

3.2.3. Ethnography

Ethnography provides a comprehensive, immersive understanding of cultural phenomena through direct observation and participation (Hammersley & Atkinson, 2007). While this methodology is robust for exploring cultural contexts and social behaviours, it requires prolonged engagement within the community, which may not be feasible given the scope and timeframe of my research. Moreover, ethnography tends to focus on cultural practices and social interactions at a broader community level, potentially overshadowing the individualised, subjective experiences central to my study (Smith et al., 2022). IPA's focus on individual lived experiences allows for a more detailed exploration of how intersecting identities shape mental health experiences within a specific socio-cultural context.

3.2.4. Case Study

Case Study methodology allows for an in-depth, contextual analysis of a limited number of events or conditions and their relationships (Yin, 2017). While case studies are useful for understanding complex issues in real-life contexts, they can be limited by their focus on specific cases, which may not adequately capture the broader range of experiences among Ghanaian and Nigerian youths. My research seeks to generate findings across a seemingly wider population, making IPA's idiographic focus more suitable for identifying convergence

and divergence within individual experiences that may resonate across the community (Smith et al., 2022).

3.2.5. Discourse Analysis

Discourse Analysis (DA) is a broad, compelling methodology that examines how language constructs and reflects social realities (G. Brown, 1983; Gee, 2014; Johnstone, 2018). DA would enable an exploration of how mental healthcare discourses shape and are shaped by the experiences of Ghanaian and Nigerian youth. This approach could uncover the power dynamics and ideologies embedded in language used by healthcare providers and service users. However, DA may not be entirely compatible with my research aims. While DA focuses on language and its role in constructing social realities, my primary interest lies in understanding the lived experiences and personal meanings of mental healthcare for these young individuals. With its emphasis on personal meaning-making and the phenomenological exploration of experiences, IPA is better suited to capture the depth and complexity of individual experiences (Smith et al., 2009). This is central to my research objectives

In conclusion, while grounded theory, narrative inquiry, ethnography, case study, and discourse analysis methodologies offer valuable insights, they do not align as closely with my research goals as IPA. IPA's commitment to exploring how individuals make sense of their personal and social worlds, combined with its compatibility with intersectionality, CRT, and the social model of mental health, makes it the most appropriate methodology for investigating the nuanced experiences of Ghanaian and Nigerian young people's mental healthcare in Inner London.

3.3. Interpretative Phenomenological Analysis

As a qualitative research methodology, phenomenological philosophy profoundly influences Interpretative Phenomenological Analysis (IPA). In IPA, the emphasis is placed on exploring individual subjective experiences through psychological perspectives (Smith et al., 2009). Stemming from Husserl's phenomenological philosophy, IPA delves into the study of

consciousness and experiences, examining these phenomena from a first-person perspective (Smith et al., 2022).

Phenomenology can be understood both as a discipline focused on the structures of consciousness and as a historical movement led by philosophers such as Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty, and Jean-Paul Sartre (D. W. Smith, 2018). Husserl's approach to phenomenology emphasised transcendental consciousness, extending beyond human consciousness to abstract knowledge that surpasses everyday experiences (Larkin et al., 2006). This idea aligns with transcendental idealism, suggesting that all objects or experiences are mere representations of things in themselves beyond common assumptions (Allison & Allison, 2004). Husserl's methodology involved bracketing everyday assumptions related to context, religion, history, tradition, and culture to uncover the essence of phenomena as they present themselves to consciousness (Husserl, 1970).

However, Heidegger, a mentee of Husserl, along with Merleau-Ponty and Sartre, argued that Husserl's reductionist approach was insufficient. Heidegger contextualised phenomenology within human experience, while Merleau-Ponty emphasised that human perception is structured across space and time and can be communicated through appropriate expression (Merleau-Ponty, 2012). Sartre integrated existential philosophy, focusing on human freedom, responsibility, and action within bio-historical and social contexts, emphasising the significance of viewing individuals as social beings and producers of history (Mahaira-Odoni, 1975).

IPA was developed to address the limitations of Husserl's approach by incorporating the "structure of the lifeworld" as described by Alfred Schutz, which refers to the every day, intersubjective, and culturally informed framework guiding individual experiences and social interactions (Schütz, 1974). This concept highlights the person-in-environment construction of reality, which is crucial for comprehensively understanding subjective lived experiences and their meaningfulness. As succinctly put, "IPA is clear about the contribution that subjective knowledge of this sort can make to psychological understanding" (J. A. Smith et al., 1999, p. 219).

Smith and Osborn (2008) highlighted IPA's capacity to explore the psychological and social worlds of research participants, gaining access to their deep thoughts and feelings. Larkin and Thompson (2011) emphasised that while IPA may not elucidate causation, it can provide valuable insights into participants' psychosocial processes and personal experiences at different levels, enhancing our understanding of lived experiences.

I draw on Houston and Mullan-Jensen's (2012) article aligning IPA with social work. They articulate that phenomenology is the descriptive study of service users' experiences, focusing on how individuals perceive and make sense of their everyday realities within the context of social work interventions. Hermeneutics is the method of interpreting human actions and narratives, emphasizing the uncovering of intentions and meanings within social contexts, which is crucial for understanding clients' perspectives. Additionally, idiography focuses on unique client experiences rather than general trends, highlighting the importance of personal narratives for a nuanced understanding of social phenomena and practice.

These three key theoretical pillars underpin IPA: phenomenology, hermeneutics, and idiography. They provide a robust framework for examining individuals' nuanced and subjective experiences within their specific sociocultural contexts. I briefly discuss these theoretical foundations and their relevance to my research below.

3.3.1. Phenomenology

As a foundational pillar of IPA, as discussed above, phenomenology focuses on exploring lived experiences from the perspective of those who experience them (Husserl, 1970). Rooted in the philosophical traditions of Edmund Husserl and Martin Heidegger, phenomenology seeks to uncover the essence of phenomena as they appear in consciousness (Smith et al., 2009). In my research, phenomenology allows me to go deeply into the subjective experiences of Ghanaian and Nigerian young people, capturing their unique perspectives on anxiety and depression within the socio-cultural ambience of Inner London.

Husserl's concept of "intentionality" is central to phenomenology, emphasising the inseparability of consciousness and the world it perceives (Husserl, 1970). This concept is

crucial in understanding how young people perceive and interpret their mental health experiences in relation to their cultural backgrounds and societal influences. By focusing on participants' lived experiences and meanings, phenomenology aligns with the critical race theory's emphasis on the importance of marginalised voices in understanding systemic inequities (Crenshaw, 1989; Delgado, 2023). Drawing on Houston and Mullan-Jensen's (2012) article aligning IPA with social work. They articulate that phenomenology is the descriptive study of service users' experiences, focusing on how individuals perceive and make sense of their everyday realities within the context of social work interventions.

3.3.2. Hermeneutics

Hermeneutics, the theory and methodology of interpretation, forms the second pillar of IPA. It involves the interpretative process through which researchers make sense of participants' experiences. Schleiermacher, Heidegger, and Gadamer are key figures in hermeneutic philosophy, each contributing to the understanding of interpretation as a dialogical and dynamic process (Schleiermacher, 1998). In this research, hermeneutics enables a nuanced interpretation of the narratives of Ghanaian and Nigerian young people. Schleiermacher's notion of the "hermeneutic circle" highlights the iterative process of understanding parts of a text (or experience) in relation to the whole and vice versa (Schleiermacher, 1998). This iterative process is vital for uncovering the layers of meaning in participants' accounts of anxiety and depression, considering the intersectional factors of race, culture, and migration.

Heidegger's concept of "Dasein" or "being-in-the-world" further enriches the hermeneutic analysis by highlighting the contextual nature of human existence (Heidegger, 2010). For my study, this means interpreting participants' mental health experiences within the broader context of their identities as young Black individuals navigating life in Inner London. This approach aligns with the social model of mental health, which emphasises the impact of social, economic, and environmental factors on mental well-being (Pilgrim, 2017).

3.3.3. Idiography

The third pillar, idiography, emphasises the detailed and in-depth analysis of individual cases. Unlike approaches that seek generalizable findings, idiography in IPA focuses on the

particularities of each participant's experience (Smith et al., 2009). This commitment to understanding individual experiences aligns with the core tenets of intersectionality, which recognises the unique and intersecting identities that shape one's experience of oppression and privilege (Crenshaw, 1991).

My study's idiographic approach allows for a comprehensive exploration of each participant's narrative, acknowledging the diversity within the Ghanaian and Nigerian communities in Inner London at individual and group levels. By paying close attention to individual stories, I can capture the perceived richness and complexity of their lived experiences with anxiety and depression, providing insights that more generalised approaches might overlook.

In summary, the theoretical pillars of phenomenology, hermeneutics, and idiography collectively provide a robust framework for this research on the participants' lived experiences. Phenomenology allows me to focus on the essence of their experiences, hermeneutics facilitates a deep interpretative process, and idiography ensures a detailed and individualised understanding of each participant's narrative. Together, these pillars enable a comprehensive and nuanced exploration of the intersectional factors that may be influencing mental health within these communities.

3.3.4. Potential limitations of IPA

IPA presents several potential limitations that merit critical examination. First, the inherently small sample size associated with IPA often raises concerns when compared to other qualitative methodologies (Farr & Nizza, 2019; Giorgi, 2010). However, this limitation is a deliberate design choice, as IPA aims to capture the idiosyncratic, intimate, and subjective experiences of a homogenous sample, allowing for verbatim accounts followed by intensive and detailed analysis (Larkin et al., 2006; J. A. Smith et al., 2022; J. A. Smith & Osborn, 2008). This methodological choice is feasible and effective within a small sample size (Smith et al., 2022). Indeed, there is a growing acceptance within qualitative research that conducting in-depth interviews and analyses with fewer participants can provide richer insights than a more superficial analysis of a larger sample (Noon, 2018).

Second, the absence of a strictly defined method for data analysis in IPA poses a challenge (J. A. Smith et al., 2022). Larkin et al. (2006, p. 116) note that “the wide range of available interpretative frames” can be practically problematic. To address this, I adhered to the structured, step-by-step guidance Smith et al., (2022) provided that ensures a traceable systematic approach to data interpretation.

Third, while qualitative methods, including IPA, primarily focus on capturing participants' experiences and accessing their social worlds, this focus can introduce interpretative biases (Creswell, 2009; Yilmaz, 2013). IPA researchers acknowledge that the researcher's perspective can significantly influence the interpretation of respondents' experiences. Cromby & Nightingale (1999) argue that the aspects of the participant's world that the researcher seeks to emphasise are often shaped by the researcher’s “moral, political, or pragmatic precepts” (p. 8) rather than purely epistemological choices. Larkin et al. (2006, p. 108) succinctly state that "we can never fully escape the ‘preconceptions’ that our world brings with it"; thus, maintaining transparency is crucial. In line with recommendations from Larkin and Thompson (2012) and Smith, Larkin, and Flowers (2022), I ensure the analytical process is meticulously detailed, organised, plausible, and transparent, as illustrated in the Analysis Section below, Chapter 4.

3.3.5. Compatibility of IPA, Social Work and Mental Health

The decision to utilise IPA is also partly influenced by its compatibility with the principles and objectives of social work, as highlighted by Vicary & Ferguson's (2024) book titled, ‘*Social Work Using Interpretative Phenomenological Analysis: A Methodological Approach for Practice and Research,’* and the complexities of mental health (Larkin & Thompson, 2012).

IPA is a qualitative research approach that explores how individuals make sense of their personal and social worlds. It is particularly concerned with the detailed examination of lived experiences, focusing on how individuals perceive and articulate their experiences (Smith etal., 2009). This methodological approach is not merely about capturing subjective experiences but also involves interpreting these experiences in the social context of the individuals' personal and sociocultural backgrounds. This approach is particularly aligned with the tenets of social work.

Social work as a profession is fundamentally oriented towards understanding and addressing the needs of individuals within their social contexts. The International Federation of Social Workers (IFSW) defines social work as

> *a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing. The above definition may be amplified at national and/or regional levels (IFSW, 2014).*

The National Association of Social Workers (NASW) Code of Ethics emphasises the importance of considering the environmental, societal, and structural factors that influence individuals' lives (NASW, 2024). Social workers are committed to principles of social justice, human rights, and the dignity and worth of every person. These principles align closely with the aims of IPA, which seeks to give voice to participants' experiences and understand these experiences in depth, in this case, mental healthcare experience.

Mental healthcare, particularly for indistinct conditions such as anxiety and depression within my research population, requires a nuanced understanding of individual experiences. The social model of mental health posits a significant aspect of these nuanced dynamics, and it posits that mental health issues are not merely the result of individual pathology but are deeply influenced by social, economic, and cultural factors (Armstrong et al., 2005; Pilgrim, 2017). This perspective aligns with IPA's commitment to exploring the context-specific meanings that individuals attach to their experiences.

In summary, the compatibility of IPAs with social work and mental health research is profound. IPA's emphasis on the detailed examination of lived experiences aligns seamlessly with social work's commitment to understanding individuals within their social contexts and developing person-centred interventions. Additionally, IPA's ability to uncover the nuanced, context-specific meanings of mental health experiences makes it an invaluable tool for

researching anxiety and depression among Ghanaian and Nigerian young people in Inner London. By integrating IPA with the theoretical frameworks of intersectionality, critical race theory, and the social model of mental health, this research aims to provide a comprehensive understanding of the participants' experiences, ultimately contributing to more effective and culturally humble mental healthcare.

3.3.6. Meaning-making, Social Work Positioning and IPA

Although this is not purely social work research, my social work background might influence how I make sense of what my participants are making sense of (Larkin & Thompson, 2012; Smith et al., 2009). In psychology, meaning-making helps individuals integrate challenging experiences with existing beliefs, fostering coherence, purpose, and psychological well-being during adversity (Batthyany & Russo-Netzer, 2014; Park, 2010). I am particularly drawn to Bruner's (1990) conceptualisation of meaning-making as a dynamic and subjective process influenced by cultural, social, and personal factors within which,

> *We shall be able to interpret meanings and meaning-making in a principled manner only in the degree to which we are able to specify the structure and coherence of the larger contexts in which specific meanings are created (Bruner, 1990, p. 64))*

Hence, it is essential for how people navigate and make sense of their lives and the world around them, shaping their narratives and worldviews. In light of these, in this thesis, I defined meaning-making as the process by which individuals interpret and make sense of their experiences, relationships, and the broader world around them.

In the context of social work, particularly when working with culturally diverse populations, meaning-making becomes a critical tool. I believe it plays a vital role in helping individuals and communities understand their circumstances and experiences, which in turn fosters resilience, empowerment, and well-being. For instance, in the experiences of young Ghanaian and Nigerian people in inner London, meaning-making is evident as they navigate the complex realities of receiving care for anxiety and depression within a system that often feels culturally irrelevant to them (Francis et al., 2002; SHSCSC, 2021). In light of the

discourses, from my context, constructing participant meaning using IPA will involve three levels:

First, ***Emphasis on Lived Experience:*** IPA will help me make sense of how my participants understand, interpret and assign meaning to their experiences. Second, ***Contextual Understanding:*** it help me consider the context in which individuals live and how this context influences their meaning-making processes. Third, ***Empowerment through Reflection***: By engaging in IPA, I can facilitate a reflective process where participants are encouraged to explore and articulate their own meanings. I believe this process can be empowering for participants as it acknowledges their agency and supports their self-determination, which is also fundamental to social work. (Houston & Mullan-Jensen, 2012; J. A. Smith & Osborn, 2008). These are underpinned by the concept that:

> *IPA is concerned with examining how a participant makes sense of, or sees meaning in, their experience. We have suggested that sense-making is indeed a core human activity and one that participants share with researchers; hence the double hermeneutic whereby the researcher is trying to make sense of the participant making sense of their experiences (Smith et al., 2022, p. 134)*

3.4. Finding My Samples

Table 3: Eligibility Criteria

Eligibility Criteria	
1.	**Age and Nationality**: ○ Ghanaian and Nigerian young people aged 16-25 years. ○ Parents or carers of Ghanaian and Nigerian young people within the specified age range. ○ Practitioners (both NHS IAPT and community-based) who have experience working with Ghanaian and Nigerian young people with anxiety and depression.
2.	**Residence**: ○ Residing in London.

3.	**Experience with Mental Health**: ○ Young people who have experienced anxiety and depression. ○ Parents or carers who have supported their children through experiences of anxiety and depression. ○ Practitioners who have provided mental health services to Ghanaian and Nigerian young people.
4.	**Willingness to Participate**: ○ Participants must be willing to engage in the study and provide in-depth insights into their experiences

In this section, I detail the methodological approach to sampling, which is consistent with the qualitative paradigm, particularly the IPA orientation. According to Smith et al. (2022, p. 185), IPA emphasises "purposive sampling" rather than probability methods to select participants who can provide in-depth insights into the specific phenomenon under investigation. My initial recruitment criteria focused on Ghanaian and Nigerian young people aged 16–25 who had utilised mental health services for anxiety and depression (commonly referred to as common mental disorders) in inner London.

I initially contacted Improving Access to Psychological Therapies (IAPT), now NHS Talking Therapy, services across 13 inner London boroughs to achieve this. IAPT was chosen due to its frontline, evidence-based approach to managing anxiety and depression in the UK (BABCP, 2021). However, recruitment challenges arose. Out of the four identified Ghanaian and Nigerian individuals within the age range, none agreed to participate; two had discontinued their care programs. It suggests the underutilisation of mental health services among these minoritised demographics (Li et al., 2020; London Assembly, 2015; SHSCSC, 2021).

However, it is essential to state that IAPT does not collect nationality data (or detailed ethnicity data); I argue that this needs to change, consistent with Lavis (2014), Butt et al. (2015), and London Assembly (2015), who highlighted the need for services to pay specific attention to the needs of sub-groups and individuals as paramount. The London Assembly

(2015, p. 5) has been unequivocal that nuanced data on ethnic subgroups "simply does not exist" in their report on *"Improving access to mental health services for London's young and Black, Asian and minority ethnic population".* They emphasised that when the nature and scale of the demand for mental health services are unknown, it inhibits policies and service planners' responses. The Assembly lamented on the frustration of funding and commissioning services with little or no knowledge of the demand for those services.

Despite my efforts to clarify the study's intent through carefully crafted research flyers and detailed information sheets, including verbal in some instances, my population remained unwilling to be involved in the study. I deduced this refusal from misconceptions about the research, misunderstandings regarding data use, and fear of the mental health system. Mclean et al.'s. (2003) work highlights the distrust and disengagement of African-Caribbean communities with mental health services in the UK, partly due to perceived discrimination and a lack of cultural sensitivity. Again, this aligns with the findings of institutional fear and (dis)trust as enunciated by the Commission on Race and Ethnic Disparities report (2021) and in the Rapid Evidence Review of the NHS Race and Health Observatory body (Kapadia et al., 2022, p. 11) revealing that Black peoples' fear and distrust of mental health services form "clear barriers to seeking help." These fears and mistrust of the system may also lead to lower participation in mental health research.

In response to these challenges observed during the pilot phase, I expanded the eligibility criteria to include any Ghanaian or Nigerian individuals aged 16–25 residing in London who had experienced anxiety and depression, regardless of their engagement with mental health services. Yet, it was still challenging to recruit participants. I employed various strategies to improve recruitment, including collaborating with community leaders and organisations, which served as gatekeepers, enhancing trust and credibility (Creswell & Poth, 2018). Social media platforms, WhatsApp, leaflets, community bulletin boards, and local newsletters were also utilised to reach potential participants. Partnering with cultural centres and religious institutions proved effective in engaging individuals who met the criteria.

Due to the absence of funding to offer financial incentives, I emphasised the research's potential community impact, aiming to develop culturally appropriate services for youth.

Highlighting my Nigerian background and my commitment to their well-being in inner London's youth was crucial in building rapport and trust. I also leveraged existing networks and community partnerships, such as religious centres and parental networks, to facilitate introductions to potential participants (Creswell & Poth, 2018; Denzin & Lincoln, 2011; Patton, 2015).

Furthermore, I adopted a snowball sampling approach, where initial participants were encouraged to refer others. This method capitalised on participants' social networks, reaching individuals who might not be accessible. Kadushin (1968, p. 694) refers to the approach as "each respondent is asked to name several others who are then interviewed, and so on". However, this approach was handled with caution due to the sensitive nature of mental health discourses within the community. Despite these efforts, challenges persisted due to the sensitive nature of mental health discussions and lingering fears and misconceptions about the system and research intentions. However, the recruitment avenues employed mitigated some of these difficulties.

The recruitment selection I have described paid attention to the recommendations of Smith et al. (2022). They emphasised selecting a small number of participants because they can provide a specific and unique perspective on the phenomena under study. These participants 'represent' an idiographic perspective, focusing on individual experiences rather than a nomothetic perspective, which aims to generalise findings across a larger population.

Both terms, idiographic and nomothetic, were coined by the German philosopher Wilhelm Windelband to describe different types of evidence-based knowledge (Windelband & Oakes, 1980). Idiographic knowledge focuses on describing and explaining specific phenomena, while nomothetic knowledge aims to identify general principles and patterns that can be universally applied across individuals (Hurlburt & Knapp, 2006; Windelband & Oakes, 1980). This implies that nomothetic psychology relies on large samples to generalise human behaviour. However, this approach was criticised by Kastenbaum, who described it as creating "indeterministic statistical zones that construct people who never were and never could be" (Cited in Datan et al., 1987).

3.5. Appropriate IPA Sample Size for a PhD Thesis

Determining an appropriate sample size is a pivotal methodological consideration, as highlighted by Smith et al. (2022). By the in-depth idiographic interviews and detailed nuance analytical focus of IPA, they recommended 3 cases for undergraduate research but noted that "it is more difficult to give a number for PhD studies which are obviously on a different scale" (p. 46), though about 10 participants were recommended when exploring a single group. However, qualitative research sample size considerations are about the question being asked and the claims you want to make, not really about the level of study. Tracy (2010) emphasises the importance of research goals and claims in guiding methodological decisions, including sample size. The principle is also echoed by Mason (2010) and Patton (2015), who stress that sample size in qualitative research depends on factors like the purpose of the study, the depth of inquiry, and the richness of the data.

I am drawn to Larkin et al. (2019) multiperspective designs in IPA, which involve capturing complex and systemic experiential phenomena by using multiple perspectives to explore the same phenomenon. These designs incorporate diverse participant groups who share direct or indirect connections to the studied phenomenon, such as different family members or related professionals. This approach enables the exploration of relational, intersubjective, and micro social dimensions, enhancing the depth and breadth of the analysis. For these designs, a sample size of three to six groups is recommended to ensure comprehensive coverage of the different perspectives involved (see Section 4,2 for the Groupings).

The recruitment of the research participants was in two phases. Phase 1, participants were recruited for a semi-structured interview to answer the research questions.

- What is the lived experience of young Ghanaian and Nigerian people regarding the care for anxiety and depression in London?
- What are the perspectives of their parents and carers?
- What are the perspectives of practitioners on the available model of care?

Each group has specific questions (see Appendix B: Interview question guide).

Phase 2 is to answer the research question via a workshop (see Chapter 6).

- How can the views and preferences of Ghanaians and Nigerians towards the care for anxiety and depression inform the mental healthcare and practice design?

The workshop served as a participatory research method, creating a platform for co-production and knowledge exchange.

3.4. Data collection

3.4.1. Semi-structured Interviews

Semi-structured interviews were my primary data collection method, as they align well with IPA's emphasis on capturing detailed, first-person accounts of participants' experiences (Smith et al., 2022). Reid et al.'s (2005) work, *"Exploring Lived Experience"* conceptualises semi-structured interviews as balancing structure with flexibility, using predetermined questions while allowing natural topic exploration. This method fosters deep, conversational engagement, which is ideal for capturing rich, qualitative data on participants' lived experiences.

In preparation for the interviews, I crafted an interview guide comprising open-ended questions (see Appendix B) to elicit comprehensive narratives from each participant group. This guide included prompts designed to facilitate a deeper exploration of their experiences, such as, "Can you tell me more about how you felt during your experience with mental health services?" "Can you share your experience with anxiety and depression?" This strategic preparation ensured that the interviews could dynamically adapt to the natural flow of conversation, focusing on areas most pertinent to each participant (Smith et al., 2022). I conducted the interviews in environments chosen by the participants to ensure their comfort, safety, and familiarity. This consideration is paramount when discussing sensitive topics like mental health, as it allows participants to feel secure and open during the interview process. Kvale (1996) discusses the importance of creating a safe and supportive environment for interviewees.

One of the primary challenges encountered was the initial low engagement from participants. In many cases, parents expressed a willingness to speak with me, but their children were hesitant to participate, even when I assured them that the interviews would

be conducted confidentially. I was able to interview two parents and their two daughters. To maintain confidentiality, I ensured they were not linked in the participants' descriptions. Inherently discussing mental health issues within these communities is highly sensitive. I address these obstacles through my social work interview skills of employing flexible and empathetic interviewing. These enable me to gather rich, in-depth data, providing valuable insights into the intersectional and systemic factors influencing mental healthcare experiences within these communities. I also observed that it was a sensitive issue even for practitioners, especially those from IAPT statutory practice.

Each interview was audio-recorded with the participant's consent and subsequently transcribed verbatim. Throughout the data collection process, ethical considerations were rigorously maintained. Participants were fully informed about the study's purpose, the use of their data, and their right to withdraw at any point. Given the sensitivity of the subject matter, measures were implemented to offer support to participants if needed, including referrals to therapeutic services.

3.4.2. Samples for Semi-Structured Interview: Meaning Saturation

The samples involved three groups of 28 participants: Ghanaian and Nigerian young people aged 16 – 25, parents/carers and practitioners. This allowed triangulation for the exploration of one phenomenon from multiple perspectives to develop a more detailed and multi-faceted account of the phenomenon. A deep engagement with each participant's narrative while also capturing a diversity of perspectives relevant to the study's focus on intersectionality, critical race theory, and the social model of mental health is fundamental (Armstrong et al., 2005; Crenshaw, 1989; Delgado, 2023).

As I previously mentioned, when I could not identify any individuals within the research age range of 16-25 who had utilised professional care for anxiety and depression, I expanded the inclusion and exclusion criteria. This adjustment led to interviewing the 28 participants. This meant that while I obtained useful broader data that were used to contextualise my understanding and will be reported in other analyses, I have focused this thesis on cases

most substantively relevant to its research questions (see Chapter 5). One might wonder how I selected the data that were analysed. Data saturation is commonly specificied in studies, but while it played a role, it was not my sole determinant.

Glaser and Strauss (1967) conceptualised theoretical saturation to fulfil grounded theory's commitment to the ongoing comparison of data, ensuring continuous (re)examination in light of emerging inquiry or arguments until no new theoretical properties or interactions emerge. Since then, the concept of saturation has evolved to include other forms, such as theme saturation (Guest et al., 2006), data saturation (Fusch & Ness, 2015), and code and meaning saturation (Hennink et al., 2017). I used meaning saturation—the point at which the participants' lived experiences of anxiety and depression, and their care, were understood 'enough' (Guest et al., 2006) that no further "dimensions, nuances, or insights" were being identified in later data collection (Hennink et al., 2017, p. 6).

However, the concept of meaning saturation may be problematic as it is inconsistent with the principles of IPA. IPA allows for subjective sense-making through participants' own words and accounts, enabling the phenomenon to reveal itself in its most authentic form (Larkin et al., 2006; J. A. Smith et al., 1999). Thus, every interviewee has the potential to introduce new meanings as each participant experiences phenomena from a unique perspective (Larkin et al., 2019). This uniqueness of individual experience aligns with the critique of meaning saturation by Braun and Clarke (2021) in the context of reflexive Thematic Analysis (TA). They argued that meaning saturation, as defined, is more aligned with a "neo-positivist, discovery-oriented" approach (p. 203) rather than with the reflexive approach advocated by TA. Reflexive TA, much like IPA, engages with uncertainty, where meaning is generated through interpretation.

3.4.3. The Samples

I drew upon Patton's (2015) perspective of information-rich cases for the data I analysed, following consideration of meaning saturation (section 3.4.2). The data analysed were from 20 participants across the three groups: **Group 1**: Ghanaians n = 4 (male n = 1, female n = 3) and Nigerians n = 7 (male n = 1, female n = 6), see Table 4. **Group 2:** Ghanaian parents (n =

0), Nigerian parents n = 4 (father n = 1, mother n = 3), see Table 5. **Group 3:** NHS IAPT practitioners (n = 3) and community-based practitioners (n = 2), see Table 6.

I analysed 20 out of 28 participants in-depth for this thesis because their narratives aligned closely with the three main GETs central to my research goals. However, I drew upon the remaining 8 participants for a broader contextual understanding of the phenomenon. These participants exhibited reluctance to answer open-ended questions directly and often veiled their responses, sometimes attributing them to observations of others rather than personal experiences. This hesitation, despite reassurances about data anonymisation, stemmed partly from fears of reprisals or mistrust in the confidentiality of the research process.

Although their input did not contribute substantially to the primary GETs explored in the thesis, these participants provided valuable general insights and highlighted barriers to openness about mental health experiences in their communities. Their perspectives offer a rich area for future analysis and potential integration into alternative discussions outside the scope of this thesis. This highlights the ethical and methodological challenges of engaging with sensitive topics in culturally specific contexts (Burgess, 2023).

3.4.4. Participants Characteristics

Table 4: Ghanaian and Nigerian Youth Characteristics

No	Pseudonym	Nationality	Gender	Age (16-25)	Birth Place	Migrated to the UK (Years)	Currently Residing in London (Y/N)
1	Adjua	Ghanaian	F	23	UK	N/A	Y
2	Agnes	Nigerian	F	16	UK	N/A	Y
3	Akua	Ghanaian	F	25	Ghana	<10	Y
4	Chichi	Nigerian	F	21	Nigeria	>10	Y
5	Daba	Nigerian	M	21	UK	N/A	Y
6	Edith	Nigerian	F	25	UK	N/A	Y
7	Efia	Ghanaian	F	17	Ghana	>10	Y

8	Ese	Nigerian	F	23	Nigeria	>10	Y
9	Kofi	Ghanaian	M	25	Ghana	>10	Y
10	Nkiru	Nigerian	F	25	UK	N/A	Y
11	Osas	Nigerian	F	25	UK	N/A	Y

Table 5: Parents/Carers Characteristics

No	Pseudonym	Nationality	Gender	Birth Place	Migrated to the UK (Years)	Currently Residing in London (Y/N)
1	Chike	Nigerian	M	Nigeria	>10	Y
2	Kemi	Nigerian	F	Nigeria	>10	Y
3	Kudi	Nigerian	F	Nigeria	>10	Y
4	Osazie	Nigerian	F	Nigeria	>10	Y

Table 6: Practitioners Characteristics

No	Pseudonym	Ethnicity	Gender	NHS IAPT Practitioner (Y/N) Statutory	Statutory Practitioner (Y/N)	Community-based Practitioner (Y/N) Non-Statutory
1	Bindun	Asian	F	Y	N	Y
2	Mikey	Black	M	N	Y	Y
3	Robert	White	M	Y	N	N
4	Shelly	Black	F	Y	N	Y
5	Uwase	Black	F	Y	N	Y

3.4.5. Transcription

The transcription process I employ adheres closely to the recommendations provided by Smith et al. (2022). The process begins with obtaining a verbatim record of each in-depth interview. This is crucial as IPA aims to interpret the meaning of the content shared by participants. Each interview is audio-recorded with the consent of the participants, ensuring an accurate and comprehensive capture of their narratives (Smith et al., 2009).

According to Smith et al. (2022), IPA does not necessitate the transcription of non-verbal communication in the detailed manner required by conversation analysis. Conversation analysis can be described as the study of talk-in-interaction, focusing on the structure, patterns, and organisation of conversations in social contexts (Heritage, 1984). Therefore, my transcription focuses primarily on capturing the semantic content of the interviews. This means documenting all spoken words conventionally, unless non-standard language is used, and making brief notes of non-verbal utterances when they significantly alter the meaning or delivery of the spoken content. This approach aligns with the recommendations by O'Connell and Kowal (1995), emphasising the importance of transcribing only information that will be analysed.

3.5. Ethical Consideration

Before finding samples, the study received ethics approval from three Research Ethics Committees (REC). (1) The Institute of Education (IOE) Z6364106/2022/02/28 health research. (2) The University College London (UCL) Z6364106/2022/10/24 social research. (3) The National Health Service (NHS), under IRAS (Integrated Research Application System) Project ID 316665 and REC reference 23/PR/0037 Health Research Authority (HRA) and Health and Care Research Wales (HCRW). See Appendix C: Ethics Approval Letters

3.5.1. Informed Consent

Obtaining informed consent was pivotal, ensuring ethical integrity and participant protection throughout the study. In operationalising the informed consent process, I gave participants comprehensive information about the study's aims, objectives, and procedures in an accessible format. This included detailed explanations of the data collection methods, the

research's purpose, and the findings' potential impact. Participants were also informed about how their data would be stored, used, and disseminated, ensuring transparency and building trust (Belmont Report, 1979). The importance of obtaining informed consent cannot be overstated, especially in research involving sensitive topics such as mental health (Wiles, 2012). I view informed consent as a fundamental ethical requirement that safeguards the autonomy and dignity of participants. It ensures that individuals are voluntarily participating with a full understanding of what the research entails and any potential risks involved (Wiles, 2012).

In this study, the demographic in question—young people of Ghanaian and Nigerian descent—may have cultural and historical contexts that influence their perceptions of mental health and research participation. Providing detailed and culturally sensitive information helps to mitigate any potential misunderstandings or anxieties about the research process. This is crucial for fostering a sense of security and openness, allowing participants to share their experiences candidly (Linney et al., 2020).

Furthermore, the consent process included verbal assurances of confidentiality and the steps taken to anonymise the data. Participants were informed that their personal information would be securely stored and that any identifying details would be removed from the research outputs. This reassured participants of their privacy and encouraged more open and honest participation (Kamau, 2013).

In summary, obtaining informed consent in my research was a carefully structured process that prioritised participants' ethical treatment and autonomy. I ensured participants were well-informed and comfortable with their involvement by providing comprehensive, understandable, and culturally sensitive information. This approach may uphold the ethical standards required for such sensitive research and potentially enhance the data's quality and reliability.

3.5.2. Data Handling and Confidentiality

Following the semi-structured interviews, I transcribed the recordings verbatim into Microsoft Office Word. This meticulous transcription process included capturing the spoken

words and notable non-verbal cues such as pauses and hesitations. To protect the participants' privacy, all identifiable data were anonymised. Pseudonyms were used, and any specific details that could potentially reveal the identity of the participants were carefully removed or altered. This process ensured that the data could be analyzed without compromising confidentiality in line with the Data Protection Act (DPA) 2018 and the General Data Protection Regulation (GDPR) 2018.

The transcribed data were stored securely on UCL's Central Filestore (desktop@ucl), which provides a secure environment with automatic nightly backups. This system ensures that the data is protected against loss and unauthorised access. Additionally, I performed weekly manual backups on an encrypted hard drive, adding an extra layer of security. For version control, I used Git and GitHub, which allowed me to document all changes to the transcripts systematically. This approach enabled me to track modifications, revert to previous versions if necessary, and maintain a comprehensive log of the data handling process (see full detail in Appendix D: Data Management Plan).

3.6. Assessing Validity and Quality

I emphasise depth, contextual sensitivity, and reflexivity to ensure validity and quality in this IPA study. While I acknowledged frameworks like Lincoln and Guba's trustworthiness, Elliott et al.'s guidelines, and Yardley's principles, proponents of IPA critique the elements of generalisability and objectivity in them. Their argument is that these may reduce the depth and width of idiographic insights and interpretative richness of IPA (Larkin & Thompson, 2011; Nizza et al., 2021).

For example, Lincoln and Guba's (1985) criteria for 'trustworthiness' and 'rigour' parallel the conventional criteria used in quantitative research. They introduced four aspects of trustworthiness: Credibility (parallel to internal validity), Transferability (parallel to external validity), Dependability (parallel to reliability), and Confirmability (parallel to objectivity). The seven key guidelines framework developed by Elliott et al. (1999) comprises Owning one's perspective, Situating the sample, Grounding in examples, Providing credibility checks, Coherence, Accomplishing general versus specific research tasks, and Resonating with

readers. Yardley (2000) identified four broad principles, which are Sensitivity to context, Commitment and rigour, Transparency and coherence, Impact and importance.

In 2018, Levitt et al. developed the Journal Article Reporting Standards for Qualitative Research in Psychology (JARS-Qual). They provide clear guidance for writing and reviewing qualitative research, detailing the structure and content required for reports, abstracts, introductions, methodology, data collection, analysis, and discussion sections (Levitt et al., 2018). These standards support the writing of all qualitative work, with most of its criteria related to IPA.

For IPA, using specified criteria is not encouraged. Instead of prescribing specific criteria, Smith et al. (2022, p. 150) refer to "the markers of relative quality within IPA studies". Therefore, in assessing the quality of this study, I align with the core elements an IPA paper must have:

> *an orientation to phenomenology and a clear focus on the experiential; it must be interpretative and use the analyst's insights to move beyond the superficial and merely descriptive to offer new insights into the phenomena. Finally, there should also be a clear sense of the individual case (i.e. be idiographic) and the particular rather than focusing on more nomothetic work (i.e. addressing claims for whole populations) (J. A. Smith et al., 2022, p. 151).*

In other words, I will consider these as they apply to my study in Chapters 4 and 5. Furthermore, IPA encourages and prides itself in flexibility, creativity, and innovation. As Smith et al. (2022) also note,

Doing high-quality valid IPA research is thus not a matter of following a rule book. Therefore, criteria for validity, or indeed quality, always need to be flexibly applied; something that works for one study will be less suitable for another (p. 154). Therefore, to ensure the validity and quality of my research, drawing on Smith et al. (2022) and other relevant sources as highlighted above, I outlined my strategies to maintain high standards throughout the research process in two concepts characterised by depth, contextual sensitivity, and reflexivity: (1) Establishing Validity and ()2 Enhancing Quality, discussed in Sections 3.6.1 and

3.6.2, respectively. In addition, Sections 3.6.3 Patient and Public Involvement and 3.6.4 Bracketing were also part of my quality strategy.

3.6.1. Establishing Validity

Establishing Validity involves Sensitivity to Context, Commitment and rigour, Transparency and Coherence, Impact and Importance.

2. **Sensitivity to Context:** In accordance with Yardley's (2000) principle of sensitivity to context, I ensured that my research design, data collection, and analysis were deeply embedded in the socio-cultural contexts of my participants. This involved acknowledging and respecting the unique cultural backgrounds, historical experiences, and societal challenges Ghanaian and Nigerian youth in Inner London faced. I immersed myself in relevant literature and engaged with the communities to build a comprehensive understanding of their lived experiences. This approach aligns with critical race theory, which emphasises the importance of contextualising research within the specific realities of marginalised groups (Armstrong et al., 2005; Crenshaw, 1989; Delgado, 2023).
3. **Commitment and Rigour:** I employed systematic and thorough data collection and analysis procedures to ensure rigour in my research (Lincoln & Guba, 1985). I conducted in-depth, semi-structured interviews, allowing participants to express their experiences in their own words, thus capturing the richness of their narratives. Rigour was also demonstrated through meticulous transcription and multiple readings of the data. This approach ensures a deep and nuanced understanding. I used an iterative coding and theme development process conceptualised in IPA as Exploratory Noting and Personal Experiential Theme (PTE), respectively. I continually refine my analysis to accurately reflect the participants' experiences, as recommended by Smith et al. (2022).
4. **Transparency and Coherence:** ***Transparency*** in my research was achieved by providing a clear and detailed account of my methodological decisions and analytical processes. I maintained an audit trail, documenting every step from data collection to analysis, which is available for peer review. ***Coherence*** was ensured by presenting

a logically structured and well-argued narrative that linked my findings to existing literature and theoretical frameworks. This approach resonated with the guidelines established by Levitt et al. (2018) for reporting qualitative research.

5. **Impact and Importance:** To maximise the impact and importance of my research, I focused on producing findings that were not only academically rigorous but also practically relevant and accessible to practitioners, policymakers, and the communities involved. By highlighting the unique challenges and strengths of young Ghanaian and Nigerian people in navigating mental healthcare with accessible language, my research aimed to inform culturally sensitive interventions and policies. This aligns with the social model of mental health and social work paradigm, which advocates addressing the socio-environmental factors affecting well-being (Vicary & Ferguson, 2024).

3.6.2. Enhancing Quality

Enhancing Quality: This involves high-quality data collection, analytical depth and flexibility, independent audit and peer review, and iterative writing and feedback.

1. **High-Quality Data Collection** is the cornerstone of perceived robust qualitative research (Lincoln & Guba, 1985). I ensured this by employing effective interviewing techniques, fostering a safe and open environment for participants, and being attentive to non-verbal cues and contextual nuances during interviews. Smith et al. (2022) emphasise the importance of high-quality data, which I achieved through rigorous training in qualitative interviewing and ongoing reflexivity to mitigate any researcher biases.
2. **Analytic Depth and Reflexivity:** This was underpinned by Elliott et al. (1999), Larkin & Thompson (2011), Nizza et al. (2021) and Smith et al. (2022) of moving beyond mere description to provide interpretative insights that revealed the underlying meanings and implications of participants' experiences to achieve analytic depth. This involved engaging deeply with the data, identifying patterns, and drawing connections between individual narratives and broader social contexts. Reflexivity was a

continuous process where I critically examined my positionality, assumptions, and potential biases, ensuring they did not unduly influence the research outcomes.

3. **Independent Audit and Peer Review:** To further enhance the credibility of my findings, I conducted an independent audit as described by Smith et al. (2022). This involved having the supervisors review my data and analytic process to verify the coherence and plausibility of my interpretations. Additionally, I sought feedback from peers and supervisors at various stages of the research, incorporating their insights to refine and strengthen my analysis.
4. **Iterative Writing and Feedback:** Good IPA writing, as noted by Smith et al. (2022), often requires multiple drafts and revisions. I allocated sufficient time for iterative writing, continually refining my narrative to ensure clarity, coherence, and analytic depth. I also engaged with expert-by-experience advisory groups, comprising individuals with similar backgrounds to my participants, to validate my interpretations and ensure that my findings resonated with their lived experiences.

In conclusion, by adhering to these rigorous standards and frameworks, I ensured that my research on Ghanaian and Nigerian young people's lived experiences of care for anxiety and depression in Inner London would meet validity and of high-quality stretch hold. The integration of intersectionality, critical race theory, and the social model of mental health provided a comprehensive and nuanced understanding of the complex factors influencing mental healthcare experiences among these communities. Additional steps that ensure quality and validity are discussed in the two Sections below - Patient and Public Involvement and Bracketing.

3.6.3. Patient and Public Involvement

The Patient and Public Involvement (PPI) project, supported by the National Institute for Health and Care Research (NIHR) and the University College London Hospitals (UCLH) Biomedical Research Centre (BRC), aimed to engage Black Africans, specifically Ghanaian and Nigerian young people and their parents (see Appendix E: PPI Award Letter). PPI ensures research aligns with community needs, increases trust, and enhances cultural competence. It improves relevance, fosters patient-centred outcomes, and empowers communities to

engage in their health, particularly in diverse contexts like mental health in inner London (Jackson et al., 2020; Veldmeijer et al., 2023; Yu et al., 2021). The establishment of PPI in the UK can be traced back to the creation of INVOLVE in 1996, funded by the NIHR to support and promote public involvement in research (Department of Health, 2007; Palm et al., 2024)

My primary goal was to involve these communities in the research to enhance its relevance, quality, and trustworthiness (Levitt et al., 2018; Lincoln & Guba, 1985). The initiative, titled "Let's Talk Common Mental Disorders – Anxiety and Depression", also sought to increase awareness of mental health issues and address the unique cultural perspectives and needs of these communities in inner London. Additionally, the project aimed to reduce stigma, combat harmful superstitions, and foster a more open understanding of CMD through direct community engagement.

PPI Activities and Feedback: Due to protracted and unwarranted complexities in the funding release process, only two scaled-down PPI events were conducted, as the anticipated funding was never received. Jackson et al. (2020) discuss various aspects of PPI in research, including barriers such as late funding, which can hinder meaningful involvement from the early stages of research. For each event, I solicited to give a 15-minute talk titled "Let's Talk Common Mental Disorders," followed by questions and answers. One event took place in a church organised by youths, involving about 40 attendees. The other occurred during a birthday gathering in a Nigerian family home of about 20 guests, including eight young people within the research age range and their parents.

Feedback from these events instigated a few changes. (1) the PPI event revealed that the term "common mental disorder" was perceived as offensive and stigmatising. Consequently, the terminology was revised to " anxiety and depression" (See Figure 1) to better resonate with the community. This change aimed to foster a more inclusive and less stigmatising dialogue around mental health, as participants expressed that the original term carried a strong negative connotation. Saying the “mental disorder” in "common mental disorder" is stigmatising. Adjusting the language helped create a safer space for open discussions and encouraged more engagement with the study. (2) More than half of the attendees did not view anxiety and depression as disorders requiring treatment. This kind of attitude and

stance regarding anxiety and depression might also explain the underutilisation of IAPT (discussed in Section 2.4). This finding prompted me to integrate a stronger educational component into the study to challenge misconceptions and superstitions in the interview prompts. I also incorporated discussions about the symptoms and impacts of anxiety and depression in culturally relatable terms, aiming to bridge the gap between clinical understanding and community beliefs (Lincoln & Guba, 1985). This also involved collaborating with faith leaders and community influencers to address these issues further, reflected in the impact workshop (see Chapter 6). (3) I also recognised, more significantly, the need for more intentional family involvement in the research. The PPI feedback revealed that parents' attitudes towards mental health significantly influenced how young people understood and addressed their mental well-being. In response, I revised the study to actively engage parents in the conversations around anxiety and depression, ensuring that any interventions or recommendations aligned with family values and dynamics. This change aligned with the literature on the importance of family in culturally informed mental healthcare(Lavis, 2014; Seale, 2018).

Figure 1: 'Common Mental Disorder' changed to 'Depression and Anxiety'

A systematic review by Veldmeijer et al. (2023) highlights the importance of involving service users and people with lived experience in mental healthcare innovation. Their involvement through design approaches enhances engagement, collaboration, and the tailoring of interventions, ensuring the research addresses real user needs. PPI also democratises the research process by shifting traditional power dynamics, giving participants a stronger voice and sense of agency (Pearce, 2021). For example, changing the terminology I discussed above, and my experience with my PPI events play a subtle role in my interpretation of the data . By integrating service users/communities, not just subjects, PPI fosters a collaborative environment where their insights directly influence research outcomes, thus enhancing the findings' quality and applicability (Allen et al., 2020).

On reflection, while I acknowledge the benefits of PPI in research are manifold, challenges such as tokenism and the additional resources required for meaningful engagement need to be addressed. Tokenism can occur when PPI is implemented superficially rather than substantively, limiting the impact of participants' contributions. Additionally, meaningful PPI requires significant time, effort, and resources to support genuine involvement. To overcome

these challenges, a thoughtful and strategic approach is necessary, ensuring that PPI is inclusive and impactful (Jackson et al., 2020; Supple et al., 2015). The study by Yu et al. (2021) on PPI training at UCLH BRC also points to the importance of continuous support and comprehensive evaluations to maintain the effectiveness of PPI initiatives.

In conclusion, the PPI project to engage Ghanaian and Nigerian young people and their parents in mental health research elucidates the importance of culturally sensitive approaches and the need for genuine community involvement. Despite the challenges encountered, including funding delays and not being received, the project demonstrated the potential for PPI to improve the relevance and quality of healthcare research. The integration of community feedback, tailored training, and continuous support are critical for the success and sustainability of such initiatives.

3.6.4. Pre-reflexive Reflexivity and Bracketing

Engaging with participants' lived experiences in IPA necessitates acknowledging the interplay of my personal, cultural, and professional influences on the research process. Practising "pre-reflective reflexivity" (Smith et al., 2022, p. 135) allowed me to critically examine potential biases and preconceptions. My background as a social worker and lecturer within mental health services heightened my awareness of systemic barriers faced by minority communities. However, I remained vigilant to avoid overemphasising particular themes rooted in my experiences (Berger, 2015). Reflexive consideration of my positionality was essential to ensure interpretations were grounded in participants' narratives rather than influenced by my professional lens (P. Drake, 2010; Finlay, 2002).

My cultural identity as a member of the African diaspora added complexity to this process. While shared cultural ties fostered empathy, I was cautious not to project my experiences onto participants or assume shared understandings where differences might exist (Berger, 2015). Balancing empathy with analytical distance was critical to maintaining the integrity of the study (Giorgi, 2009).

The broader social and political contexts of the research further informed my reflexivity. The experiences of Ghanaian and Nigerian youth navigating mental healthcare in Inner London

are shaped by systemic racism, socioeconomic factors, and cultural stigmas. Guided by Critical Race Theory (CRT), I remained attentive to these influences while ensuring participants' voices were not overshadowed by theoretical commitments (Delgado, 2023; Larkin et al., 2006). My goal was to authentically capture their lived experiences without imposing pre-existing frameworks.

Bracketing complemented reflexivity as an essential methodological tool. As an insider—a Black man sharing similar cultural contexts—it was crucial to set aside preconceptions to authenticate with participants' narratives. Bracketing, rooted in Husserl's concept of epoché, required acknowledging and suspending biases to understand the phenomenon as purely as possible (Stanford Encyclopedia of Philosophy, 2022; Tufford & Newman, 2012). I delineated personal and professional influences through bracketing interviews, reflexive journaling, and supervision, ensuring they did not contaminate data collection and analysis.

Theoretical frameworks like intersectionality (Crenshaw, 1989) and CRT shaped my understanding of participants' experiences but demanded a nuanced approach to avoid reductive assumptions. The social model of mental health (Pilgrim, 2019) further highlighted the importance of sociocultural contexts in understanding mental health issues. Bracketing ensured that participants' voices remained central, allowing for a richer, more authentic representation of their lived realities (Fernando, 2010).

Bracketing also upheld the ethical rigour of the study. By consciously setting aside assumptions, I amplified participants' agency, addressing the historical marginalisation of Black communities in mental health research (Metzl, 2010). While achieving complete separation from "pre-understanding" may be unattainable of Husserl's pure consciousness (Chung & Ashworth, 2006, p. 5), sustained reflexivity enabled meaningful engagement with participants' experiences (Larkin & Thompson, 2012).

In conclusion, reflexivity and bracketing were indispensable in ensuring this research's quality, credibility, and ethical integrity. These practices allowed me to produce findings that are perceived to authentically represent the mental health experiences of Ghanaian and Nigerian youth in Inner London.

3.7. Chapter Summary

This chapter outlines my research methodology, rooted in a constructivist-interpretivism paradigm enriched by intersectionality, CRT, and the social model of mental health. These frameworks enable an in-depth exploration of how cultural, social, and individual factors intersect to shape mental health experiences. Ontologically, I adopt relativism, acknowledging reality as socially constructed, and epistemologically, interpretivism, emphasizing understanding participants' subjective interpretations. This philosophical stance underpins my choice of qualitative methods, specifically IPA, which prioritises depth, contextual sensitivity, and reflexivity.

IPA aligns with my focus on intersectionality and unique cultural contexts, as its theoretical foundations—phenomenology, hermeneutics, and idiography—support an idiographic and interpretive analysis of participants' lived experiences. While considering alternatives like grounded theory, narrative inquiry, and ethnography, I found IPA best suited for exploring subjective meaning-making. Semi-structured interviews facilitated rich narratives, addressing sampling challenges through community collaboration and snowball sampling.

Ethical considerations, including informed consent and confidentiality, were rigorously maintained with ethics approvals from relevant committees. Validity strategies, such as Yardley's principles and Lincoln and Guba's criteria for trustworthiness, ensured methodological rigour, alongside continuous reflexivity to acknowledge my positionality as an African diaspora member. PPI enhanced cultural relevance, influencing terminology and addressing stigma.

This chapter demonstrates a methodologically robust and culturally sensitive approach to investigating young Ghanaians and Nigerians' intersectional mental health experiences in Inner London.

Chapter 4: Phase I: IPA Analysis

4.0. Overview

In this section, I detail the IPA process I adopted in exploring the lived experiences of Ghanaian and Nigerian youth, their parents, and practitioners regarding anxiety and depression care. I discuss key concepts such as moving from descriptive to interpretative stages, meaning saturation, and strategies like de-contextualisation and memoing. I explained how I derived Personal and Group Experiential Themes, maintaining IPA's idiographic focus while interpreting individual meaning-making processes. This chapter sets the foundation for subsequent discussions of findings and their broader implications.

4.1. Introduction

Smith et al.'s (2022) description of IPA as an inductive process informed my analytical approach. Their common processes and principles (below) guided my analysis of each case. In IPA, "cases" are conceptualised as detailed accounts from individual participants, emphasising their unique experiences and personal meaning-making processes (Larkin & Thompson, 2012; J. Smith et al., 2009).

> *IPA can be characterised by a set of common processes (e.g. moving from the particular to the shared, and from the descriptive to the interpretative) and principles (e.g. a commitment to an understanding of the participant's point of view, and a psychological focus on personal meaning-making in particular contexts) which are applied flexibly, according to the analytic task. (Smith et al., (2022, p. 75)*

I attended to the "descriptiveness" of IPA cases outlined in Husserl's 1913 work, "Ideas Pertaining to a Pure Phenomenology." Husserl emphasised describing phenomena as they are experienced, aiming to capture their essence without interpretation (Kersten, 1982). I adopted Heidegger's interpretative phenomenology for the "interpretiveness" of IPA. Building on Husserl's work, Heidegger argued that interpretation is inherent in understanding. In his 1927 work, "Being and Time," Heidegger emphasised exploring the underlying meanings of experiences (Heidegger, 2010). The "flexibility" of IPA also shaped

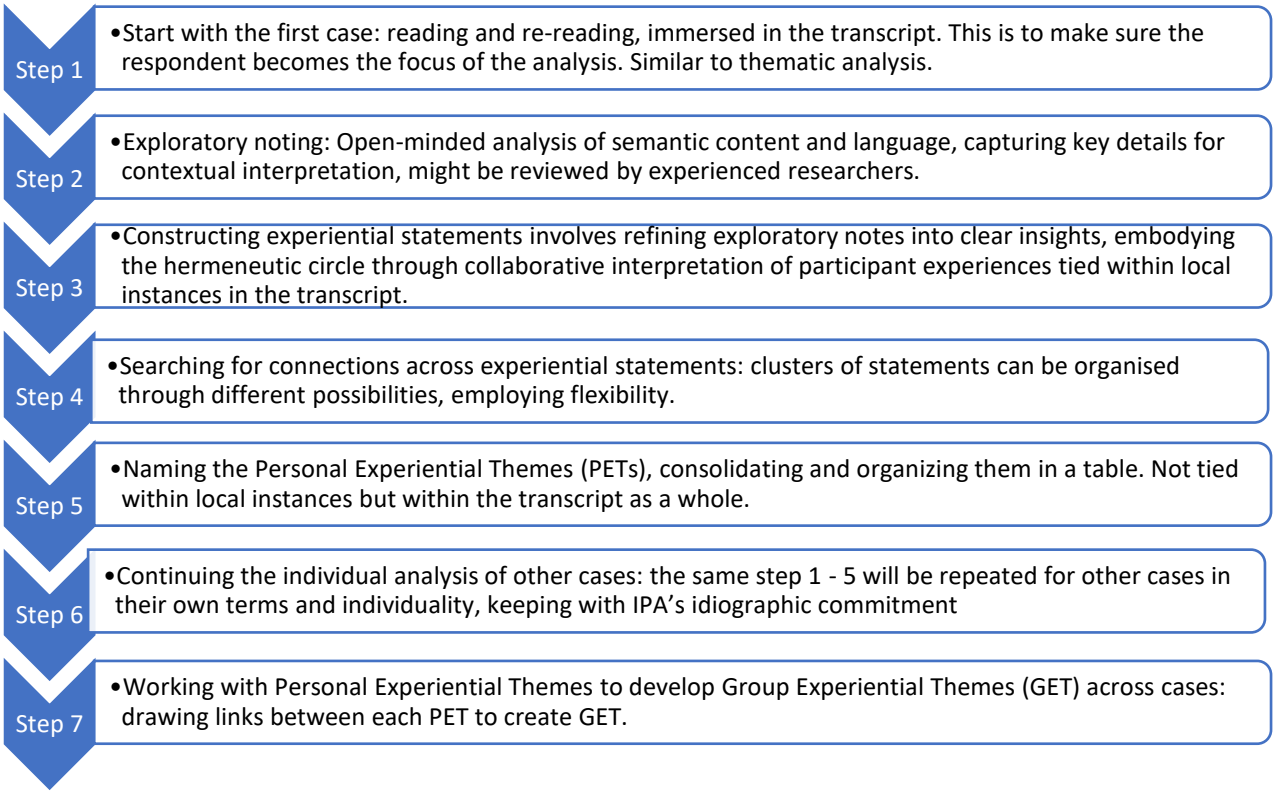
my analysis. Proponents of IPA, such as Larkin et al. (2006), Smith et al. (1999), and Smith & Osborn (2008), consistently highlight its idiographic nature, allowing for analytical flexibility. Eatough & Smith (2017, p. 21) encourage researchers "to be imaginative and flexible in the design and execution of a research study within the parameters of some clearly accessible guidelines." As Smith et al. (2022) described, I followed seven steps (see section 4.4 – 4.10). In the Sections below, the analysis is organised to facilitate auditing for rigour—from initial exploratory notes on the transcript to the development of experiential statements, initial groupings, and themes to the final naming and clustering of experiential themes. As a resource, I demonstrate these traceable analytic processes using the Kofi case in Appendix F: Step 3: Constructing Experiential Statements.

4.2. IPA New and Updated Terminologies

I adopt current IPA-updated terms throughout my analysis (Smith et al., 2022), as described below and highlighted in Figure 2.

1. **Exploratory Notes**: Refers to the initial detailed notes taken to capture significant elements within the data, facilitating the development of experiential statements.
2. **Experiential Statements**: Formerly known as **emergent themes**, these statements focus on specific participant experiences and the meanings they derive from them.
3. **Personal Experiential Themes (PETs)**: These replace the old term **superordinate themes** and are formed by clustering related experiential statements. **PETs** reflect a cohesive understanding of an individual participant's experiences.
4. **Group Experiential Themes (GETs)**: These themes emerge from a cross-case analysis, identifying patterns of similarity and difference across Personal Experiential Themes (PETs) from multiple participants.

Figure 2: Steps in doing IPA adapted from (J. A. Smith et al., 2022)



4.3. Step 1: Starting with the first case: reading and re-reading

Although I personally conducted the interviews, I recognised the necessity of subsequently immersing myself deeply in the data by listening to the audio recordings. This process allowed me to begin conceptualising the essence of each participant's perspective and ensured that the analysis remained participant-centred. All interviews were audio-recorded with the participant's explicit consent to ensure that no significant details were overlooked. Despite having previously provided participants with an information sheet and obtained their signed consent, I also sought verbal consent on the day of the interview. Qualitative researchers such as Creswell and Poth (2018), Denzin and Lincoln (2011), and Patton (2015), emphasise the importance of securing informed consent throughout the research process, including verbal consent at the commencement of interviews. This practice allowed me to reaffirm participants' willingness to participate, ensuring that their consent was both current and active. It also provided an opportunity to address any new concerns or questions that may have arisen, thereby upholding ethical standards by respecting participant autonomy and acknowledging the potential for changes in consent status (Informed Consent, discussed in Section 3.5.1).

While listening to the audio recordings, I applied the principles of memoing, as articulated by Glaser and Strauss (1967), a practice that I started implementing during the live semi-structured interviews. This approach facilitated a potentially deeper engagement with the data, enriching the subsequent analysis.

4.3.1. Memoing

Throughout my research, I utilised memos to meticulously document my thoughts, insights, and reflections, anticipating the need to revisit them. Glaser & Strauss (1967) conceptualised "memos" in qualitative data analysis to record thoughts, reflections, theoretical insights and observations that emerge during the data coding process. Memoing is referred to by Rivas (2018, p. 432) as “holding that thought”, and Birks et al. (2008) as a prompt to assist the researcher in recording relevant statements and ideas. According to Glaser and Strauss, memos are critical to capturing evolving thoughts and connections that could be missed or ignored. Similarly, for IPA, Smith et al. (2022) recommended recording some of the researcher's most powerful recollections of the interview experience, initial, and most striking observations.

4.4. Step 2: Exploratory Noting

In this phase, I attempt to engage in an initial exploratory analysis of the semantic content and language in the transcript with an open mind, recording any notable observations (Heritage, 1984; Ratcliffe, 2019). It involves examining semantic content (meaning) and language use, noting anything of interest, ensuring familiarity with the transcript, and identifying how the participant understands and discusses issues (J. A. Smith et al., 2022). This step increased my familiarity with the transcript while pinpointing specific manners in which the participant discusses, comprehends, and considers the topic, illustrated in Kofi’s excerpt in Table 4. Column 2. I used Column 2, captioned **Exploratory Noting,** to jot down notes directly on the transcript during the first reading, with the opportunity to add more exploratory notes or comments during further reviews.

Table 7:: An Excerpt of Kofi’s Exploratory Noting

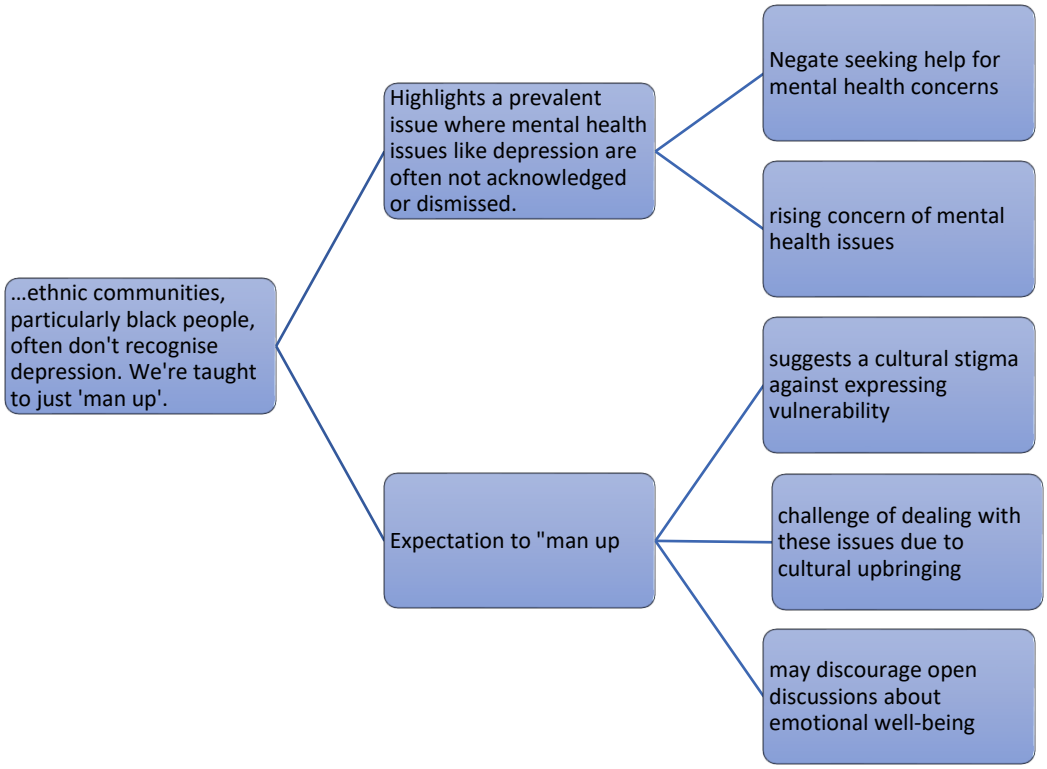
Kofi Transcript	**Exploratory Noting**
Could you share your understanding of depression and anxiety, in your own words? Speaker 2: From my understanding, anxiety is like being constantly worried about something, like feeling watched or judged, akin to social anxiety. You're always on edge. Depression is being in a state where you feel trapped, with no way out and no one to help, regardless of what you're going through. It's like seeing no other options, leading some people to consider suicide or self-harm as an escape. Speaker 1: Have you had any personal experiences with depression? Speaker 2: Yes, I've been deeply depressed before. In my experience, ethnic communities, particularly black people, often don't recognise depression. We're taught to just 'man up'. Mental health and depression are rising issues in our community, but expressing feelings is difficult due to our upbringing. When I was in a depressive state, I didn't know how to cope. Prayer and faith in God were my refuges. I believe it's about tuning your mindset to find ways out of depression, not just accepting being stuck. Therapy helped me greatly in this process. Speaker 1: You've shared quite a bit, thank you. Let's explore these points, starting with therapy. What specifically helped you during that time?	Shows appreciable understanding of what depression or anxiety entails The explanation seemed deep from a place of deep experiential knowledge Highlights a prevalent issue in some ethnic communities where mental health issues like depression are often not acknowledged or dismissed. The expectation to "man up" suggests a cultural stigma against expressing vulnerability Or seeking help for mental health concerns. Silent struggles many youths endure Reinforces the theme by pointing out the rising concern of mental health issues in certain communities Coupled with the challenge of dealing with these issues due to cultural upbringing that may discourage open discussions about emotional well-being. Provides insight into their personal experience with depression and how they sought solace in spirituality. Showcase resilience, such as the therapeutic outlets found in

	cultural ties and creative expression.

4.4.1. Interpretative Noting

Building on this initial noting, I was engaged in a “more interpretative noting” (J. A. Smith et al., 2022, p. 79). This helped me to comprehend the reasons behind participant concerns. It involved analysing the language used, considering the context of their concerns within their lived experiences, and identifying broader concepts that elucidated the patterns in their narratives. This introduced an additional layer of annotation involving more interpretive and reflective efforts. This is illustrated with Kofi’s narrative in Figure 3.

Figure 3: Illustration of an additional layer of annotation involving more interpretive and reflective efforts of Kofi’s narrative



The figure above demonstrates the essence of Kofi’s narrative in context. It highlights a prevalent issue in some ethnic communities where mental health issues like depression are often not acknowledged or dismissed. *More interpretations:* The expectation to "man up"

suggests a cultural stigma against him expressing vulnerability of seeking help for mental health concerns. *Additional layer:* It also shows the silent struggles he endured, reinforces the significant concern of mental health issues in certain communities coupled with the challenge of dealing with these issues due to cultural upbringing, which may discourage Kofi's open discussions about emotional well-being.

However, according to Smith et al. (2022, p. 79), some of these interpretations may be speculative and could "be discarded later" as the analysis progresses, while others may be further refined and developed. To emphasise, this level of my initial notes focuses on accepting things as they appear and emphasising the elements that shape the participant's thoughts and experiences. Ratcliffe (2019) highlighted a key aspect of the phenomenological method, which could involve recognising the evaluative and positional meanings typically associated with words expressing emotions. Smith et al. also highlighted metaphors' key role in this analysis stage. These words can bridge descriptive and conceptual understanding. For example, when Kofi said, "*We're taught to just 'man up'".* He evokes relocating a sense of guilt away from "self". This metaphor located the sense of guilt to masculinity and cultural stigma against expressing vulnerability of seeking help for mental health concerns such as anxiety and depression. They also highlight the need to engage more interrogatively, which might typically indicate a shift away from the participant's direct statements, as illustrated in Figure 3. It entails drawing from my professional and/or experiential knowledge. According to Smith et al. (2022), What matters is that the interpretation was inspired by and emerged from paying attention to the participant's words rather than being introduced from external sources. Overall, throughout the transcript, I stayed engaged in analytic dialogue with each line by questioning the meaning of words, phrases, and sentences, trying to ascertain their significance for the participant (Larkin et al., 2006).

4.4.2. Strategies of De-contextualisation:

I also employed the "strategies of de-contextualisation" as recommended by Smith et al. (2022, p. 84). With this strategy, I aim to deeply understand participant narratives by disrupting the natural flow of text. This method, involving reading sections backwards or out of sequence, helps researchers focus on specific words and meanings, avoiding surface-level

interpretations and emphasising the embedded nature of participants' experiences within their broader contexts (Smith et al., 2022). Friberg et al. (2000) highlight the importance of separating individual experiences from their context to identify emerging common patterns and themes.

Example of how I utilised De-contextualization

Original Context:

Kofi discusses his experience with depression, explaining how his ethnic community often doesn't acknowledge mental health issues and emphasises "manning up" instead. He describes how therapy and faith in God helped him cope.

De-contextualised Analysis:

1. **Isolated Segment:** "From my understanding, anxiety is like being constantly worried about something... Depression is being in a state where you feel trapped with no way out and no one to help."
2. **Backward Reading:** I read the segment backwards like: "...no one to help and no way out feels you where state a in being is Depression (...) something about worried constantly being like is anxiety understanding my..."
3. **Focused Re-interpretation:**
    - **Semantic Focus:** I identify key phrases such as "trapped," "no way out," and "no one to help" to highlight the depth of despair and isolation Kofi feels.
    - **Linguistic Focus:** I analyse the use of words like "trapped" and "constantly worried" to understand the severity and continuous nature of his experience.
    - **Conceptual Focus:** I then explore the underlying cultural implications of "manning up" and how this exacerbates feelings of isolation and helplessness.

My perception of De-contextualization:

- **Enhanced Detail:** By breaking down and analysing specific words and phrases, I can gain deeper insights into the participant's experiences and their emotional weight.
- **Avoiding Simplistic Interpretations:** This strategy helps avoid surface-level readings that might miss the nuanced meanings embedded in the participant's language.

- **Contextual Relevance:** It highlights how cultural context influences personal experiences, providing a richer, more layered understanding of the participant's narrative.

By breaking down and analysing specific words and phrases used by participants, I can uncover deeper insights into the subtleties of their experiences and the emotional weight they carry. This method allows for a more precise understanding of how participants express their thoughts and feelings, capturing the complexities often hidden beneath their words. It helps to avoid simplistic interpretations that risk missing the intricate layers of meaning embedded in their language. Additionally, this approach brings into focus the contextual relevance of each narrative, illustrating how cultural and social contexts shape personal experiences and perceptions. By considering these influences, I gain a richer, more nuanced understanding of participants' stories, revealing the dynamic interplay between individual experiences and the broader cultural frameworks that inform them.

However, I paid considerable attention to Van den Berg's (2008, p. 179) critiquing of decontextualisation, stating that neglecting the social context within conversation analysis "can run the risk of abstract empiricism." in other words, decontextualisation in qualitative research risks misinterpreting data by disconnecting it from its social and situational contexts, which can lead to a shallow understanding of the data, where significant meanings are potentially overlooked or misconstrued. For this thesis, I employed a decontextualisation strategy with caution.

4.4.3. Parse for meanings

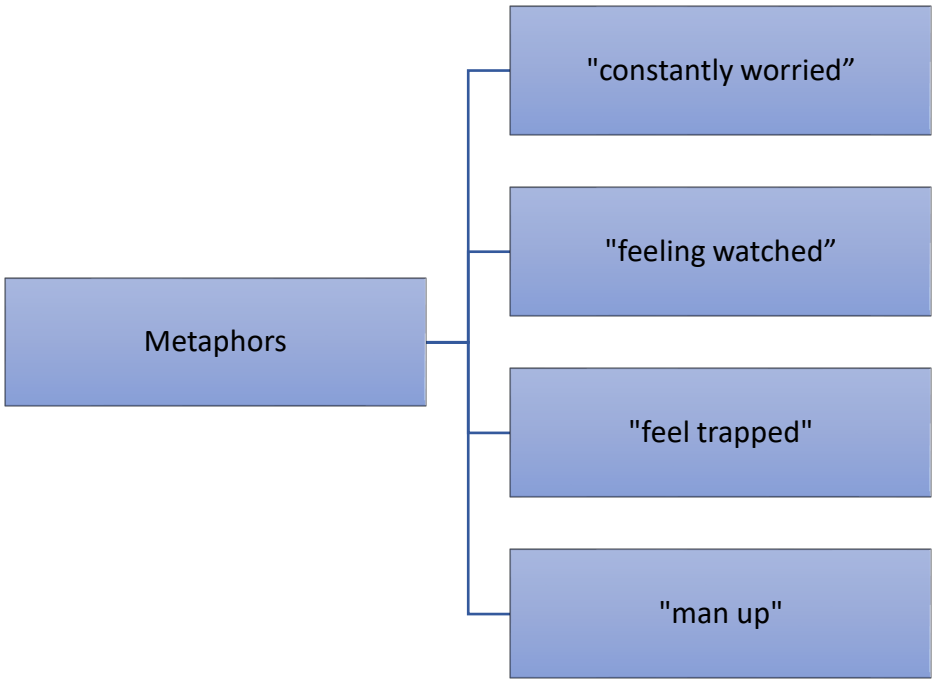
Another strategy I adopted is to parse for meanings, which refers to the detailed analysis and interpretation of textual data to uncover deeper insights and understandings. Unlike the decontextualisation strategy, I break down the data into smaller units and examine them for underlying meanings. Smith et al. (2022, p. 68) highlight:

> *Sometimes important meanings get lost quite early on, because they lack precision in the notes (e.g. writing 'emotions' instead of 'fearful of the hospital*

gown'). Try to keep things specific and visible in your notes to be able to use them at the next stage.

Parse for meaning involves carefully examining and understanding textual or spoken data to uncover deeper insights and patterns (Heidegger, 2010; Manen, 2016). Gadamer, a central figure in hermeneutics, highlighted the necessity of understanding a text's context and historical backdrop to interpret its meaning in terms of significance (Gadamer, 2003). He stressed the active role of the interpreter in engaging with the text and co-creating meaning to reveal the phenomenon in its original form. I analyse the specific words used and the context in which they are used to reveal the underlying meaning and significance of participants' words and actions. See example in Figure 4.

Figure 4: Illustration of Parse for Meaning



This example shows how I focussed on Kofi's specific language, context, and underlying significances that reflect his experience with depression and therapy. Kofi articulates his understanding of depression and anxiety, distinguishing them based on personal feelings and societal observations. Parsing for meaning here, Kofi uses metaphors like being

"trapped" and "watched" which suggest a deep sense of powerlessness and scrutiny that could be culturally informed. This was brought into subsequent analysis.

4.5. Step 3: Constructing experiential statements

At this point, I focussed on refining and consolidating my thoughts as I created experiential statements (column 1 of Table 8), detailed in Appendix Fi. My role in handling the data shifts to mainly working with the exploratory notes instead of the transcript itself. This involves a process of reducing the amount of detail in the exploratory notes (column 3 of Table 8), while still capturing their essential elements and maintaining their complexity. Nonetheless, my analysis remains closely tied to the original transcript (Smith et al., 2022).

Table 8: Step 3: Constructing Experiential Statement_ Kofi (Ghanaian Male)

Experiential Statement	Kofi Transcript	Exploratory Noting
Appreciable Understanding of the term depression silent struggles Cultural attitudes towards mental health in ethnic communities	Could you share your understanding of depression and anxiety, in your own words? Speaker 2: From my understanding, anxiety is like being constantly worried about something, like feeling watched or judged, akin to social anxiety. You're always on edge. Depression is being in a state where you feel trapped, with no way out and no one to help, regardless of what you're going through. It's like seeing no other options, leading some people to consider suicide or self-harm as an escape. Speaker 1: Have you had any personal experiences with depression? Speaker 2: Yes, I've been deeply depressed before. In my experience, ethnic communities, particularly black people, often don't	Shows appreciable understanding of what depression or anxiety entails The explanation seemed deep from a place of deep experiential knowledge Highlights a prevalent issue in some ethnic communities where mental health issues like depression are often not acknowledged or dismissed.

Showcase resilience	recognise depression. We're taught to just 'man up'. …	The expectation to "man up" suggests a cultural stigma against expressing vulnerability

4.5.1. Hermeneutic Circle

Hans-Georg Gadamer, in his work *"Truth and Method"* described the hermeneutic circle as:

> *The anticipation of meaning in which the whole is envisaged becomes explicit understanding in that the parts, which are determined by the whole, themselves also determine this whole (Gadamer, 2013, p. 302).*

This description encapsulates the essence of the hermeneutic circle, which highlights the interplay between understanding the whole and its parts in the process of interpretation. As my analysis evolves, I continue to transform notes into experiential statements, creating a succinct and meaningful summary that captures the key points from the notes associated with the transcript phrased in column 1 above. As Smith et al. (2022) recommended, in line with the hermeneutic circle, I phrased these statements in a manner that reflects the core experience of the text, balancing specific details with a level of abstraction that allows for conceptual understanding. My goal is to highlight what is most important at this juncture in the text while also considering the influence of the entire text. This process exemplifies one hermeneutic circle (Schleiermacher, 1998), where each part is interpreted in the context of the whole and the whole in terms of its parts. For example, look at the experiential statements that have been constructed in Table 5 above and below , which is a snippet of the hermeneutic circle.

Appreciable understanding of the term depression: Kofi describes depression as a profound sense of entrapment, highlighting its severity with potential outcomes like suicide when one sees no escape.

Silent struggles: He reveals the internal and unspoken battles within ethnic communities where mental health issues are often ignored or dismissed due to cultural stigmas.

Cultural attitudes towards mental health in ethnic communities: Kofi points out the reluctance of ethnic communities, especially among black people, to acknowledge depression, emphasising a culture that values stoicism over vulnerability.

Showcase resilience: Through his journey, Kofi illustrates resilience by utilising therapy and spirituality to transform his mindset from helplessness to proactive engagement in overcoming depression.

Personal experience and coping with depression: He shares his personal coping mechanisms during depressive episodes, where prayer and faith were initial steps before turning to professional therapy for substantial recovery.

This process continues throughout the whole transcript; details of Step 3 in Appendix F. Smith et al.'s (2022) recommendation is not to stay too close to the original data to avoid overwhelming statements. As the analysis progressed, I consistently critically evaluated whether the experiential statements truly reflected the analysis or merely rephrased the original data. If the latter is the case, I classify some of these statements as exploratory notes. According to Smith et al. (2022), this is nonlinear, but the back-and-forth process is a natural part of the analysis, expected within the hermeneutic circle, which was my experience.

4.6. Step 4: Searching for connections across experiential statements

Having established sets of experiential statements within the transcript, in this step, I develop a chart of how I think the statements fit together. However, when I repeated this process in other cases, not all experiential statements were incorporated into this stage of the analysis. Some were discarded. Smith et al. (2022) highlighted that what is important is that I looked for a way of bringing together all the included experiential statements and then produced a structure that allowed me to point to all the essential aspects of the participant's account.

I first copied and pasted all the experiential statements on a new Word document to look for connections. To locate the experiential statements, I included supporting quotes with page numbers. The 22 experiential statements were now separated from their quote and placed in a new Word document (Box 1).

Box 1: The 22 Experiential Statements separated to be re-arranged

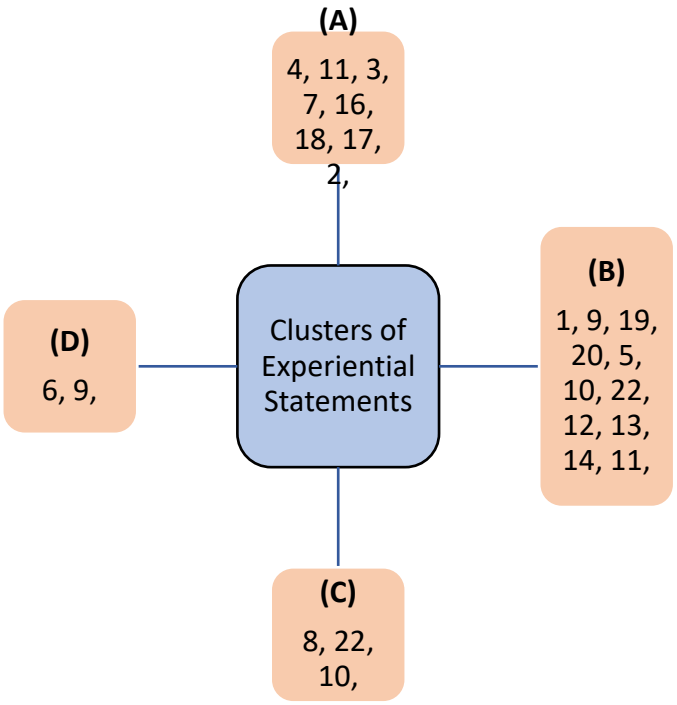
Kofi's 22 Experiential Statements separated to be re-arranged
1. Silent Struggles 2. It is not talked about in my community 3. Prayer and Faith Were My Refuges 4. silent struggles 5. Cultural Attitudes towards Mental Health in Ethnic Communities 6. Showcase resilience 7. Prayer and Faith Were My Refuges 8. Experiences with Care for Anxiety and Depression (Therapy) 9. "They (didn't) really help me" 10. Personal Experience and Coping with Depression 11. Experiences With My Therapist 12. It is not talked about in my community 13. Empowerment and Breaking Free from Limitations 14. Importance of Face-to-Face Therapyf 15. Experiences with Care for Anxiety and Depression (Therapy) 16. "They (didn't) really help me" 17. The Role of Ethnicity in Therapeutic Relationships 18. Understanding and Cultural Cues 19. Importance of Accessible Therapy 20. Silent Struggles 21. Experiences With My Therapist 22. Prayer and Faith Were My Refuges

The statements are randomly distributed, disrupting their initial sequence to allow for a more conceptual organisation. As I search for connections between the statements, I consider each one equally important. By arranging the statements in a Word document, I can better discern potential links between them. This method provides a comprehensive overview, enabling me to rearrange the statements as I explore various connections easily, as illustrated in Figure 5. This process was underpinned by the hunches I built from the analytic work. I also adopt an open-minded approach with considerable flexibility to look at

these clusters in novel ways, always returning to my recollections of the participant and their account, as advised by Smith et al. (2022). The fundamental question I was mindful of was whether these clusters reflect their experiences and social world.

Looking across these statements, I move them around so that statements that seem related in some ways are brought together. According to Smith et al. (2022), there is no single recommended way of doing this. It is a creative process of determining what goes with what. It largely depends on the material in front of me, addressing the research question. I spent considerable time looking at these statements, drawing and redrawing links, trying different connections, and then changing to try others (see Figure 5, each number representing Experiential Statements).

Figure 5: Clusters of Experiential Statements



4.7. Step 5: Naming the Personal Experiential Themes (PETs) and consolidating and organising them in a table

As Smith et al. (2022) recommended, I assigned each cluster of experiential statements. These clusters then become the participant's Personal Experiential Themes (PET).

After organising Kofi's experiential statements into four meaningful clusters (A, B, C & D), forming a clear framework that illustrates his ideas. These themes define Kofi's lived experience of care for depression and anxiety in London through four primary PETs. Each PET is presented in **BOLD UPPER CASE** for prominence, while sub-PETs are identified by **lowercase bold** titles. Under each sub-theme, relevant experiential statements are grouped, tracing back to earlier analysis phases. Each statement is pinpointed by page number and key phrases from the interview, aiding in tracking the analytic process and emphasising the interactive dialogue between participant and researcher during the analysis. This not only organises information but also showcases the interpretative efforts involved. See Appendix G: Group Experiential Themes (GETs) with experiential statements.

4.8. Step 6: Continuing the individual analysis of other cases

After thoroughly analysing the first case, I moved to the second participant's transcript, applying the same systematic methodology to ensure a robust and consistent analytical approach across the study. I initiated the process by selecting the next transcript and engaging with it through an initial reading. This initial reading was focused yet open, allowing me to immerse myself fully in the unique experiences of the second participant without the immediate influence of themes identified in the first case. This step was critical to approach each transcript without preconceived notions, thereby respecting the idiographic commitment of IPA (J. A. Smith et al., 1999, 2022; J. A. Smith & Osborn, 2015). This idiographic nature was carefully observed from step 1 through to step 5.

This rigorous process was then replicated for each subsequent case in my sample. Each time, I approached the transcript with the same disciplined methodology but remained vigilant to the emergence of new themes and insights that were specific to each participant. This ensured consistency across the analyses and allowed for the individuality of each

participant's experience to be highlighted and honoured, fulfilling the idiographic commitment of IPA.

4.9. Step 7: Working with Personal Experiential Themes to develop Group Experiential Themes across cases

Following the individual case analysis in developing Personal Experiential Themes (PETs), I transitioned to synthesising these into Group Experiential Themes (GETs). I aim to discern patterns of similarity and difference across the PETs to form a coherent set of GETs in the cross-case analysis (Summary in Appendix G). I was being mindful of the goal of IPA, which is not to create a generalised norm but to illuminate the shared and unique aspects of ideographic experiences across cases (Smith ea al., 2022).

To initiate this process, I first reviewed the tables of PETs for each participant. I then cut all PETs from all the cases and pasted them into a new MS Word document. First, identifying five named GETs reflects Smith et al.'s (2022) suggestion that researchers can "work the other way, creating first a larger analytic entity before moving to smaller ones" (p. 97). I later reduce it to three main GETs. I looked for overarching similarities and differences, trying to recognise if certain themes appeared consistently or utilised similar terminology (as illustrated in Figure 5, but now scaled across cases). This initial scan helped me reorganise the Personal Experiential Themes so that similar PETs appeared in the same sequence across three named GETs. This was a similar process to how I arrived at PETs, but this time it was of a larger scale across all PETs. As I looked at the set of PETs, it allowed me to question

> *What lies at the heart of this experience? How did each of your participants live through it? How did each one make sense of it? What connections are there across the contributing cases? (Smith et al., 2022, p. 100)*

This stage required a dynamic approach, shifting between different analytical levels. As I identified potential GETs, I annotated connections directly on the PETs by numbering. Some themes aligned smoothly into GETs, while others demanded deeper theoretical reflection and re-labelling to fit into a higher-level organisational framework that spanned multiple participants. I constantly moved between various analytical lenses, checking the fit of

emerging themes and adjusting as necessary. If a sub-theme from one participant didn't align with the emerging GET, I explored whether it connected better with another theme or perhaps indicated a new sub-GET.

Ultimately, this iterative and creative process led to a set of GETs that were well-grounded in the data and reflected both shared and unique aspects of the participants' experiences. Each GET was supported by experiential statements, ensuring the analysis remained closely tied to the participant's narratives (Smith et al., 2022). This rigorous approach honoured the idiographic intent of IPA and enriched the interpretative synthesis of the group-level understanding. For prominence, I presented the three main GETs in **BOLD UPPER CASE**, while **Lowercase Bold** titles identify sub-GET. Under each sub-GET, relevant experiential statements are grouped, tracing back to earlier analysis phases, which facilitated cross-case analysis, as illustrated in the Box 2 excerpt. See Appendix G: Group Experiential Themes (GETs) with experiential statements for all participants – Young people, parents and practitioners. This then forms the resource for Chapter 5, the Findings Section.

Box 2: Group Experiential Themes (GETs) with experiential statements for all participants.

GET 1: THE MODEL ITSELF ISN'T MADE FOR DIVERSE PEOPLE
Sub-GET 1.1: They (Didn't) Really Help Me "I got help from my school (…) it really helped me to find that confidence again " (Agnes, Nig female, p. 20). "They kind of didn't acknowledge my struggles (...) walk or go out and have a run " (Nkiru, Nig female, p. 141) I have looked into the NHS Talking Therapy services waiting list, but I didn't end up using them." (Adjua, Gha female, p. 2) "I have been referred twice by my head of year " (Efia, Gha female, p. 88) "Therapy was immensely helpful. It allowed me to express myself and get advice " (Kofi, Gha male, P. 123) **Sub-GET 1.2: "It's Someone From A Different Race"** "The therapists were really good (…) It's someone from a different race" (Agnes, Nig female, p. 26). "I didn't find the therapist friendly. I really didn't. I don't think I got anything out of the service." (Nkiru, Nig female, p. 144) "People often underestimate therapy, but it's very beneficial " (Kofi,Gha male, p. 123) …
GET 2: I HAVE NOT HEARD OF THIS BEFORE
Sub-GET 2.1: It is something not acknowledged in my community "Depression isn't commonly discussed in my family." (Kofi, p. 131-132) "I think it's something that is not acknowledged in our community." (Adjua, p. 2) "I'm sure those who are already here know there's something like that, but maybe no one told me." (Akua, p. 35) "I feel like we don't get enough (…) it's kind of like seen as a taboo to speak on." (Chichi, female Nigerian, P. 47) **Sub-GET 2.2: Approaches to Improving access: "Take our interventions to them"** …

4.10. Chapter Summary

In this chapter, I have elaborated on the IPA method employed in my study, advancing from the descriptive to the interpretative stages, as delineated by Smith et al. (2022). I draw upon

Husserl's descriptive phenomenology to capture participants' lived experiences and Heidegger's interpretative phenomenology to explore the underlying meanings of these experiences. The flexibility inherent in IPA allows for a nuanced approach, particularly in relation to the unique, personal meaning-making processes of each participant.

The study focuses on the experiences of three distinct participant groups: Ghanaian and Nigerian youth (16-25), their parents, and practitioners. This multiple-perspective approach enables triangulation of the care for anxiety and depression in these communities while capturing diverse viewpoints on intersectionality, critical race theory, and the social model of mental health. I highlight how theoretical saturation was not the sole determinant of the data analysed; instead, saturation guided my decisions. This approach, however, introduces tensions between the uniqueness of IPA's subjective sense-making and the risk of overgeneralising participants' experiences. The chapter details my systematic IPA approach, beginning with exploratory noting, followed by more interpretative noting to explore deeper meanings. Strategies such as de-contextualisation and parsing for meaning were critical in this process, allowing me to dissect participants' narratives and uncover embedded cultural implications, such as the expectation to "man up" in Black communities. My method of memoing played a key role in documenting evolving thoughts while also allowing me to refine experiential statements and GETs across cases.

Each step in the analytic process—from reading and re-reading transcripts to organizing experiential statements into PETs and GETs—is meticulously described, demonstrating how the data were synthesised while maintaining a focus on the idiographic nature of IPA. My demonstration of how I engage with the hermeneutic circle, balancing the whole and its parts in each participant's narrative, highlights this analysis's dynamic, iterative nature. Ultimately, this chapter serves as a detailed account of the analytic journey, bridging theoretical foundations with the lived realities of the participants and preparing the groundwork for the subsequent Chapters 5 and 7.

Chapter 5: Phase I: Findings

5.0. Overview

In the chapter, I first introduce the sample, and then I address the study's three primary sub-questions within the Main Group Experiential Themes (GETs) and Sub-GETs:

1. How do young Ghanaian and Nigerian individuals in London make sense of their lived experiences with care for anxiety and depression?
2. How do parents and carers of young Ghanaian and Nigerian individuals interpret and understand their own experiences with anxiety and depression about their child's care?
3. What are the perspectives of practitioners on the available model of care?

Table 9: Summary of the Main GETs and Sub-GETs

Main Group Experiential Themes (GETs)		
Main GET 1: THE MODEL ITSELF ISN'T MADE FOR DIVERSE PEOPLE Experiences of Ghanaian and Nigerian youth within the mental health system with the below sub-GETs	**Main GET 2: I HAVE NOT HEARD OF THIS BEFORE** Highlights the pervasive lack of awareness about mental healthcare among participants	**Main GET 3: COPING WITH THE WEIGHT** Experiences of coping with trauma – adversity and depression
Sub-Group Experiential Themes (Sub-GETs)		
Sub-DET 1.1: They (Didn't) Really Help Me (Young people and parent's perspectives) Expressed dissatisfaction with inconsistent mental health support, feeling forgotten, dismissed, and struggling with access to appropriate care	**Sub-DET 2.1: It Is Something Not Acknowledged In My Community** (Young people and parent's perspectives) Emphasised the lack of awareness and acknowledgment of mental health issues in	**Sub-DET 3.1: It Was Traumatising** (Young people's perspectives) Experiences of trauma through racism, family pressure, illness, and loss.

	their communities, where cultural and religious beliefs often replace professional care	
Sub-DET 1.2: It's Someone From A Different Race (Young people's perspectives) Experiences with therapists of different racial backgrounds and the impact of cultural differences on the effectiveness of therapy.	**Sub-DET 2.2: Approaches To Improving Access: "Take Our Interventions To Them"** (Practitioner perspectives) Recognised the need for proactive outreach and engagement to improve access to mental healthcare.	**Sub-DET 3.2: Just Man Up** (Young people and parent's perspectives) Discussed the internal struggles they faced, often silently, due to societal and cultural pressures
Sub-DET 1.3: The Trend: What I Observe With My Clients In Therapy (Practitioner perspectives) Noted low engagement among Black clients, addressing issues like stigma, cultural disconnect, and socioeconomic challenges.	**Sub-DET 2.3: Family Expectation And Intergenerational Dynamics: "Stay Strong"** (Young people and parent's perspectives) Revealed the pressure of family expectations and the generational gap in understanding mental health	**Sub-DET 3.3: Prayer And Faith Were My Refuges** (Young people and parent's perspectives) Explored how they cultivated strength and resilience, finding refuge in faith, therapy, and social support.
Sub-DET 1.4: There Has(n't) Been Enough In The Model Of Care (Practitioner perspectives) Discussed the limitations of the current model of care and emphasised the need for cultural adaptability and flexibility in therapy.		

These summaries provide an overview of the experiences of Ghanaian and Nigerian young people, their parents, and practitioners as they navigate the mental health system in inner London. The themes capture both the challenges and the strategies employed to cope with anxiety and depression in a context that often lacks cultural relevance and understanding.

I begin by introducing each theme with a summary of key insights, followed by noting the contributing participants. It is important to note that while there were no strict criteria for participant inclusion within a theme, all participants contributed to the identified GETs. This analysis represents one possible interpretation of the data, acknowledging that multiple perspectives and interpretations are possible. To illustrate each Sub-GET, I include verbatim extracts from the transcripts, accompanied by references that trace the quotes back to the original transcripts, ensuring transparency as emphasised by Smith et al. (2022).

To enhance readability and maintain the flow of the chapter, I have made necessary editorial adjustments to some quotes, such as removing hesitations and non-essential utterances. Where applicable, ellipses (…) indicate omitted material, square brackets [ ] provide additional explanatory information. Pseudonyms are used to protect the anonymity of participants. Appendix G contains resources supporting these findings, including extended Sub-GETs with relevant participant quotes and traceable page numbers.

This findings chapter is informed by Smith et al. (2022, p. 100), where the intention is not to establish a 'group norm' but rather to "highlight the shared and unique features of the experience across the contributing participants." Therefore, this chapter is organised by GETs and Sub-GETs rather than by participant groups. However, when a Sub-GET includes contributions from multiple participant groups, these groups are clearly delineated within the Sub-GETs; each Sub-GET is then summarised by highlighting the “shared and unique features of the experience across the contributing participants”.

5.3. Main GET 1: THE MODEL ITSELF ISN'T MADE FOR DIVERSE PEOPLE

In this Main GET 1, I explored the lived experiences of Ghanaian and Nigerian youth within the mental health system and the care for anxiety and depression under four sub-GETs (Table 9).

5.3.1. Sub-Get 1.1: “They (Didn't) Really Help Me”

Even though none of the participants has used the IAPT services, a few shared their experiences within the mental health system and their encounters with care for anxiety and depression. I observe both shared themes and unique elements that shape their narratives. One prominent theme is the inconsistency in receiving adequate support, particularly within educational settings. The contributing participants are Ghanaian young people – **Adjua** (Ad), **Efia** (Ef) and **Kofi** (Ko). Nigerian young people - **Agnes** (Ag) and **Nkiru** (Nk). Parents include two Nigerian mothers - **Kemi** (Ke) and **Osazie** (Os).

Young People’s Perspectives

All the contributors captured the essence of this Sub-GET: “They (Didn't) Really Help Me”. Starting with Agnes reflection,

> *I got help from my school's Step Therapy Program, and it really helped me to find that confidence again to interact with people and not be scared about what they're going to say to me (Ag:20).*

The Step Therapy Program emerges as a pivotal turning point for her, helping her rebuild confidence in social interactions despite her prior fears of potential judgments. The program's impact on Agnes can be understood as a form of empowerment as she begins to reclaim agency in her social world. She reflected on how she felt before engaging with the school's program

> *I sometimes feel like [not] talk to some people because usually they make racist comments to me, yeah (Ag:18)*

Her hesitance to interact with certain individuals due to prior experiences of racism suggests the profound impact that societal prejudices have had on her mental health and ability to

engage fully with others. I see this as more than just a functional success of therapy; it is a deeply personal journey towards rebuilding trust in social spaces that had previously felt unsafe and hostile to her. She also makes sense of her experience in her previous school.

> *In the London school, they didn't give me much help. They told me to get on with what I was doing and just ignore everything. They didn't really help me in any way, and because I was ignoring it, they were doing it even more and more (Ag: 23)*

Agnes reveals a stark contrast between the supportive therapeutic intervention she received later and the dismissive attitude of her previous school in London. She recounts how the institution's approach—telling her to simply ignore the racist remarks—exacerbated the problem rather than alleviating it. This dismissal of her emotional and psychological distress is emblematic of a wider failure in the system to address the intersection of race and mental health, leaving Agnes to fend for herself. The lack of appropriate support highlights the emotional toll of not only enduring racism but also the subsequent invalidation by those in positions of authority. This reflects the deeply personal and isolating experience of being overlooked in an environment that should offer care and protection. Agnes' feeling of being dismissed and ignored in her formal school resonates with Nkrus'.

Nkiru describes her struggles within the system as dismissive and invalidation,

> *"I did reach out to a GP (…) They kind of didn't acknowledge my struggles and said that I was so young [and I was told] to go out and have a walk or go out and have a run. You'll be OK" (Nkiru: 141)*

The suggestion to *"go out and have a walk or a run"* minimises the complexity of her emotional struggles, reducing her distress to something that could be easily resolved with physical activity. This response likely reflects the GP's lack of cultural sensitivity and a superficial understanding of mental health, especially as it intersects with Nkiru's youth and possibly her ethnic background. It reflects a profound misunderstanding of her reality, much like the way Agnes' concerns were dismissed in her school.

Like Agnes, Efia, in another school setting, shares a sense of being overlooked that deeply resonates with me. She talks about being referred multiple times for counselling:

> *I would have liked to see a counsellor since I was referred three times. Every time my head of year would mention getting a counsellor, but it never happened (…) I just thought they forgot about me. (Efia: 94)*

Efia's narratives convey a sense of repeated disappointment and neglect. She expresses a desire for professional support that was promised but never delivered, leaving her feeling overlooked and unimportant. The repeated references to the Head of Year discussing the possibility of counselling, only for it to not materialise, suggest an ongoing frustration. Her thought, "*I just thought they forgot about me*," implies a growing sense of abandonment, highlighting how the lack of follow-through on these referrals reinforced her perception of being disregarded. It reveals the emotional weight of being left in limbo without the care she was led to expect. In addition, the word *"forgot"* stands out to me. It is not just about being neglected; it is also perceived as being completely erased from the system's priorities. To feel forgotten in a time of her need is profoundly isolating within a system that ought to be with and possibly provide highly anticipated care for her in adversity.

Efia also adds that while counselling may be helpful, many *counsellors are white.* Her statements read:

> *Honestly, I didn't think a counsellor would do much. As much as counsellors help, I feel like a lot of the counsellors are white and don't understand the experiences that African children go through (Efia: 95).*

Efia reflects on her scepticism about the effectiveness of counselling in addressing her specific needs. While she acknowledges that counsellors can be helpful in general, her doubt stems from a perceived cultural disconnect. The reference to *"a lot of the counsellors are white"* suggests that Efia feels their lack of shared cultural background might impede their ability to truly understand her lived experiences as an African child. Efia's words highlight her concern that her unique experiences, shaped by her cultural identity, would not be adequately recognised or addressed by counsellors from different backgrounds. This scepticism was born out of what she noticed from her friend who has used the school's

counselling services. The word *"understand"* here is crucial for me. It is not just about knowing or being aware; it is about truly grasping the depth and nuance of her lived experiences, something she feels these counsellors may lack.

This lack of understanding creates a barrier to effective care, one that Nkiru also experienced. She states,

> *When I was first signposted (…) I think it was cognitive behavioural therapy. It didn't really work well for me. I didn't find it useful. I found it very white-focused (Nkiru: 142)*

Nkiru reflects on her personal dissatisfaction with the therapeutic approach offered to her. She expresses a clear disconnect between her own needs and the therapeutic model, suggesting that Cognitive Behavioural Therapy (CBT) failed to resonate with her. By describing it as *"white-focused,"* Nkiru implies that the framework and techniques of the therapy did not align with her cultural context or lived experience. Her words suggest a perceived cultural bias in the approach, making it difficult for her to relate to or benefit from the interventions she felt were designed with a different demographic in mind. This highlights her sense of exclusion within a therapeutic space that did not accommodate her specific background. This disconnect led Nkiru to seek out a Black and ethnic minority therapist, which she found helpful. She shared.

> *I think it helped because of the familiarity of where I was coming from. They asked for your demographic, your age, and your cultural background as well as your struggles. (Nkiru: 145)*

Nkiru was unequivocal on the positive impact of a more personalised and culturally sensitive approach in therapy. She highlights how the inclusion of her demographic details, such as age and cultural background, contributed to her feeling understood and acknowledged. This familiarity with her identity and experiences would have allowed her to feel more connected to the therapeutic process. By emphasizing that they asked about her struggles in relation to her specific context, Nkiru calls attention to the importance of tailoring care to the individual's unique circumstances, which made the intervention more meaningful and

effective for her. I see "familiarity" as more than just comfort; it's about finding a space where she felt seen, understood and possibly validated in a way that transcends the clinical.

Another germane issue expressed that captures the essence of the theme, "They (Didn't) Really Help Me", was the protracted issue of long waiting time narrated by Adjua. She shares her frustration with navigating the system,

> *It was frustrating because I think being in a place where you're depressed and feeling low, you want to get better. So you go and find these services but there's like a 12-week wait I think. And then you just feel a bit like 'Oh I want the help but I can't get it now.' It's quite disheartening because you're making the steps to get better but you can't because you have to wait 12 weeks (Ad: 11).*

Adjua reveals the profound emotional and psychological distress she experiences as a result of delayed access to mental health services. Her use of the word *"frustrating"* speaks not only to the inconvenience but also to the emotional exhaustion of seeking help while already feeling depleted by depression. By stating, *"you want to get better,"* she conveys an urgent desire for healing, which is central to the struggle of mental illness, the innate hope to overcome the darkness of depression. Yet, her efforts to take control of her mental health are undermined by systemic delays, making her feel powerless. The phrase, *"I want the help but I can't get it now,"* encapsulates a deeper sense of abandonment, where, despite taking proactive steps, the system fails to meet her immediate needs. This dissonance between her intention to improve and the imposed waiting period would have intensified her feelings of helplessness. Adjua's reference to the *"12-week wait"* may have added a temporal dimension to her frustration, where time becomes an additional burden. For someone in a state of vulnerability, each passing week can deepen feelings of despair. The waiting period, in her eyes, becomes another obstacle to her recovery, amplifying her emotional distress. Adjua also uses the word *"disheartening"*, which captures the erosion of her motivation and optimism, illustrating how the system's delay acts as a psychological barrier, undermining the progress she is trying to make. Ultimately, Adjua's words reveal the paradox of seeking mental health support: the very act of seeking help becomes a source of further frustration and emotional depletion when that help is inaccessible. Her narrative highlights the

detrimental impact of systemic delays, which are capable of turning the pursuit of recovery into a demoralizing experience where the urgency of her emotional pain is not met with a requisite responsive system. The waiting period is not just a delay; it's a prolonged period of suffering without support, which can be incredibly "*disheartening",* as Adjua puts it.

Kofi also captures the narratives of long waiting times and brings in the system's paid service dimension.

> *The accessibility of therapy, especially on the NHS where wait times can be long, should be improved (p127)*
>
> *Speaker 1: You did private?*
>
> *Speaker 2: Yeah, private therapy. Not everybody can. Yeah, I went to private therapy. My workplace paid for it (p138).*
>
> *(Kof)*

First, he aligns with Adjuas that the accessibility of therapy on the NHS is problematic because long wait times need to *"be improved"*. This reflects his frustration with the delays in receiving care through public services, necessitating him to use a paid service. He reflected on the financial barriers he encountered to accessing private therapy, which possibly was the only available option if he needed service in a timely manner. Kofi acknowledged that "not everybody can afford it." He was fortunate that his workplace paid for his private therapy, but he recognises that this is not an option for many people. The statement underlines his awareness of the limitations within the mental health service, both in terms of access and affordability. Kofi also highlights Nkiru's experience with the mental healthcare system's Whiteness. Despite attempting to engage with available services, Kofi eventually found that a paid service, which catered specifically to Black and ethnic minority clients, was more beneficial: *"I started to use a paid service (...) I found that very helpful" (Ko: 145).* He contrasts this with earlier attempts at therapy within public services that were culturally misaligned with his needs. These statements reflect Kofi's ultimate decision to pay for therapy, as the public system lacked the immediate and culturally tailored support he needed during his mental health journey.

Parent's Perspective

For Kemi, a Nigerian mother, her experience within the mental health system is characterised by the irregularity of her and her daughter's immigration status. Kemi, a Nigerian mother, talks about her inability to support her daughter due to her own depression and the challenges of being undocumented in a foreign country. She states.

> *I think the whole thing came from the fact that we didn't have paper [immigration paper], so therefore, we had no mouth to say anything. We could not express our pains at all (Ke: 216)*

Kemi's statement emotionally captures the sense of voicelessness and disempowerment she experienced due to her precarious immigration status. By stating, *"we didn't have paper,"* Kemi identifies the absence of legal documentation as the root cause of her silence, where the lack of immigration status symbolised the loss of agency and the inability to advocate for her own and her daughter's needs. Firstly, within this community, which I am familiar with, *"no paper"* means 'undocumented.' She alluded to this 13 times during the interview. In this context, the word "undocumented" carries a heavy burden, not just a legal status but a marker of invisibility and marginalisation that compounds her and her childs' mental health struggles. It makes me think about the additional layers of difficulty faced by those who are even more vulnerable within the already vulnerable. See the essence of her making sense of her experience of caring for her daughter with depression and anxiety in section Section 5.5.1.

The phrase, *"we had no mouth to say anything,"* metaphorically expresses her feelings of being silenced, as though her existence was rendered invisible or illegitimate without proper documentation. This sense of enforced silence is deeply tied to her inability to help or convince her daughter to express her emotional and physical pains, revealing how their undocumented status not only restricted their access to resources but also stripped her of the basic human right to communicate their suffering. During the interview, she told me that she was advised that she and her daughter could be deported if she used the service. The pain she refers to is multifaceted—both the tangible struggles of navigating life without legal status and the deeper psychological burden of being denied the ability to voice her

experiences and hardships. Kemi's reflection reveals the profound connection between legal recognition and the capacity to express one's pain, stressing how the absence of formal status extends beyond legal limitations to permeate her sense of self, agency, and humanity. Her words speak to the dehumanising effect of being undocumented, where the lack of legal standing translates into an inability to articulate one's struggles, reinforcing a state of isolation and internalised oppression.

Osazie, another Nigerian mother's experience within the mental health system in supporting her child, reveals a sense of isolation and frustration stemming from a lack of proactive support. Osazie reflects,

> *I never thought of being referred to any services. Maybe because I didn't ask for it all my GP would say is, 'let us know if you need any support.' I didn't have anybody come to my home to say, 'we heard what happened; how are the children doing?' I think we need to start from that (...) I shouldn't have to ask for support (Os: 275)*
>
> *Certainly the school did not offer support (…) The school could have called the children at least every week to check on them, but none of that happened, and they didn't make any referrals (Os: 283)*

Osazie had just lost her husband, the father of her children. When I reflected on her interactions with the healthcare system, Osazie expressed that there was no automatic outreach or follow-up from healthcare providers; she believes such is necessary. She highlights this absence when she says, *"I never thought of being referred to any services. Maybe because I didn't ask for it."* Her words reveal the assumption that individuals in her situation have to be aware enough of their own needs to request help, a burden she suggests should not fall solely on those in crisis. Her GP's indifferent response—*"let us know if you need any support"*—might have highlighted how the system perhaps placed the onus on her to seek assistance instead of offering it. For Osazie, The lack of inquiry into her and her children's well-being after such a significant loss reflects a systemic failure to engage with patients in a holistic and compassionate manner. In Osazie's view, this oversight stresses a deeper problem: *"I shouldn't have to ask for support."* She emphasises a desire for a

healthcare system that recognises the needs of families in distress without requiring them to actively seek out help, especially in moments of vulnerability. Her experience with the school system echoes similar frustrations. She reflected on the inaction of her children's school, which did not make any effort to check in or provide referrals. She feels like a continuation of the same disengaged attitude she encountered with her GP. Osazie notes that *"the school did not offer support,"* even though her children were clearly going through a difficult time. Her belief that *"the school could have called the children at least every week"* points to an expectation that institutions caring for children should take a more active role in their emotional and mental well-being, especially when there are clear indicators of distress. The school's failure to follow up or offer counseling reinforces her feeling that those who should be watching out for vulnerable children were neglecting their duties, leaving her family unsupported during a crucial time.

Osazie attempted to compare Nigeria and the UK systems, but it was not really about comparing the mental health systems in both jurisdictions. Osazie said,

> *The therapy back home was in the form of family therapy (...) Here grand aunties might come and stay for a week or four days, but in the UK you can't do that (…) You will fall apart (Os: 285)*

Her reflections on the differences between the UK system and her cultural expectations of therapy provide a communal expressive insight into the disconnect she feels within the system. Describing therapy back home as *"family therapy,"* Osazie illustrates how care and support were embedded within the fabric of family and community relationships. The absence of such structures in the UK—*"grand aunties might come and stay for a week or four days, but in the UK you can't do that"*—heightens her sense of isolation. In her words, *"you will fall apart,"* she expresses a deep fear of emotional collapse in the absence of familiar, culturally grounded forms of support. The UK system, with its reliance on professional services like antidepressants or therapy, felt insufficient and foreign to her, especially in the absence of the communal care she had known.

Summary of the Shared and Unique Features of Participants' Experiences

The participants shared common experiences of being dismissed or neglected by the mental health system, particularly within educational and health settings. They described systemic barriers, such as long waiting times and a lack of proactive care, that exacerbated their feelings of helplessness and frustration. A recurrent theme was the inadequate cultural sensitivity in therapeutic practices, with participants like Efia and Nkiru expressing that the predominantly white therapists may not fully understand the unique challenges faced by African youth.

Each participant's experience had its own distinctive aspects. Agnes benefited from a school's Step Therapy Program but also faced racism and neglect in a previous school. Nkiru sought therapy from a Black therapist, which she found culturally affirming, after feeling disconnected from the "white-focused" approach of Cognitive Behavioural Therapy. Adjua emphasised her frustration with the 12-week waiting time for services, while Kofi turned to private therapy funded by his workplace, acknowledging that this option was inaccessible to many. On the parents' side, Kemi, an undocumented Nigerian mother, described how her legal status silenced her ability to seek help for herself and her daughter. Osazie, another Nigerian mother, felt her children were unsupported after the death of her husband, highlighting the absence of outreach from both healthcare providers and schools during her family's time of need.

5.3.2. Sub-GET 1.2: It's Someone From A Different Race

Having explored how five young people and two parents' research participants make sense of their experiences within the mental healthcare system for anxiety and depression in Sub-GET 1, this Sub-GET focuses specifically on the voices of the three participants who had direct contact with a therapist. The contributing participants making sense of their lived experience on client-therapist relationships are all young people: **Agnes** (Ag), a Nigerian female in a school setting while **Kofi** (Ko), a Ghanaian male and **Nkiru** (Nk)**,** a Nigerian female, both of whom accessed paid services within the wider community.

Only Young People's Perspectives

Agnes's experience with her therapist was largely positive despite acknowledging that her therapist was *"someone from a different race"*. In her words, she states,

> *The therapists were really good (…) It's someone from a different race (Ag: 26). They would like ask how is my day? Sort of like if it was good or bad (…). I feel like that was quite helpful. Quite a lot (Ag: 22). There was quite a few different things that they told me like different apps I could use to help myself (Ag: 25).*
>
> *They need to continue the therapy program and all that they are doing because they really help me (Ag: 28).*

A strong sense of appreciation and trust in the therapeutic process and space marks her experience with her therapist. She consistently highlights the helpfulness and support she received, using direct and simple language to convey her feelings. For instance, when she reflects on the therapist's questions, like *"how is my day? Sort of like if it was good or bad,"* it suggests that even these routine check-ins were meaningful for her. The act of being asked about her day, whether positive or negative, seems to provide her with a sense of being seen, valued and heard, an opportunity to reflect that perhaps she did not have elsewhere. Agnes emphasises how beneficial the therapy was, repeating that it was *"quite helpful. Quite a lot"*. This repetition possibly signals that the therapy's impact on her was significant, perhaps beyond what she initially expected. For her, the effectiveness of the therapy outweighed any potential cultural disconnect. The fact that Agnes found these interactions *"quite helpful"* further reinforces the idea that the therapists' approach resonated with her, even if they were from different cultural backgrounds. It is not just the structured elements of therapy, like conversations or the introduction of tools, but the entire process itself that she found valuable. Moreover, she notes how the therapists introduced her to practical tools: *"There was quite a few different things that they told me like different apps I could use to help myself"*. For me, It shows that her therapeutic experience extended beyond the sessions. The therapists equipped her with resources she could use outside the confines of their meetings, further enhancing her sense of agency in managing her mental health. This focus on self-help tools implies a shift towards autonomy, where Agnes was not just

passively receiving help but actively engaging with strategies that could empower her outside of therapy. In addition, her statement that *"they need to continue the therapy program and all that they are doing because they really help me"* demonstrates a sense of advocacy. Agnes recognises the value of the program not only for herself but implies its importance for others.

In contrast, Nkiru had a much more challenging experience with her therapist.

> *Nkiru: I found it very white-focused (p142).*
>
> *Interviewer: So, you had not heard of IAPT at that time. So what therapy did they eventually signpost you for?*
>
> *Nkiru: CBT. … I found it very white-focused (p142)*
>
> *Interviewer: … So, what is your experience with your therapist?*
>
> *Nkiru: It was foreseeably fair. Yes, the experience was just... I don't think it was thorough enough.*
>
> *Interviewer: Why do you think it wasn't?*
>
> *Nkiru: I didn't find the therapist friendly. I really didn't. I don't think I got anything out of the service.*
>
> *Interviewer: From what you said, it looks as if the therapist is not from your ethnic background.*
>
> *Nkiru: No. So, the therapist was a white woman. I had about 3 sessions with her, and that was it. Because I went there and was not getting anything. I said this is not helping me. It's not doing anything.*
>
> *(Nk: p144-145)*

Her initial experience with the NHS therapist left her feeling unseen and unsupported. The phrase "I didn't find the therapist friendly", for me, is not just a complaint about mannerisms but points to a more significant problem of emotional and cultural alienation. The therapist, a white woman, may not have shared Nkiru's cultural background but lacks an understanding of the unique struggles tied to her Nigerian identity. Nkiru's dismissal of the service as "white-focused" speaks to this feeling of exclusion, where the therapy seemed tailored to a different population, failing to consider her context and worldview. This highlights how therapy, even when well-intentioned, can feel irrelevant or distant when cultural context is absent. Her decision to stop attending after just three sessions signals a

breakdown in trust. She says, *"I went there and was not getting anything,"* which suggests that the therapeutic techniques or the therapist's approach did not resonate with her lived experiences. The lack of recognition of her cultural identity likely hindered building rapport, which is critical in any therapeutic space and relationship. For Nkiru, the issue went beyond method or expertise—it was about a fundamental mismatch between her needs and what the therapist offered. She also makes sense of her experiences, having changed her therapist to a more culturally compliant one. She narrated,

> *It's not through NHS.(…) I ended up seeking private help (…) I think it helped because of the familiarity of where I was coming from. They asked for your demographic, your age, and your cultural background as well as your struggles (…). Having that information helped with signposting me to the right therapist and I felt like I was getting something out of the service." (Nk: 146-147)*

In contrast, her experience with the private, paid service offers a stark difference. When she reflects, *"I think it helped because of the familiarity of where I was coming from,"* Nkiru highlights how pivotal it was for her therapist to acknowledge her demographic and cultural background and identity. The data she described is more than a superficial detail; it provided a foundation upon which Nkiru could feel understood. Her cultural background, age, and struggles were integrated into the therapeutic process, making her feel seen and possibly respected. The way she says, *"Having that information helped with signposting me to the right therapist,"* suggests that just being asked about these aspects of her identity stimulated a perceived validation in itself, leading to a more meaningful engagement with therapy. This shift from feeling alienated to feeling supported shows how Nkiru's perception of the therapist changed when the service did not align with her cultural reality. Her initial experience failed because it treated her as a generic client, not a Nigerian woman with specific cultural experiences, while the private service succeeded by treating her holistically. Nkiru's relief in saying, *"I felt like I was getting something out of the service,"* reveals the importance of culturally sensitive care in transforming therapy into a space where her healing can occur.

Kofi offers another dimension to this dynamic. His encounter with his therapist was a pivotal moment in his journey through depression. He speaks

> *Therapy was immensely helpful. It allowed me to express myself and get advice and daily guidelines for recovery. People often underestimate therapy, but it's very beneficial for depression, anxiety, PTSD, and similar issues (Ko: 123).*
>
> *I had face-to-face therapy with a professional. We discussed what was causing my depression and strategies for improvement. One impactful concept was whether I would remain imprisoned by my mind or break free to explore future possibilities. This helped me realise I needed to better myself and move forward in life (Ko: 124)*

He refers to therapy as a space where he could express himself freely, something he had not done before. A valuable outlet to express his emotions and receive practical advice for recovery, enabling him to voice thoughts and feelings he had previously kept hidden. Kofi's therapist played an instrumental role in helping him confront his depression, particularly through a key concept that stayed with him: *"One impactful concept was whether I would remain imprisoned by my mind or break free to explore future possibilities."* This moment in therapy helped Kofi shift his mindset from feeling trapped in his thoughts to seeing a path forward, pushing him to consider his future beyond his current struggles. Despite initial reservations, Kofi acknowledges that his therapist, though not from the same ethnic background, still understood him.

> *She was Black but I'm not sure of her exact origins (p125). The conversations we had were directly relevant to my situation, and the help she offered was progressively beneficial (Ko: 126).*
>
> *So then I thought, no, this isn't me. Maybe a therapist would help. It kind of helped me, yeah (Ko: 137).*

Kofi's words suggests that while ethnic background might have been a factor initially, it was the relevance of the therapist's approach to his personal experience that mattered most to him. The understanding and support she offered were what Kofi found most beneficial in his

therapy sessions. Kofi reflects on how this relationship helped him realise the importance of seeking help outside himself: *"At first I said I didn't need therapy. Like what's a therapist going to do for me, you know?" (Ko: 136).* His resistance faded as he realised that therapy offered something he couldn't achieve alone. Over time, therapy became not just a means of coping but a transformative process that allowed him to regain control of his life: *"It kind of helped me, yeah" (Ko: 136).* Kofi emphasises that his therapist didn't just listen but actively helped him uncover strategies for moving forward. The guidance provided was not merely theoretical but practical and directly applicable to his life, shaping his recovery process and allowing him to start imagining a future beyond depression.

Summary of the Shared and Unique Features of Participants' Experiences

All three participants—Agnes, Nkiru, and Kofi—experienced therapy as a significant part of their mental health journey, though their relationships with their therapists varied. A shared feature among them is the acknowledgement of therapy's value in addressing their mental health concerns.

In terms of the unique features of each participant, Agnes appreciated the practical help from her therapist, emphasising the supportive nature of routine check-ins and resources like apps, despite the cultural differences. For Kofi, therapy provided a space to reflect deeply on his mental state and receive relevant advice that helped him shift his mindset, highlighting the therapist's personal impact. Nkiru's experience, however, was markedly different; she struggled with the lack of cultural understanding in her initial sessions and only found meaningful help after switching to a therapist who recognised her Nigerian background. These unique experiences accentuate the varying levels of cultural connection and understanding each participant felt in their therapeutic relationships.

5.3.3. Sub-GET 1.3: The Trend: What I Observe With My Clients In Therapy

The previous two Sub-GETs give voice to the young people and their parents' perspectives of their lived experience of the mental healthcare systems and then voices of young people regarding the care they have received in the context of their experience with contact with therapists. Building on this, I have used this Sub-GET to understand this phenomenon

through the therapists' experiences and what they observe in the therapeutic space. Two NHS IAPT Practitioners, **Bindun** (Bi) and **Uwase** (Uw) described their experiences. They provided key insights into the trends, challenges, and dynamics that shape therapy with this demographic.

Practitioners Perspectives

An NHS IAPT practitioner, Uwase, succinctly captured the essence of this Sub-GET. She reflects deeply on the trend observed among Black clients, particularly Black men, regarding their engagement in therapy. I began by highlighting Uwase's experience on how few are the actual number of Black men who seek and complete therapy is notably low. She narrates,

> *When I think about it now, reflecting on how many Black men I've seen, it's not that many, you know, and I've been in this service for five years. I could probably count on two hands the number of Black men that I've seen. And actually, if I think more deeply, a lot of them have dropped out of treatment. They might have received a referral, booked an appointment, but then disengaged (Uw: 427).*

This disengagement from therapy is further exemplified when Uwase recounts one particular case:

> *I'm thinking of one person in particular who rescheduled the first appointment and then later emailed saying he didn't think he needed therapy anymore and pulled out of the treatment (Uw: 427).*

Uwase attributes this pattern of disengagement to several factors, one of which is the mistrust many Black men have towards the healthcare system. She reflects,

> *Are we offering a service that they look at and say, 'this service is for me. It will meet my needs. I can trust these professionals? (Uw: 429).*

Uwase's narrative conveys a sense of concern and reflection, suggesting that the issue of disengagement is something she has observed repeatedly and finds troubling. The way she frames her experience, *"I could probably count on two hands",* implies a striking rarity, reinforcing how unusual it is for her to see Black men in therapy over a five-year span. The fact that she can almost numerically quantify this experience indicates how much this

absence stands out in her work. Her deeper reflection about *"a lot of them have dropped out of treatment"* points to a pattern she has identified, which adds a sense of frustration or helplessness. Her recounting of the specific case brings the disengagement into sharp focus, giving it a personal, almost intimate dimension. The act of pulling out of treatment after just a rescheduled appointment suggests more than mere inconvenience or life pressures; it may symbolise a deeper reluctance to engage with the therapeutic process. Uwase's focus on this single case reveals how much it resonates with her, possibly because it encapsulates the broader trend she has observed. Finally, Uwase's reflection—*"Are we offering a service that they look at and say, 'this service is for me'"*—is particularly instructive. Here, she voices her own uncertainty, raising the question of whether the services provided are genuinely perceived as welcoming or suitable for Black men. The phrasing *"this service is for me"* echoes with a need for belonging and affirmation, suggesting that therapy, in its current form, might be missing key elements that make these clients feel understood and supported. Her question also implies a deep-seated mistrust toward the healthcare system, which she identifies as a major barrier, as she mentions,

> *There's a lot of mistrust partly due to negative experiences with healthcare in the past or concerns about confidentiality or privacy. There's also a lack of understanding about symptoms and not enough normalization of mental health problems within the Black community (Uw: 429)*

Importantly, Uwase also touches on the socio-economic pressures faced by many Black individuals, which lead to mental health issues being deprioritised:

> *In deprived areas where people are just trying to survive, mental health gets deprioritised (…) They're trying to eat, feed their children, keep going, get a job (Uw: 429).*

Uwase recounts how this sense of survival often overshadows the recognition of mental health challenges such as depression or anxiety. Uwase summarises this by stating that Black clients may not seek therapy because *"they're not hearing voices so they think they don't need help"* (Uw: 429). This signals that they would not seek help until the condition gets worse. Through these observations, Uwase conveys a complex picture of how structural

issues like mistrust, stigma, and socioeconomic pressures affect the engagement of Black clients, particularly Black men, in therapy. I resonate with Uwase's suggestion that part of the problem lies in how mental health services are presented to Black men. She mentions that

> *I think it's partly because we do not engage them enough in terms of our offering. We're thinking about how we appear to be visible for Black men (Uw: 429).*

It suggests how crucial it is to not only offer mental health services but also to ensure that these services are culturally sensitive and trustworthy in the eyes of those who need them.

Bindun, also an NHS IAPT practitioner's reflections, reveal the nuanced engagement with the layers of complexity her clients bring into the therapeutic space. At its core, her observations point to an ongoing tension between the structured, goal-oriented nature of CBT and the lived realities of her clients, many of whom present with multifaceted emotional and practical struggles. Her words suggest that therapy, as it is traditionally structured, is antithetical to the more fluid, urgent needs her clients express. For example, Bindun notes that many of her clients arrive in therapy with pressing practical needs such as housing, finances, or safety concerns that they hope therapy will address. This reflects a broader pattern where clients may misunderstand or overestimate what therapy can offer:

> *Sometimes clients are going through very real socioeconomic issues (…) Clients might come to me expecting that I can solve [their] housing issues or financial problems (...) I have to kind of come back to [say] I can [only] support you on an emotional level (Bi: 304)*

Here, she acknowledges a gap between the client's expectations and the reality of therapy. This reflects not just a misunderstanding but a deeper issue: for many clients, emotional distress is intertwined with their material circumstances, congruent to Uwase's observations. As Bindun observes, therapy contends with the limits of its capacity to address these holistic needs. Her role becomes not just about emotional support but about helping clients recalibrate their expectations, which could be a difficult and delicate process. At the same time, Bindun repeatedly emphasises the prevalence of trauma in her client base, particularly

among Black clients in the Borough. This trauma often creates a demand for therapeutic spaces that are less structured and more open, allowing clients to process their experiences on their terms, in her narratives,

> *Sometimes we're not able to be as structured (…) because sometimes a client wants to just process something that has been affecting them or we have to talk about the reality of the life that they're living in [the Borough] where they might feel unsafe to go out (Bi: 306)*

Bindun implicitly critiques the rigidity of CBT here. While CBT relies on structure, clear goals, and specific techniques, her clients' realities often resist these boundaries. Trauma, especially trauma rooted in ongoing experiences of street violence ("*feel unsafe to go out"*) or systemic oppression, might not easily conform to the confines of traditional therapeutic timelines or methods. Bindun finds herself having to adapt her approach, offering her clients a space to *"process"* rather than simply follow the structured steps of CBT. This suggests a more relational and responsive style of therapy, one that accommodates her clients' needs even when they conflict with standard protocols. Another recurring theme in Bindun's observation is safety, specifically its lack. Her clients often come from environments where violence, financial instability, and fear are commonplace, impacting their ability to engage with therapy:

> *I've had one client who couldn't afford the bus to come and see me, and another client who was too scared to leave her house because she feared someone might attack her or her son has been involved in some kind of gang violence (Bi: 307)*

These narratives reveal how safety is not just a psychological concept for her clients but a real, present concern that affects their day-to-day lives. Therapy, in this context, becomes a space where the boundaries between psychological distress and practical survival blur. For Bindun, the expectation that clients can fully engage in therapy while facing such immediate threats to their physical safety seems almost unrealistic. Bindun's acknowledgement of this reality demonstrates an understanding that emotional healing might not happen in isolation from the material conditions of her clients' lives.

Summary of the Shared and Unique Features of Participants' Experiences

Both NHS IAPT therapists, Uwase and Bindun, observe significant barriers to therapy engagement among Black clients, particularly Black men. These barriers include a deep-seated mistrust of the mental healthcare system, often due to negative past experiences and concerns about confidentiality. Clients from deprived areas who are focused on survival also deprioritise mental health, viewing therapy as less urgent compared to pressing socioeconomic challenges. Additionally, both therapists note that trauma and unsafe living conditions complicate engagement in structured therapeutic methods like CBT, highlighting the need for more flexible approaches that accommodate clients' realities.

Regarding the unique features of each participant, in summary, Uwase particularly emphasises the disengagement of Black men from therapy, reflecting on the rarity of seeing them complete treatment. She attributes this to mistrust and cultural stigma within the Black community, suggesting that services might not be perceived as trustworthy or relevant to Black men. Bindun, on the other hand, focuses on the practical struggles her clients face, such as housing instability and safety concerns, which they often expect therapy to address. She implicitly critiques the structured nature of CBT, suggesting that many of her clients require a more relational and flexible approach due to the complex trauma they experience.

5.3.4. Sub-GET 1.4: There Has(n't) Been Enough In The Model Of Care

After I explored practitioners' experience of what they observe during therapy in the context of young Black people in Sub-GET 1.3, this Sub-GET details practitioners making sense of their actual model of care. As I analyse the insights shared by the NHS IAPT practitioners **Bindun** (Bi), **Robert** (Ro) and **Uwase** (Uw) and Community-based Practitioners **Mikey** (Mi) and **Shelly** (Sh), it becomes apparent that their Model of Care is simultaneously unified by a commitment to evidence-based practices and fragmented by the challenges of adapting these practices to diverse populations. The inherent tension between adhering to established protocols and the need for cultural sensitivity is a recurring theme across the practitioners' experiences.

Practitioners Perspectives

Nwase, an NHS IAPT practitioner, reflected on the current model of care centring on the Western focus of CBT and its need for adaptation, highlighting a potential recognition of a fundamental mismatch between the model's design and the diverse needs of her clients. She states,

> *I suppose by default it's been made for a Western audience or population so it's not always going to be wholly appropriate in every culture. However, that's our job as a therapist to make it adaptable and make it as personal as possible. So the model itself isn't made for diverse people. It's not made for diversity but it doesn't mean that they can't benefit from it (Uw: 444)*

Her words highlight an inherent limitation in the model itself. Nwase acknowledges that CBT was not created with diversity in mind, reflecting the broader issue of mental health models being developed through a Eurocentric lens. The phrase *"by default"* indicates a passive acceptance of the model's origins, suggesting that it was not consciously designed to exclude non-Western populations but that its development naturally catered to the dominant cultural group in which it was conceived. However, Nwase does not completely dismiss the model's utility for Black young people, stating, *"It doesn't mean that they can't benefit from it."* This implies a belief in the model's overall effectiveness despite its cultural limitations. Her use of *"our job as a therapist"* positions adaptation as the therapist's responsibility, suggesting that it is up to individual practitioners to bridge the cultural gap rather than the model itself being revised or expanded to account for diverse populations. This approach places a significant burden on therapists, who would have to navigate the complexities of cultural adaptation without a dedicated framework that inherently supports it. Nwase's interpretation reflects a pragmatic view: even though CBT is not ideal for everyone, it can still be made to work if therapists take the initiative to tailor it to their clients' needs. She further remarks on the need for cultural adaptations in therapy, revealing a deeper frustration with the lack of institutional support for this process. Nwase highlights

> *I think there should be a difference in terms of how we culturally adapt our therapy, but I don't think there's been enough training on that (...) not really active ongoing culturally competent training specifically for working with Black populations (Uw: 432)*

When she mentions that there is a need to be a difference in how therapy is culturally adapted, but there has not been enough training, she highlights the gap between the recognised need for culturally appropriate care and the training therapists receive. For Uwase, the lack of ongoing culturally competent training specifically for working with Black populations illustrates a systemic issue where cultural appropriateness is treated as an afterthought rather than an essential part of the therapeutic model. This suggests that while the need for adaptation is acknowledged, the infrastructure to support it is inadequate, leaving therapists underprepared to make meaningful adjustments for Black clients. Nwase's use of *"not enough"* and *"not really active"* suggests passivity within the system, where cultural sensitivity is acknowledged but not prioritised. Her resolve to adhere to the laid down evidence-based procedure is captured in the statement:

> *I would say I do stick within the boundaries, to be honest, because that's what I've been taught to do in terms of the model. You know you conceptualise problems within it but yes I think having more training in that area of how to make a cultural adaptation would be helpful (Uw: 444)*

Her personal approach to therapy, as reflected in her statement, *"I do stick within the boundaries (…) because that's what I've been taught to do,"* shows her reliance on the traditional framework of CBT. This phrase implies a certain level of constraint, where Nwase, like many other practitioners, feels bound by the model she has been trained in. Despite her recognition of the need for cultural adaptation, she admits to staying within the *"boundaries"* of what she has been taught, revealing a tension between what she knows is necessary and what the model allows her to do. Her use of *"that's what I've been taught to do"* points out the model's rigidity and the limits of her training, which has not equipped her with the tools to make the kinds of cultural adaptations she knows would be beneficial.

Nwase's statement suggests that therapists are not empowered to fully step outside of the prescribed model without additional training, which is currently lacking.

Robert, another NHS IAPT practitioner's understanding of the model of care for anxiety and depression within IAPT is shaped by a balancing act between standardised treatment protocols and the necessity for cultural sensitivity. He acknowledges that the core framework of care in IAPT, particularly CBT, is rigid and designed to offer the same treatment structure for all clients, regardless of background. In Robert's words,

> *Within IAPT, we follow quite a structured protocol (...) It doesn't matter who presents with what, they'll usually be offered one or a combination of CBT therapy (...) The protocols usually stay fairly similar. Similar approaches will be applied within each, which is why clinician differences really come in there." (Ro: 366-367)*

Robert reveals a tension between uniformity and the need for personalisation in care. His mention of offering a standard treatment regardless of the presenting issue highlights the rigidity of the system. Yet, he subtly emphasises the importance of clinician individuality within this structure. The phrase *"clinician differences really come in there"* suggests that while the protocol may remain constant, it is through the nuances of the therapist's engagement that the care becomes meaningful and adaptable. Significantly relatable to Uwase's narratives. His words imply that despite the standardisation, there is room for therapeutic flexibility, but it rests heavily on the clinician's ability to personalise the approach within those boundaries. The care model, therefore, is experienced as both structured and reliant on the practitioner's interpretive role to bridge the gap between protocol and individual needs. While Robert highlights the need for cultural sensitivity, his reliance on the standardised CBT model limits how far this sensitivity can be integrated into practice:

> *The treatments will look very different if you ask those nuanced questions around race and culture (...) In South London, there's a huge push to make the protocols sensitive to BAME clients, particularly working in South London (Ro: 367)*

He notes the importance of tailoring treatment to account for cultural differences, such as when he asks clients about their race, culture, and community engagement. Yet, his practice seems constrained by the structure of the IAPT model itself. Although he emphasises asking culturally relevant questions, the core treatment remains largely unchanged. However, he states,

> *where the nuancing in treating this client group comes in, maybe not with the specific symptom as such, it's more like how you might go about treating the symptom (Ro: 361)*

As he describes it, the nuance lies more in *"how you might go about treating the symptom"* than in fundamentally altering the treatment approach. This suggests that while cultural considerations are acknowledged, they are incorporated into an existing framework rather than prompting a reevaluation of the model itself. Furthermore, Robert's critique of the model reveals a significant tension regarding time allocation, stating,

> *More time is needed (...) particularly people from ethnic minorities (...) I think we should be offering more time to go through race and culture questions and tailor the treatment as much as we can (Ro:381)*

Robert's reflection on the need for more time in therapy, especially for individuals from ethnic minorities, highlights his awareness of the limitations within the current care structure. His emphasis on offering more time for exploring race and culture speaks to the recognition that these aspects are not merely peripheral but central to the therapeutic process. In my view, the word *"tailor"* signifies his desire to move beyond the one-size-fits-all model and create space for meaningful discussions that are often neglected within standardised protocols. His call for more time suggests that the current framework is too rigid to fully accommodate the complexities of diverse experiences, particularly when it comes to cultural and racial identity, which he sees as integral to effective treatment. This signals an awareness that healing for ethnic minorities requires both time and a nuanced approach, something he feels is currently lacking in practice. This critique points to a broader structural limitation within the IAPT model in terms of its efficiency-driven approach, which prioritises short-term interventions, often at the expense of deeper, more

culturally nuanced care. This notion is reflected in Nwase and Robert's narrative so far The model's rigid structure and focus on standardised, time-limited sessions may prevent clinicians from fully engaging with the cultural contexts that significantly influence mental health in Black communities as been described. Robert's reflection on the model also raises questions about the effectiveness of cultural sensitivity training within the IAPT framework. While he mentions that there is a *"huge push"* in South London to make the protocols more sensitive to Black and ethnic minority clients, he also hints at the superficiality of these efforts. As he presents it, cultural sensitivity seems to be an add-on rather than an integral part of the treatment model. For me, the push for cultural adaptation appears to be reactive, aiming to patch up the shortcomings of a protocol that was not originally designed with diverse cultural backgrounds in mind. This suggests a deeper flaw in the model: cultural sensitivity is treated as a supplement to an otherwise uniform framework rather than a fundamental aspect of therapeutic care.

When I asked if there was a need to develop a new model? For Bindun, also an NHS IAPT Practitioner, she states.

> *It's not about making a new model because there is (…) research showing that existing models work. It's about ensuring the model is not one-size-fits-all but is adapted and flexible for everyone because we all deserve good therapy" (Bi: 341).*

In Bindun's narratives, there is an underlying recognition that the current models, while effective in many contexts, fall short without modifications. Her emphasis on the need for flexibility points to the rigidity of the established framework, which assumes a universal applicability that doesn't necessarily align with the lived experiences of Black clients. By advocating for a more tailored approach, she implicitly highlights that the current structure, if left unchanged, may not sufficiently accommodate the cultural and individual nuances of all clients. Her description of culturally adapted therapy adds further insight into the areas where the model needs adjustment. Bindun explains,

> *We analyze our stats to see how many people access the service and what helps Black clients recover. We've noticed that Black clients weren't attending as many*

sessions as their white counterparts. So we now offer extra sessions to our Black clients (...) All our staff are trained in culturally adapted therapy (Bi: 330-331)

Here, the introduction of additional sessions for Black clients might indicators that the standard model, in its usual form, may not provide enough time or support for them to engage with or benefit from therapy fully. This suggests that the established number of sessions or the default approach to therapy might be insufficient for addressing the specific challenges faced by Black clients. For Bindun, the need to adapt through more sessions and targeted staff training reveals that the existing system doesn't automatically serve all clients equally, prompting a rethinking of how the model is implemented for different populations. Bindun also reflected on *"westernised model", which* further highlights her point. She acknowledges,

As a therapist, I am very aware of how therapy is developed from a westernised model. For me, it's important to make therapy applicable, adapted, open, and validates Black people's experiences (Bi: 340)

Her recognition of the Western roots of the model highlights an important tension: while the foundational principles of therapy may be effective, they are rooted in cultural assumptions that do not necessarily resonate with or validate the experiences of non-Western clients. Bindun feels therapy needs to be "applicable" and "adapted" indicating that the existing framework, without these adjustments, might fail to connect with Black clients in meaningful ways. Her focus on validating clients' experiences suggests that the current model may risk overlooking or misunderstanding the cultural context from which these clients come, thereby limiting its effectiveness.

Shelly, a Community-Based Practitioner, offers a nuanced understanding of the model of care. Shelly points out that while CBT is beneficial for some, it does not meet the needs of all. She states,

Cognitive Behavioural Therapy, for some young people, is fine and it's helpful [but] for others, (…) they need something else, and that's why they would consider Growing Minds as an option for additional support (Sh:397)

Shelly recognises the limitations of CBT in addressing the complex mental health issues that Black young people face. For her, the model of care has to be flexible, acknowledging that a standardised approach like CBT, while useful, might not resonate with those whose experiences are deeply embedded in cultural and social contexts not fully addressed by this method. Further expanding on this, Shelly highlights the importance of referrals to Growing Minds, a culturally specific service, when mainstream services like IAPT fall short in addressing the needs of young Black people. She notes, *"That's why they would consider Growing Minds as an option for additional support."* This illustrates that the model of care Shelly now works within is fundamentally about providing alternatives tailored to the young people's cultural realities. The decision to refer to Growing Minds is based on the understanding that these young people may require a deeper, more culturally resonant approach than what is offered in a traditional CBT session. Shelly sees this as an essential component of the care model, ensuring that young people are not left to navigate a model that may not have fully accommodated their experiences. A central tenet of Shelly's making sense of the model of care is the role of cultural representation among practitioners. As she narrates,

> *The idea with this project was that all the practitioners were of African Caribbean heritage. The advantage they had was they were able to have a lived experience (...) The idea was for young people to see someone that looked like them and had a lived experience (Sh: 400).*

In Shelly's view, the model of care is most effective when the therapist shares a cultural background with the client, fostering a sense of trust and relatability. This shared identity allows the young person to feel understood not only in terms of their mental health needs but also in the context of their cultural experiences. For Shelly, this cultural alignment is not a superficial feature of the model but a core aspect that enables young people to engage more meaningfully with therapy. Shelly also emphasises that the model of care need to actively incorporate discussions about cultural identity from the outset. She explains,

> *In the beginning stages, we talk about our heritage as therapists and invite young people to talk about race, culture, and identity. We encourage those*

conversations about race, culture, and identity, and we share that ourselves as practitioners (Sh: 407)

This highlights that the therapeutic process is designed to be an open space where young people can bring their whole selves into the conversation. For Shelly, discussing identity is not just an optional part of therapy; it is integral to creating a therapeutic environment where the young person feels seen and validated. This approach, where identity is acknowledged and explored from the start, sets the tone for a model of care that is potentially holistic and deeply connected to the young person's lived experience.

For Mikey, another community-based practitioner, making sense of the model of care, first explained the remit of the service. He explains,

"The non-clinical service that we provide, for example, does not prescribe any medication. We don't work or support those with a clinical diagnosis because our support is at a very low level. It is community mental health/emotional support very much like that (Mi:345)

Mikey explained their services as low-level support, which he describes as essential for individuals who may be isolated or lacking someone to talk to about their mental health challenges. The model of care is centred on emotional support and empowering individuals by giving them a safe space to share their feelings. Mikey then offers an explanation of the model's tool kit:

We have recently adopted an assessment toolkit called the Recovery Star. It looks at eight or ten areas of someone's life. We do this assessment with the service user and have them give themselves a score between 1 and 10. We use that toolkit to assess where they need help, where they're strong, and then we just take it from there (Mi: 352)

For Mikey, the *"Recovery Star"* looks at all areas of the client's world, allowing the practitioner and service user to collaborate on identifying areas where support is needed. Mikey emphasises the collaborative nature as integral to the model of care, as it helps in setting goals and monitoring progress in a structured yet user-centred way. His

interpretation of their model of care also involves consistent and seemingly holistic engagement with individuals. He recounts,

> *We should continue in how we work – being empathetic, continuing to provide people with a space, a confidential space, and a relationship where they can build rapport with us as professionals (…) If you work with people, you need to put your pen and paper down. If you don't look at them, if you're not engaging them as people, then they will lose interest (Mi:355)*

He describes the model as one of *"regular contact,"* providing a listening ear and helping clients navigate their challenges by connecting them to community resources or peer support groups. By maintaining this ongoing contact, Mikey reinforces a support system that is non-judgmental and confidential, which is a core component of his care model. He further emphasises the importance of empathy and flexibility in how care is provided. He believes that working with people requires a less rigid approach, stating that *"you need to put your pen and paper down"* and truly engage clients as individuals. He indicates that the model helps foster a commitment to building rapport and ensuring that service users feel valued and heard, which he believes is vital for effective mental healthcare. In his view, utilising the assessment kit of the model of care enables it to be fluid and allows for adaptation based on the client's specific needs.

Summary of the Shared and Unique Features of Participants' Experiences

Practitioners highlight the reliance on structured, evidence-based practices like CBT, acknowledging their limitations for diverse populations, particularly Black youth. While cultural sensitivity is emphasised, the current NHS IAPT framework lacks full support. Efforts for cultural adaptations exist but remain supplementary. Clinicians advocate for greater flexibility and deeper integration of cultural considerations, such as race and identity, into therapeutic models.

In terms of the unique features of each participant, Uwase stresses the responsibility placed on therapists to adapt CBT within its boundaries, pointing out a lack of institutional support for culturally competent training. Robert reflects a similar tension but highlights the constraints of time and the rigid structure of IAPT protocols, advocating for more time to

explore cultural aspects with clients. Bindun, while recognising the effectiveness of existing models, insists on their adaptation to avoid a one-size-fits-all approach, implementing additional sessions and staff training to better serve Black clients. From a community-based perspective, Shelly emphasises the importance of cultural representation among therapists and advocates for culturally resonant alternatives like Growing Minds. Mikey focuses on non-clinical, community-centred emotional support, employing tools like the Recovery Star to assess clients' needs collaboratively, prioritising empathy and ongoing engagement over formal diagnostic models.

5.3.5. Main GET 1 Summary

The analysis of GET 1: THE MODEL ITSELF ISN'T MADE FOR DIVERSE PEOPLE reveals the inadequacy of IAPT CBT for young Ghanaian and Nigerian individuals due to its Eurocentric design. Participants highlighted structural limitations, emphasising unmet cultural needs. Sub-GET 1.1 captures dissatisfaction with inconsistent support, as young people feel neglected and dismissed. Sub-GET 1.2 examines client-therapist dynamics, highlighting the value of cultural sensitivity and the alienation caused by its perceived absence. Sub-GET 1.3 reflects practitioners' observations of low engagement among Black clients, especially men, due to cultural disconnection, stigma, and socioeconomic barriers. Sub-GET 1.4 critiques the rigid, Western-focused model, advocating for flexibility and culturally competent training. Insights highlight a disconnect between standardised care and Black youth's lived realities.

5.4. Main GET 2: I HAVE NOT HEARD OF THIS BEFORE

In Main **GET 1**, I highlight the experiences of young Ghanaians and Nigerians who are sufficiently aware to have had an encounter with the mental healthcare system, describing feeling forgotten, dismissed, and misunderstood in mental healthcare, citing a lack of cultural relevance. Despite these challenges, they acknowledged some available help, though it often felt inadequate. As such, I have used this Main **GET 2** to showcase how participants highlighted the pervasive lack of awareness of professional care for anxiety and depression in London, with three sub-GETs (Table 9)

5.4.1. Sub GET 2.1: It Is Something Not Acknowledged In My Community.

This Sub-GET highlights these young participants' awareness of care for anxiety and depression within their community. In examining the experiences shared by these individuals, I find myself struck by the pervasive lack of awareness around mental health, particularly the care for anxiety and depression within their communities. The contributing participants are young people: Ghanaian - **Adjua** (Ad)**, Akua** (Ak and **Kofi** (Ko) and Nigerians - **Chichi** (Ch)**, Daba** (Da) and **Edith** (Ed)**.**

Young People Perspectives

> *Yes, during that time, I didn't even understand what depression was. I couldn't comprehend how someone could be depressed. But it's different when you experience it yourself; then you realise that it's not about what you have or can do (Ko: 132). Kofi: No, depression isn't commonly discussed in my family. We're often taught to be brave and hide our emotions, but everyone experiences emotions. We're conditioned to suppress our feelings and just carry on (Ko: 131-132)*

Kofi's initial understanding of mental health issues, particularly depression, was minimal and shaped largely by a lack of prior experience or discussion. He found it difficult to comprehend depression, viewing it as something distant and almost irrelevant to his life. His family culture, which emphasised emotional suppression and resilience, further limited his awareness. The idea that emotions should be hidden and one should simply *"carry on"* meant that mental health struggles like depression were not openly acknowledged, leaving Kofi unaware of the significance or reality of these issues until he personally encountered them. His understanding only deepened once he experienced depression himself, marking a shift from ignorance to a more personal and nuanced awareness.

> *Yeah, it took me like three months to decide to go to therapy. At first, I said I didn't need therapy. Like, what's a therapist going to do for me, you know? (Ko: 136)*

Interviwer: "Have you heard of Improving Access to Psychological Therapy (IAPT), Now NHS Talking Therapy?".

Kofi: No (Ko: 124)

Similarly, Kofi's awareness of care for anxiety and depression was equally limited. Initially, he was sceptical about seeking help, questioning the value of therapy and doubting its potential benefits. This scepticism, combined with unfamiliarity with therapeutic services like IAPT, delayed his decision to seek support. His slow journey toward accepting therapy reflects a broader lack of exposure to or discussion about mental healthcare within his community. Over time, however, Kofi came to recognise the importance of these services, but this awareness emerged gradually, shaped more by his personal struggle than by any prior knowledge or guidance on how to access care.

Similarly, Adjua articulates a broader cultural reluctance to acknowledge mental health issues, noting that in African households, *"it's just not something you talk about" (Ad: 21).* She emphasises,

"I think it's something that is not acknowledged in our community. I think it affects a lot of young people (…). Maybe they're not aware, but that's what they're going through (…). Yeah I've experienced depression and anxiety. I'd say a number of times in my life, maybe twice (...) In terms of services, I have looked into the NHS talking therapy services waiting list, but I didn't end up using them" (Adjua: 2)

Adjua expresses a sense of frustration and concern about the lack of awareness surrounding mental health issues in her community. She seems to feel that many young people are unknowingly affected by anxiety and depression, yet this struggle remains unacknowledged, leaving them without the language or understanding to identify what they are experiencing. Her words convey a sense of isolation in her own journey with depression and anxiety, suggesting that this lack of awareness creates a barrier to recognising the significance of these feelings. When she mentions looking into services but not using them, there is an underlying ambivalence or hesitation, as if the unfamiliarity with available care contributes

to a reluctance to engage fully with it. Her feelings reflect a deep sense of disconnection between her internal experiences and the external support that could potentially help.

For Akua, she attributed her unawareness of care for depression to the fact that she is relatively new in the UK. She states,

> *I'm sure those who are already here know there's [dedicated care for anxiety and depression], but (…) no one told me. I am like some people who can really hide their depression. So you do not even know there's something wrong with them (Akua: 35).*

Akua's reflection highlights the hidden and isolated nature of mental health struggles, particularly in communities where stigma and silence surround issues like anxiety and depression. Her comment that "no one told me" points to a possible lack of accessible information about mental healthcare in the UK and also back home in Ghana, particularly anxiety and depression. By saying she can "really hide" her depression, Akua emphasises the invisible burden she can carry, where societal pressures to appear strong may lead to the internalisation of her struggles..

Chichi and Daba both highlight the impact of cultural beliefs' strong relationship with mental health and its care awareness. Chichi points out the taboo nature of discussing depression within the Black community, where one is often told *"to pray about it".*

> *You won't find many people going to seek psychiatric help (…) especially in the black community because many of us come from religious backgrounds where it's seen as like a taboo to have depression you're told to pray about it (Chichi: 48)*

This suggests that in her community, depression is either misunderstood or not recognised at all, with no space for open conversations or awareness about mental healthcare. For Chichi, the absence of this acknowledgement leaves those struggling with anxiety or depression without the support they need.

Daba expresses a profound sense of detachment when recounting on the lack of awareness around mental health issues. He admits, "I don't really talk about it" (Da: 58), conveying a feeling of isolation regarding his struggles with depression and anxiety. This opaqueness

concerning mental health issues, particularly within his family, creates a barrier to understanding his emotional experiences. His statement, "I feel like I just learned to shrug it off if that makes sense" (Da: 58), suggests a resignation to handling these issues alone, shaped by the absence of mental health discourse in his environment. For Daba, the lack of awareness is not merely about ignorance but a feeling of disconnection from the services available to help. He appeals passionately to the UK Government, saying:

> *The UK government. I'll just say to make the service more prominent. Just the lack of healthcare system to make it more available to us. Just find ways that they can advertise more, just to make it more prominent that it is available to us (Daba: 62).*

Daba makes sense of this gap as a profound disconnect between himself and the healthcare system, where services designed to provide support seem distant and inaccessible. He expresses frustration at the invisibility of these services, suggesting they are not sufficiently advertised or made prominent enough to feel like a viable option for those in need. This reflects a deeper sense of exclusion, where existing support is out of reach or shrouded, leaving him to navigate mental health challenges with little external guidance. Daba's emphasis on the need for greater visibility reveals a desire for a system that offers care and actively engages and communicates with individuals like him, bridging the gap between knowing help is there and feeling empowered to access it.

Edith's reflections on her experience with depression also reveal a deep sense of disconnection from both herself and her environment. Edith statement,

> *looking back on it, I was probably very depressed, but I don't think I knew what depression was then (Ed: 70)*

> *I know that a lot of young people when they feel depressed they take their life or something like that. So maybe if they knew that the way they're feeling is not out of the ordinary, then they know where to go to or who to turn to (…) Maybe like adding mental health modules or something like that into schools. So that young people are aware. So they're aware that their feeling is not out of the ordinary and it's okay to feel this way and where to go (Ed: 80)*

First, she noted the absence of personal insight into her emotional state. The use of "probably" suggests uncertainty, even in hindsight, about what she was experiencing, which reflects the void created by the lack of awareness of mental health issues. For Edith, depression was not a concept she had access to at the time, making her emotional turmoil feel ambiguous and unnamable. This points to a significant gap between her lived experiences of emotional distress and the tools or knowledge required to interpret them. Edith's inability to identify depression during her struggle left her without the language or framework to seek help, encapsulating a broader cultural or social silence around mental health that isolates her during her pain.

As Edith continues to reflect, she moves from personal experience to a more collective observation about young people in general, suggesting that the consequences of this lack of awareness can be dire, as illustrated by her comment on suicide: "when they feel depressed, they take their life or something like that." For Edith, awareness is not just about recognising depression but about offering a framework for understanding that *"the way they're feeling is not out of the ordinary."* This conveys her belief that knowledge normalises emotions that otherwise seem alien or overwhelming, and this normalisation is key to guiding young people towards seeking help. Edith's proposal to introduce mental health modules in schools represents her desire to transform this awareness gap into proactive education, equipping young people with the tools to interpret their emotions and, crucially, know *"where to go to or who to turn to."* For Edith, the meaning she attaches to this lack of awareness is one of danger—a life-or-death scenario for some—further emphasising her conviction that early intervention through education can be life-saving. Edith's message here is clear: awareness equals validation, and validation opens the door to accessible care.

Summary of the Shared and Unique Features of Participants' Experiences

Participants commonly highlight a lack of mental health awareness, especially about anxiety and depression. Therapy is often met with scepticism or is poorly accessible, leaving needs unmet. This invisibility of services exacerbates isolation and widens the gap between individuals and care.

Each practitioner offers perceived distinctive perspectives. Kofi's experience reflects how his personal encounter with depression shifted his understanding, as his family culture emphasised emotional suppression. Adjua discusses the isolation of experiencing depression and anxiety compounded by the unawareness of available care in a community that does not openly acknowledge these issues. Akua, being new to the UK, highlights how the invisibility of mental health services compounds the challenge of navigating care. Chichi emphasises the cultural taboo of seeking mental health help in religious communities, while Daba discusses the inaccessibility of services, appealing for more prominent mental healthcare visibility. Edith highlights the importance of awareness, suggesting that educating young people in schools could help normalise their emotional experiences and guide them toward available support.

Sub GET 2.2: Approaches To Improving Access: "Take Our Interventions To Them"

Having seen the pervasive lack of awareness of professional care for anxiety and depression among these youths, I used Sub-GET 2.2 to examine how practitioners perceive their roles and the efforts of their practices/institutions in improving awareness and access to care within this minoritised demographic. The contributing participants are the NHS IAPT practitioners **Bindun** (Bi), **Robert** (Ro) and **Uwase** (Uw) and the Community-based practitioners **Mikey** (Mi) and **Shelly** (Sh).

Practitioners Perspectives

Uwase, an NHS IAPT practitioner, reflects on her concern and insight into how her service's initiatives, though well-intentioned, fall short of effectively engaging Black communities. Her words express a recognition of the gaps between effort and impact.

> *The service definitely has initiatives going (...) to try to engage different communities. But honestly, I don't think enough time is given for those initiatives (Uw: 430). We need to engage more communities and actually take our interventions to them, as opposed to trying to get them to come to us (p438). When they go onto our website, actually addressing stigma, addressing myths in mental health quite immediately could be helpful (Uw: 437)*

Uwase acknowledges that there are active efforts within the service to engage Black communities, but she feels that these efforts are inadequate due to a lack of sustained focus and time. The phrase *"the service definitely has initiatives going"* shows that she sees these efforts as a step in the right direction, indicating that the service is aware of the need for community engagement. However, she also acknowledged, *"But honestly, I don't think enough time is given for those initiatives,"* revealing her frustration with the limited resources and attention devoted to these initiatives. To her, the issue isn't the absence of initiatives but rather the lack of dedication and consistency in following through. There is an implication that these efforts are seen as peripheral rather than core elements of the service's strategy, resulting in initiatives that don't fully reach their potential. Uwase's tone suggests that while the service is trying, these efforts may feel tokenistic or underdeveloped without the necessary investment of time and energy to drive real change. Uwase shifts from discussing the internal shortcomings of the service to proposing a solution rooted in proactive outreach. She is advocating for a fundamental change in how the service operates, emphasising the need for the service to meet Black communities where they are, both literally and figuratively. The use of the word *"actually"* in *"actually take our interventions to them"* conveys a sense of urgency and action, suggesting that she sees this approach as not only preferable but necessary. It reflects her understanding that many Black young people may not seek out mental health services on their own due to cultural stigma, mistrust, or lack of awareness. Her proposal is grounded in the recognition that waiting for these individuals to come forward often results in their needs being unmet. Uwase believes that a more active, community-based approach—where services are brought directly to people in their environments—would break down barriers to access. This reflects a shift from passive service delivery to one that is dynamic, responsive, and embedded within the communities it seeks to serve.

Uwase also points to another critical aspect of improving access—confronting stigma and misinformation directly at the very first point of contact. By suggesting that the service's website need to *"immediately"* address stigma and mental health myths, she highlights the importance of creating a welcoming and informative first impression. She understands that many Black young people and their families may arrive with preconceptions or fears about

mental health services shaped by cultural narratives that often stigmatise mental health issues. For Uwase, addressing these concerns upfront would not only reduce hesitancy but also make it clear that the service understands and is responsive to the unique challenges faced by Black communities. The phrase *“quite immediately”* highlights her belief that this is not something that can wait to be tackled later in the therapeutic process but needs to be addressed right away to ensure that individuals feel safe and understood from the outset.

Bindun, another NHS IAPT practitioner, also reflects on her service approach to improving access for Black young people. Bindun reflected in her service-specific actions:

> *We participate in events like the big county show in [the Borough], distribute leaflets, and do outreach work. We inform GPs and other services that we have Black and Asian therapists who can provide culturally adapted therapy. We link with partner organisations like [the Borough] and Black Thrive (Bi: 325).*

This demonstrates her service’s active efforts to engage with the local community. Bindun’s words, *"We inform GPs and other services that we have Black and Asian therapists who can provide culturally adapted therapy,"* highlight their focus on ensuring that the right information reaches both health professionals and potential clients. Her services’ collaboration with local organizations, such as *“Black Thrive”* emphasises a concerted effort to connect with community-based groups that already have relationships with the target population. Bindun acknowledges the practical barriers that clients face,

> *Sometimes there's been lots of practical logistics around how we can still offer you support (...) Are there any schemes or initiatives where we can get you access to travel or support or finances, any charities that I can link you in with to still be able to offer you support? (Bi: 307)*

Bindun reflects on her service’ proactive approach to ensuring that external, non-therapeutic factors do not prevent Black young people from attending sessions. Her concern about practical logistics shows that her services’ are attuned to the everyday realities that can make therapy inaccessible. She identifies the need for adaptability, saying, *"Offering more flexibility around attendance and additional sessions for Black clients would be really helpful because what Black clients come with is so layered" (Bi: 334).* Her words reveal her

institution’s awareness of the complexity of the issues her clients bring to therapy and their belief that rigid, standardised therapeutic models may not fully serve them. Her suggestion for "additional sessions" reflects her understanding that more time may be required to adequately address these layers. Bindun touched on other nuances, saying,

> *We ensure that the examples used in therapy are relatable, considering the client's religion, community, and values. We discuss systemic racism and validate people's experiences. Culturally adapted therapy should be at the forefront of any therapeutic interventions (Bi: 331)*

Bindun practice’s commitment to culturally adapted therapy is evident when she says, *"We ensure that the examples used in therapy are relatable, "* showing that personalisation is key to her practice. She goes further to explain, *"We discuss systemic racism and validate people's experiences,"* showing their approach is not only practical but also potentially ensitive to the emotional and psychological realities of her clients' lives. Bindun also highlights the importance of self-referral and representation, stating, *"Self-referral is our main source. Our clients can self-refer via our website or by calling us" (Bi: 333)*. This makes access more direct and less reliant on external referrals. Moreover, her emphasis on representation is clear: *"It's important for the Black community to see themselves represented in the place they're seeking support" (Bi: 333),* reinforcing her understanding that having Black therapists available would help build trust and encourage engagement.

Robert, another NHS IAPT practitioner, made sense of his service approach by first focusing on cultural sensitivity as a key element in improving access for young Black people. Robert highlights how the service in SouthEast London deliberately works to adapt its protocols, noting,

> *In SouthEast London in particular (...) there’s a huge push to make the protocols sensitive to BAME clients (...) about race and culture, how might that change the protocol, or how might you adapt the protocol (...) to better align with someone from a different background (Ro: 367-368)*

This reflects his understanding that mental healthcare cannot be a one-size-fits-all solution, especially when it comes to treating Black clients. Continuously integrating race and culture

questions into the treatment process is not just about model adaptability. Instead, Robert sees the potential for more meaningful and personalised care that would resonate with the client's lived experience and would invariably enhance accessibility. With this approach, he also acknowledges the challenge of keeping Black clients engaged in therapy, reflecting on the service's efforts to reduce dropout rates.

> *We found that other ethnic groups are more likely to drop out of treatment sessions (...) So we wanted to run an audit on why that is and just improve that in general (Ro: 383-384)*

For Robert, addressing this issue is crucial. He recognises that the success of mental health services does not just lie in providing access but in ensuring sustained engagement. His reflection on the audit points to a methodical approach, where the service actively seeks to understand and resolve the barriers that might cause Black clients to disengage from treatment. This systematic evaluation is part of his broader commitment to making therapy more effective for this demographic in his service' and Borough. Moreover, Robert makes sense of the importance of outreach in improving access, particularly through targeted advertising aimed at Black communities. He explains,

> *We've recently done more tube adverts and bus stop adverts (...) Ethnic minorities were more likely to use bus transport and the tube. So we started advertising more at bus stops (Ro: 385)*

For Robert, expanding the visibility of mental health services through such advertising strategies is essential to reaching Black young people where they are. He sees this as a direct response to the realities of how these communities navigate the city, ensuring that the service is accessible and familiar in the everyday spaces they occupy. In each of these reflections, Robert's understanding of his practice is rooted in a commitment to adapting services to the cultural and social realities of Black clients, ensuring that access is not just about availability but about meaningful engagement that respects and incorporates the unique experiences of Black young people.

Mikey, a community-based practitioner's service, is focused on providing consistent support and empowerment for Black young people, particularly those who are socially isolated and lack a safe space to express their feelings. He explains,

> *It's very much like, for instance, I would call them on a regular basis. I go about trying to empower them, trying to encourage them, giving them a safe space to talk because a lot of these people are socially isolated and don't have anyone to talk to about how they're feeling (Mi: 347)*

His service is designed around regular contact, offering not just a listening ear, but also connecting clients with local organisations and activities to reduce isolation. This approach ensures that clients are not left to navigate their struggles alone but are supported in a way that fosters ongoing empowerment. In addition to this direct support, Mikey's service actively addresses the cultural stigmas surrounding mental health within Ghanaian and Nigerian communities and aims to improve access to care. Mikey states,

> *As an African, generally speaking, even with my Nigerian friends and the people I know, it's something which is improving [distimatising mental health discourses]. But when I say it's improving, I'm only referring to the mindset that we share in the West. We live in a day and age where, especially my generation, we are taking the lead on the importance of this topic. We're trying to break barriers and the negative perceptions that mental health within the Nigerian and Ghanaian communities have had (Mi:.349).*

Mikey reflects, *"We're trying to break barriers and the negative perceptions that mental health within the Nigerian and Ghanaian communities have had."* It suggests that the service acknowledges the generational divide in attitudes toward mental health, particularly in immigrant communities, and positions itself as part of a movement to reshape these perceptions. Mikey's service is leading this shift by creating a space where mental health is normalised and discussed openly, helping to break down long-standing stigmas that often prevent Black young people from accessing care. Mikey's practice is also distinguished by its emphasis on fluidity and empathy. He explains

> *We should continue in how we work being empathetic, continuing to provide people with a space, a confidential space, and a relationship where they can build rapport with us as professionals. I think we should continue working in a fluid way (Mi: 355)*

Mikey feels his service prioritises a flexible, person-centred approach, where the relationship between the practitioner and client is key. Rather than adhering to rigid protocols, his service adapts to the needs of each individual, ensuring that care is provided in a way that is sensitive to both their emotional state and cultural background. By fostering an empathetic, fluid, and non-judgmental environment, Mikey feels his service creates a space where Black young people feel comfortable seeking and receiving the support they need. One of the key strategies Mikey suggests to increase accessibility further is to engage with the community in familiar and trusted spaces. He suggests,

> *Maybe I would want and appreciate it if they would engage communities or circles or places where Ghanaians and Nigerians often go to, for example, church, the barber shop... The approach should be very intentional, deliberate." (Mi: 354)*

His service recognises that to truly improve access, mental health support needs to meet people where they already are. This is related to Uwase's idea of the NHS IAPT practitioner. For Mikey, by focusing on these community hubs, his organisation's service would not only increase visibility but also might be able to improve trust-building, creating a more accessible and less intimidating pathway to mental healthcare.

Shelly, the other community-based practitioner, reflects on her organisation's commitment to improving access to mental health services for young Black people, particularly those of African and Caribbean heritage. Central to their approach is the recognition that cultural representation and lived experience, engagement with culture and identity and tailoring therapy to client needs are critical in making mental healthcare accessible. Shelly narrates,

> *The idea with this project was that all the practitioners were of African Caribbean heritage (...) The idea was then for young people to see someone that looked like them and had a lived experience." (Sh: 400)*

> *In the beginning stages, we talk about our heritage as therapists and invite young people to talk about race, culture, and identity (...) We encourage those conversations about race, culture, and identity (…) For some young people, counselling is something they have been encouraged to engage with. There may be mistrust or fear around mental health services (...) We are looking into developing a more community-oriented project where community ACH (African Caribbean Heritage) people would be around (Sh: 407)*

Shelly explains that the project was deliberately designed with practitioners from African and Caribbean backgrounds to ensure that young people could see *"someone that looked like them and had a lived experience."* This intentional representation offers more than just familiarity. It thus establishes a sense of trust and relatability, which can dismantle initial engagement barriers. Shelly's belief is that when young people encounter therapists who reflect their heritage, the therapeutic space becomes less foreign and more welcoming, which could minimise access barriers. Her emphasis on engagement with culture and identity as a foundational element of the therapeutic relationship is another critical approach. Shelly notes, *"In the beginning stages, we talk about our heritage as therapists and invite young people to talk about race, culture, and identity."* It seems to me that this is not just a surface-level acknowledgement of cultural differences but a deliberate strategy to normalise discussions about identity, race, and culture within therapy to foster access. Shelly also demonstrates a thoughtful tailoring of therapy to client needs by recognising that traditional counselling methods may not be sufficient for all young people. She acknowledges that *"for some young people, counselling is something they have been encouraged to engage with,"* but that *"there may be mistrust or fear around mental health services."* To address this, Shelly makes sense of how her team is working toward a *"community-oriented project"* where young people can receive care in familiar spaces surrounded by people from African Caribbean Heritage backgrounds. I am cautious to say that the shelly organisation's approach respects the fact that Black young people may be hesitant to engage in clinical settings that feel disconnected from their communities. Shelly's sensitivity to these concerns reflects an awareness that mental healthcare needs to be

flexibly accessible. In terms of providing access through alternative therapy models and challenges and barriers. Shelly reflects.

> *I've found that with the 11 to 16-year-olds, creative art therapy is a model they engage with more (...) Instead of sitting and talking to someone, they use art therapy and art materials (Sh: 401).*
>
> *Religion plays a part in young people coming over from Ghana or Nigeria and adjusting to the culture in England (...) It can be challenging for a lot of young people to access services (Sh: 411)*

Shelly's excerpt highlights the success of creative art therapy as a way to reach younger clients. She notes that *"with the 11 to 16-year-olds, creative art therapy is a model they engage with more,"* contrasting this with the discomfort some may feel in traditional talk therapy settings. By offering art therapy, Shelly's service provides a non-verbal, expressive form of engagement that resonates more deeply with young clients. This is a crucial adaptation, as it acknowledges that not all young people will feel comfortable or able to articulate their emotions in words, particularly in environments where mental health discourse may not be normalised. However, Shelly is also keenly aware of the challenges and barriers that complicate access to mental health services for Black young people. She observes that *"religion plays a part in young people coming over from Ghana or Nigeria and adjusting to the culture in England."* This speaks to the complex interplay of cultural and religious values, which can sometimes discourage engagement with mental health services. Shelly's understanding of these barriers is nuanced; she does not view them as mere obstacles but as essential considerations in shaping her approach to access. Her work involves navigating these cultural tensions, acknowledging that religion and family expectations can be both sources of support and sources of pressure for young people. Shelly is reflective about supporting long-term engagement in a way that acknowledges the realities of fast-paced services to improve access. She notes that *"if people don't engage at first, there might be a variety of reasons why,"* but laments the lack of capacity to follow up with young people who initially disengage. This speaks to her desire to provide more sustained support, ensuring that young people have the opportunity to return to services

when they are ready. Her suggestion of revisiting clients who may have struggled to engage reflects a patient-centred, flexible approach to care, which prioritises the long-term well-being of her clients rather than simply the number of sessions completed.

Summary of the Shared and Unique Features of Participants' Experiences

Practitioners emphasise culturally sensitive care, addressing stigma and mistrust, and enhancing accessibility through outreach, local collaborations, and representation. Community engagement via events and familiar spaces is pivotal in overcoming barriers.

Distinct features emerge in how each practitioner or service adapts their approach. For example, Uwase focuses on taking services to the community advocating for proactive outreach to break down barriers, while Bindun emphasises practical logistical support, such as offering travel or financial assistance to ensure clients can attend therapy. Robert highlights the adaptation of clinical protocols to be more culturally relevant, noting efforts to audit dropout rates and improve sustained engagement. Mikey, working in the community sector, focuses on offering regular, consistent contact to socially isolated young people, while Shelly emphasises creative therapies, such as art therapy, particularly for younger clients, and acknowledges the challenges posed by cultural and religious values from immigrant backgrounds. These distinct approaches reflect the diverse strategies each practitioner adopts to meet the needs of the Black communities they serve.

5.4.3. Sub-GET 2.3: Family Expectation And Intergenerational Dynamics: "Stay Strong"

This Sub-GET explores participants' experiences in navigating their family expectations and intergenerational dynamics within their Ghanaian and Nigerian households regarding the care for anxiety and depression. The contributing participants are a young Ghanaian, **Efia** (Ef), seven young Nigerians, **Agnes** (Ag), **Chichi** (Ch), **Daba** (Da), **Edith** (Ed), **Ese** (Es), **Nkiru** (Nk), and **Osas** (Os), and two Nigerian mothers, **Kemi** (Ke) and **Kudi** (Ku).

Young People Perspectives

> *I report to the headmistress and my parents (…) "My parents, they try and like (…) want me to stay strong. To do something about it, but the headmistress comes back to me or the headmaster comes back to me and just says deal with it (Ag: 19).*

For Agnes, during her interview, she mentioned a few times how her parents wanted her to stay strong. She reveals a palpable tension between her emotional experience and her family's expectations. Agnes seems pressured to embody resilience, as the phrase *"stay strong"* may reflect her parents' belief in emotional fortitude as a key value. This expectation likely leaves her feeling isolated, as it places the responsibility on her to navigate painful experiences like racism and bullying on her own. The instruction *"to do something about it"* might imply an emphasis on personal agency, reinforcing that her parents expect her to resolve these issues herself and to persist in complaining to the school's authority. Agnes' emotional frustration and perhaps a sense of being overwhelmed emerge in contrast to these expectations, especially as she encounters a lack of support from school authorities. Her parents' desire for her to be strong may inadvertently exacerbate her feelings of helplessness as she faces the reality that strength alone is not enough to combat systemic challenges. Agnes reveals how these familial expectations create a complex emotional landscape where her need for support clashes with the pressure to remain resilient.

Also, Chichi seems to carry the weight of academic expectations imposed by her family. She recounts,

> *"While I was stressing I felt like there were many things in my uni module I didn't know. I felt like the pressure of my family members telling me that I couldn't leave uni and I had to finish uni even while I was stressed added to it." (Ch: 43)*

Chichi's experience reveals the profound pressure she feels from her family's academic expectations, which compounds her stress. Her words suggest a sense of being trapped between her own struggles and the unyielding expectations of her family, who emphasise that leaving university is not an option. The weight of these expectations seems to magnify her feelings of inadequacy as she grapples with not fully understanding aspects of her

university coursework. For Chichi, even amid her evident distress, the relentless family insistence on academic success adds to her burden. I sense the struggle in balancing these expectations with her mental health, especially within the context of an African household where academic success is often paramount and prioritised. Chichi captured the essence of her African background in her own words.

> *Coming from an African background, we hear a lot of times but you have to do your best. You have to get the highest grades, so not being able to achieve those things that you are being pressured to achieve also plays a major part (Ch: 51).*

Chichi's voice reveals a deep sense of internal conflict and pressure stemming from her family's high expectations, which she connects to her African background. The repeated emphasis on *"you have to do your best"* and *"get the highest grades"* creates a rigid standard that leaves little room for vulnerability or failure. Not meeting these expectations intensifies her feelings of inadequacy, contributing significantly to her depression. The weight of these familial pressures seems overwhelming, as Chichi equates her academic struggles with personal failure, making it hard for her to separate her self-worth from her performance. Chichi's fear of not meeting these expectations causes not only disappointment for her and her family but also leads to considerable emotional and psychological distress.

Efia speaks to the fear of disappointing her parents, who have made sacrifices for her:

> *I'm the first child, and my parents have worked hard to get me into this country. I'm really scared of disappointing everyone who worked so hard to bring me here (Ef: 101).*

Efia's words reveal the intense pressure she feels to live up to the expectations of her family, who have made significant sacrifices to bring her to the UK. Her status as the first child amplifies this responsibility, as she feels a deep obligation to succeed not just for herself but as a reflection of her parents' efforts and dreams. I feel her fears of failure are intertwined with a sense of guilt and anxiety as she carries the weight of their hard work on her shoulders. Her statement, *"I'm really scared of disappointing everyone,"* possibly highlights how the cultural value of 'staying strong' in the face of adversity is linked to familial duty and

the expectation to honour sacrifices made by her parent. She brought another dimension to the interview. Efia recounts,

> *African parents should be more open-minded about discussing mental health because when they hear about mental health, they think you're going crazy (p92). We are so tied to superstitions and religion. As a Christian, I don't believe God thinks you're crazy for going through this (Ef: 93)*

For Efia, it reveals the generational rigidity she faces, where mental health issues are immediately dismissed or misunderstood as signs of going *"crazy."* This immediate leap to extreme conclusions creates an environment where mental health is not just stigmatised but is treated as something taboo or unspeakable within her family, earlier touched on by Chichi. Efia's plea for more open-mindedness emphasises her desire for her parents to move beyond this narrow perspective, but she also acknowledges the weight of deeply embedded cultural beliefs when she says, *"We are so tied to superstitions and religion."* These words suggest that the problem isn't just about her parents' attitudes but a larger web of generational beliefs that they are caught within. Despite this, Efia, rooted in her own Christian faith, differentiates her beliefs from theirs, saying, *"I don't believe God thinks you're crazy for going through this."* Her expression challenges the misapplication of religion she sees in her family and community, where faith is used as a reason to dismiss or invalidate mental health struggles. Through her words, we can sense Efia's internal conflict between her own faith and the rigid views held by her parents, calling for a shift not just in mindset but in how religion, mental health, and family expectations can coexist.

Edith brought in intergenerational dynamics. As I make sense of listening to Edith, I hear a clear distinction between her generation's approach to mental health and that of her parents. She recounts,

> *I don't think it's talked about. I feel like in my generation, it's more talked about, and we're more aware that anyone can have depression [and] anyone can have anxiety (Edi: 75)*

Edith's reflection on generational differences highlights her perception that mental health issues like depression and anxiety are more openly acknowledged in her generation than in

her parents' generation. Growing up in a Nigerian household in the UK, Edith feels that her parents, especially her mother, have started to become more aware of mental health issues, possibly due to her mother's work background. The clash between the two generations stems from differing cultural understandings of mental health, where her parents may see depression as sadness rather than a condition that requires attention. For Edith, this dynamic adds to her sense of isolation as she navigates both cultural and generational barriers while attempting to process her emotions within an environment that traditionally avoids discussing mental health openly.

Nkiru further echoes this generational gap,

> *The way my parents see mental health is slightly different from mine. Going through my struggles with my mental health (…) has opened my parents' eyes (Nk:.149).*

Nkiru's feelings reflect the tension between traditional family expectations and the evolving understanding of mental health across generations within her family. Her statement suggests that her parents held a more limited or stigmatised view of mental health, possibly shaped by cultural norms and generational values. Nkiru's personal struggles with mental health as recounts acted as a catalyst for shifting these perceptions, highlighting the intergenerational disconnect between her experiences and her parents' views. By navigating her mental health challenges, she has not only broadened her own perspective but also prompted her parents to reconsider and expand their understanding.

Ese adds another layer to this dynamic by highlighting the impact of geography and culture:

> *My dad lives in Nigeria, so I don't think he has a greater awareness of that. To be frank, I don't think these conversations are being had as much in his generation in Nigeria as with my mom, who is in the same generation but here. So that's more than just a generational divide but also kind of geographical and cultural combined (Ese: 119).*

Ese's reflection brings out the complexity of family expectations by pointing to how geographical and cultural contexts can shape intergenerational dynamics. Ese reflects on

how her father's perspective, rooted in Nigeria's context, seems less informed about the emotional struggles she may face, contrasting with her mother's, who, living in the UK, has more exposure to mental health conversations. Ese identifies not just a generational gap but also a geographical and cultural one, suggesting that the 'stay strong' mentality varies depending on where family members are situated and the cultural norms they adhere to. For Ese, this divide influences how expectations are communicated and understood within her family, revealing a layered tension between tradition and the evolving realities of her experience.

Osas reflects on a different dimension,

> *I would say Nigerian parents downplay depression and anxiety a lot, and that could be due to their own childhood experiences because they haven't really received any type of love from when they're going through things like that, so they don't really know how to (...) tap into it with their own children." (Osas: 168)*

Osas sees generational disconnect, emphasizing how Nigerian parents often *"downplay depression and anxiety"* due to their own emotionally distant childhoods. She alluded that these parents, having *"not received any type of love"* during their own struggles, are unable to *"tap into"* their children's emotional needs. She implies that this inability to provide support stems from a lack of experience with nurturing or addressing emotional pain, creating a significant barrier. For Osas, this means that parents, conditioned by their own upbringing, fail to engage with their children's mental health struggles, leaving the children feeling emotionally unsupported and misunderstood.

Daba's narrative shows the recurring theme of a lack of being misunderstood and communication between generations. Daba reflects,

> *My parents' generation (…) I feel like they're just not informed about it, so because they're not informed about it, it's hard for them to understand where you're coming from.(…) That's why a lot of the times not just with me, my generation, they are misunderstood because of that. Their generation just fails to understand, and that's why we don't communicate (Da: 66)*

For Daba, the persistent gap in understanding between his generation and that of his parents usually leads to a breakdown in communication. He observes that his generation is often *"misunderstood"* because their parents *"fail to understand,"* creating a sense of frustration and alienation. For Daba, this failure of understanding is not isolated to him alone but is a shared experience among his peers. This suggests a widespread issue within the dynamics of family expectations. The inability of the older generation to grasp the experiences and emotions of the younger generation silences open dialogue, leaving Daba and others feeling unheard and unable to express their struggles. In other words, I sense in his words a deep frustration with the generational disconnect, which seems to prevent meaningful dialogue about important issues like mental health.

Efia also captures this sentiment when she says,

> *"With my dad, I can't really say 'Hey, this is how I feel. I'm not okay right now'" (Ef: 92).*

In Efia's words, she expresses a sense of emotional restraint and the inability to communicate her true feelings to her father. This reflects the pressure of family expectations, where she may feel obliged to maintain a facade of being *"okay"* rather than burdening her father with her struggles. It, thus, suggests a generational divide, where her father's approach to emotions or mental health may differ from hers, making it difficult for her to open up. The phrase conveys a deep sense of isolation and the weight of unspoken expectations within her family.

Despite these challenges, I notice moments of hope and connection. For example, Edith recalls a time when her mother took a proactive step to address one of her sisters' possible depressive symptoms, *“she did sit everyone down and talk to [us] about it" (Ed: 79).* I see this as a significant moment of support that, while rare, shows the potential for understanding and change. Similarly, Nkiru mentions that her struggles have *"opened my parents' eyes.*" As already discussed above, Nkiru's experience reveals a shift in the intergenerational dynamic within her family, as her personal struggles with mental and physical health have *"opened [her] parents' eyes"* to issues they previously did not fully understand. She acknowledges that there is a difference in how her parents perceive mental health compared to her own

views, but her challenges have prompted a change in their perspective. Nkiru's journey illustrates how her parents/family expectations may have evolved through lived experience, as her parents, initially holding a more limited understanding of mental health, begin to recognise its significance because of her struggles. This shift, though subtle yet important, is a transformation in the way her parents engage with and support her, bridging some of the generational divide. This suggests to me that, even in the face of deeply ingrained cultural beliefs, there is room for growth and learning.

As I make sense of these young participants' narratives, I observe significant tension between first-generation migrant parents and their second-generation children. The expectations placed on the younger generation and the evolving understanding of mental health among parents create a noticeable strain. This tension is further complicated by cultural, religious, and generational differences, leading to a disconnect that hinders communication and mutual understanding within families. It is clear how important it is to address these gaps in order to foster healthier relationships and improve mental health outcomes in these communities.

Parent's Perspectives

Kemi, a Nigerian mother, reflects deep emotional turmoil regarding her inability to meet family expectations about not being able to support her daughter's dreams of becoming a doctor. The feelings of guilt and regret characterise her account. Kemi recounts,

> *I could not support her to be (…) what I wanted her to be or what she was driving towards. Because if a child tells you, "I want to be a medical doctor," you will play your part in that child's life, isn't it? But I wasn't able to focus on her (…) That thing is really hurting me (Ke: 230 & 235).*

Her phrases like *"I could not support her"* and *"That thing is really hurting me"* convey a deep sense of guilt and failure. Kemi's cultural framework appears to emphasise a parent's responsibility to actively guide and nurture their child's ambitions. Her words, *"You will play your part in that child's life, isn't it?"* highlight her internalised expectation that as a mother, it was her duty to ensure her daughter's success. Her inability to do so, due to various personal and circumstantial barriers, led to an internal conflict and pain that lingered with

her. The several repetitions in our discussion, *"I wasn't able to focus on her"* further highlight her deep sense of helplessness and perceived missed opportunity. For me, the meaning embedded in this statement is not just about practical support but also emotional and psychological investment in her daughter's life. It reveals a feeling of inadequacy, where Kemi measures her worth as a mother against her ability to meet these cultural expectations of parental involvement in her child's education and future.

Kemi's reflection on her daughter's depression and the delayed communication adds a layer of complexity to her emotional experience. Kemi reflects

> *I don't know about [her] depression (….) She never told me on time. (…) Only she knew what she was actually going through. By the time she told me, she had made up her mind that (…) she wanted to (…) stay away from school for some time (Ke: 208).*

Her words, *"She never told me on time"* suggest a gap in understanding and communication between generations, where the daughter kept her struggles hidden for a period of time. This may reflect a broader dynamic in which younger generations might not feel comfortable sharing their mental health issues due to fear of judgment or burdening their parents. I would rather stay with the idea that her daughter did not want to bother her. Kemi is the Nigeria mother discussed in Sub-GET 1.1, where she talked about her undocumented immigrant. During the interview, Kemi had mentioned,

> *Both of us were depressed. I couldn't put my eye on her because both of us were going through so much (Ke: 231)*

It is possible her daughter is very much aware of her mother's struggles and may not want to bother her with hers. For Kemi, this creates a sense of disconnection—her daughter's suffering was concealed from her, and by the time she became aware, her daughter had already made significant decisions, such as withdrawing from school. Kemi's phrase, *"Only she knew what she was actually going through",* emphasises this emotional distance, reinforcing her frustration at being excluded from a critical aspect of her daughter's life. This sense of being kept in the dark can be interpreted as a failure in the relationship—an intergenerational disconnect where Kemi feels shut out from supporting her daughter

emotionally. Her words, *“by the time she told me, she had made up her mind,”* add to Kemi’s feelings of powerlessness, suggesting that she had no opportunity to intervene or provide guidance, which compounds her emotional pain.

Kudi, another Nigerian mother's insights,

> *As an African woman, as everyone will understand, an African woman expects great progress from her child. Then suddenly, the child tells you she's pregnant. It was very difficult for me to accept. I struggled with that. That was one of the issues between me and her, even with her siblings, which made her leave home. Before the hospital issue, we were not very close, so this issue brought us closer together again. I regretted it (Ku: 261)*

In Kudi’s words, *“As an African woman, as everyone will understand, an African woman expects great progress from her child,”* I interpret as revealing` the significant weight placed on achievement and upward mobility within the family structure. The phrase "as everyone will understand" suggests that Kudi perceives this expectation as a collective cultural norm, implying that failing to meet these expectations is not only an individual disappointment but also one that resonates within the broader community. This cultural context intensifies her struggle to reconcile her daughter’s pregnancy with her hopes for her child’s success. When Kudi says,

> *Then suddenly, the child tells you she's pregnant. It was very difficult for me to accept. I struggled with that.*

Here, her use of “suddenly” and “struggled” captures the shock and emotional turbulence she experienced. Her internal conflict reveals a deep tension between the idealised narrative of progress she held for her daughter and the abrupt reality of an unplanned pregnancy. This tension, *“very difficult for me to accept,”* points to a profound dissonance between Kudi’s expectations and her child’s path, intensifying her disappointment. Within this feeling of disappointment, Kudi feels,

> *If she had gone home, she wouldn't have had a chance to get pregnant and not finish her education. As Nigerians, we take education very seriously. She would have concentrated on higher education and not messed herself up (Ku: 267).*

In my view, the way she phrases her statement further underlines Kudi's conviction that the cultural values of her Nigerian household could have prevented her daughter's challenges. Her belief in the protective nature of Nigerian society, particularly in shaping perceived responsible behaviour and focusing on education, reflects a strong attachment to traditional family expectations of success through education. For Kudi, the phrase *"messed herself up"* highlights her emotional frustration, not just with the pregnancy itself but with the derailment of her daughter's educational and social trajectory.

On the aspects of intergenerational dynamics within her family, Kudi's perspectives offer important insights into how she perceives the relationships between parents and children, especially in the context of mental health and emotional openness. Her statement,

> *When I started [All parents in this study have experience] in health and social care, I discovered that children do encounter things like this, especially in this country. It does exist, and because of the way they are raised and because of the parents they live with, sometimes they keep it within themselves until it's a bit too late (Ku: 253).*

Her sector significantly shifts her understanding of her children's emotional experiences. Kudi explicitly admits that she previously did not believe in anxiety or depression, revealing a generational and cultural gap. Her growing awareness of how mental health issues can manifest, particularly in a different societal context like the UK, illustrates how cultural differences exacerbated the generational divide between herself and her children. For Kudi, *"because of the way they are raised,"* in her own words, suggests that the traditional, stoic upbringing she provided may have unintentionally encouraged emotional suppression. Paradoxically, the use of *"keep it within themselves until it's a bit too late"* also reveals her concern about the delayed disclosure of struggles, suggesting a realisation that her strict upbringing may have hindered open communication between her and her children.

Moreover, in her reflection,

> *We believe there are challenges. In the world, people are born into challenges, hardship, and all sorts of difficulties. You can't say because of that, you cannot face it or want to kill yourself. Where we come from, if you stay at home saying you are unable [to], nobody comes there to attend to you (...) But here, people are attended to; there's always attention to these types of things (Ku: 256).*

Kudi's reference to hardship as an inevitable part of life encapsulates the generational expectation that one must endure adversity without showing weakness. The phrase *"you cannot face it or want to kill yourself"* reveals her prior inability to grasp the seriousness of mental health issues, rooted in cultural norms that value toughness and perseverance over emotional vulnerability. This belief forms part of the intergenerational disconnect, where her children's experiences of anxiety and depression may not have aligned with the coping strategies Kudi had been taught. Kudi's observation, *"But here, people are attended to; there's always attention to these types of things,"* suggests an evolving recognition of the differences between Nigerian and British contexts in dealing with emotional and psychological challenges. Her emphasis on *"attention to these types of things"* highlights a newfound appreciation for the mental healthcare systems available in the UK, contrasting them with the lack of support she associates with her homeland. For Kudi, this realisation marks a crucial moment in her understanding of how her children, raised in a different cultural environment, may have different needs and expectations for emotional support.

Summary of the Shared and Unique Features of Participants' Experience

Participants face a disconnect between their mental health needs and family expectations, emphasising resilience and success. Intergenerational tension, rooted in traditional values and stigma, highlights differing openness, with youth more willing to engage.

Despite the shared features of experiences, each participant's story reflects distinctive nuances. Agnes highlights the emotional toll of feeling unsupported by her family and school, amplifying her helplessness. Chichi emphasises the intense academic pressure from her family, connecting it to cultural expectations of success, which heightens her feelings of failure. Efia feels a deep fear of disappointing her parents, who made sacrifices to bring her to the UK, while also challenging the stigmatisation of mental health within her Christian

faith. Edith and Nkiru both reflect on how their struggles have begun to shift their parents' views on mental health, offering a glimmer of hope for change. Daba, however, feels that a lack of understanding leads to persistent generational disconnects, preventing meaningful dialogue. Ese brings an additional layer by emphasising the impact of geography, as her father, still in Nigeria, is less aware of mental health conversations compared to her mother, who lives in the UK. For the parents, Kemi reflects on the deep guilt she feels for not being able to support her daughter's academic dreams, a failure that she attributes to her own struggles as an undocumented immigrant. Her daughter kept her mental health struggles hidden for a long time, intensifying Kemi's feelings of powerlessness. Kudi, another mother, shares her emotional journey in accepting her daughter's unplanned pregnancy, which clashed with her expectations of academic success.

5.4.4. Main GET 2 Summary

Main GET 2 highlights the significant lack of awareness about professional care for anxiety and depression among young Ghanaians and Nigerians in Inner London. Participants described how mental health issues are rarely acknowledged in their communities, leaving many disconnected from support systems. Sub-GET 2.1 explores perspectives of youth; they shared how stigma and silence around mental health prevent open discussions or awareness of services, leading to isolation and self-navigated struggles. Sub-GET 2.2 focuses on practitioners who advocate proactive outreach and culturally adapted therapy. Meeting communities in trusted spaces like churches is key to breaking barriers and enhancing engagement, including creative models like art therapy. Sub-GET 2.3 examines how cultural values and generational divides discourage emotional openness. Stories from Nigerian mothers Kemi and Kudi reveal the pressure to meet cultural expectations while learning to support their children emotionally. The narratives highlight the need for greater mental health awareness, culturally tailored care, and improved communication to support young people and bridge gaps in understanding within families.

5.5. Main GET 3: COPING WITH THE WEIGHT

I used Main GET 1 to explore their experiences within the systems and care and Main GET 2, their awareness of available care. In Main GET 3, I explored participants making sense of their journey through trauma coping mechanisms with three sub-GETs (Table 9).

5.5.1. Sub GET 3.1: It Was Traumatising

This sub-GET gives voice to these young people on their live experience of the profound impact of trauma, loss, and external pressures on their mental health and well-being, particularly on anxiety and depression. The contributing Participants are young people: Ghanaians - Adjua (Ad), Akua (Ak), Efia (Ef), Kofi (Ko) and Nigerians – Agnes (Ag), Chichi (Ch), Daba (Da), Edith (Ed), Osas (Os), and Nkiru (Nk). Nigerian parents – Chike, Kemi and Osazie.

Young People Perspectives

Agnes traumatic experience and its impact on her mental health is deeply connected to,

> *I was not talking to people because of what I experienced (…) usually they make racist comments to me (…) I was quite scared to just talk to people (…) I feel quite annoyed. I mean, when it was originally happening, not much was done to help it right from when I was younger (Ag: 18-19).*
>
> *I was really upset because I knew that there was no one that was going to help me at all (Ag: 24).*

Agnes expresses a deep sense of decline in her mental health following her traumatic experiences, which stems from racist comments which made her scared and avoid people. Her withdrawal from social interaction is likely a means of self-protection. The recurring racist comments had a profound impact, leaving her feeling vulnerable and afraid of further harm. This fear became so pervasive that it affected her ability to engage with others, signifying a loss of trust and safety in social spaces. Agnes also reveals a lingering frustration and disappointment. Agnes feels let down and abandoned by those who could have intervened or supported her. In my view, her use of *"annoyed"* downplays the intensity of this feeling. It encompasses deeper emotions of injustice and resentment toward a system

or individuals that failed to protect her when she was most vulnerable. When Agnes says, *"I was really upset because I knew that there was no one that was going to help me at all,"* she highlights the depth of her despair. This feeling of helplessness is significant, as it suggests that her traumatic experiences were compounded by the absence of support. Agnes's awareness of being alone in her struggles possibly amplifies the emotional weight of the trauma, leaving her feeling powerless and unsupported during critical moments in her life.

For Chichi, her traumatic experience and its impact on her mental health can be deeply connected to,

> *During the COVID period, I felt stressed because of a lot of uni work that put me down and made me isolate a lot (…). One moment, I noticed I couldn't return to the online classes. I found myself unable; there was so much I had not done (Ch: 42).*

Chichi reflects on the immense pressure and emotional strain that her academic workload caused during an already challenging time. Her use of *"put me down"* suggests feelings of defeat and overwhelm, as though the university demands were too much to bear. Chichi highlights how the cumulative stress reached a point where she could no longer engage with her responsibilities at the university. The unfinished work became a symbol of her mounting anxiety and feelings of inadequacy. It is as though Chichi was trapped in a loop of stress, where the more she fell behind, the harder it became to re-engage, which likely heightened her sense of failure and hopelessness. Chichi trauma was compounded by

> *The pressure of my family members telling me that I couldn't leave uni and I had to finish uni even while I was stressed added to it (Ch: 43).*

Her family's expectations weighed heavily on her already fragile mental state, compounding her stress. The family pressure might have left her feeling unsupported emotionally, as her well-being seemed secondary to academic success. This added stress from her family might have amplified the emotional toll, as Chichi likely felt torn between the external expectations and her internal experience of being overwhelmed. Chichi's words suggest that the traumatic impact of this period was rooted in feelings of powerlessness, isolation, and

mounting pressure. The stress from university, compounded by her family's insistence that she "had to finish," contributed to her mental health decline.

In Daba's account, the loss of relationships and the stress he endured during university weigh heavily on his emotional state. He recounts,

> *In my experience, it's relationships, so just lost relationships really and stress (…) I just experienced a lot of stress at university that affected my mental health (…) For me to be mature, I have had to go through experiences to shape the kind of person you are, and a lot of those experiences may be negative experiences (Da: 56).*

His words, *"just lost",* seem to minimise the words but magnify the depth of the impact these relational losses have on his mental health. It points to a quiet resignation as if the recurring loss of connection has become a constant in his life, shaping his emotional experience. The stress he felt at university seems pivotal in his reflection, directly linked to the deterioration of his mental health. Stress, for Daba, is not just an external pressure but something that has intimately affected his psychological state, suggesting a cumulative, wearing effect. The words *"affected my mental health"* speak to this accumulation—these experiences are more than passing struggles; they have lasting consequences on how he navigates his well-being. Also, his words, *"For me to be mature, I have had to go through experiences to shape the kind of person you are,"* signal a reluctant acceptance that these traumatic moments have played a formative role in his development. This sentiment reveals a complicated relationship with the experiences—while recognising their necessity for growth, Daba frames them as predominantly *"negative experiences,"* reflecting a struggle to find meaning or positivity in what he has endured. In essence, Daba feels the burden of his past—his mental health has been shaped through loss, stress, and negative experiences, leaving an imprint that contributes to both his personal growth and the ongoing challenges he faces.

Edith's narrative offers a deep insight into her emotional response to her traumatic experience, particularly the isolation she felt during the summer without friends and the anxiety surrounding her return to school. Edith expresses how this isolation led to sadness

and a sense of abandonment, emphasising how her mental health deteriorated during this period. Edith explains,

> *I was sad because I stopped talking to a group of friends. And then I had a whole summer just by myself, not talking to anybody. (…) When I went back to school in September, I had a lot of anxiety about going back to school and seeing those girls again (…) I think it was just too much in my head." (Ed: 70-71)*

Edith reveals the depth of her loneliness and the emotional weight of losing a support network. When she reflects on the return to school, Edith vividly describes the anticipatory anxiety she experienced. The prospect of facing the same social dynamics that caused her distress earlier created a mental burden, which she captures in the phrase, *"I think it was just too much in my head."* This suggests that the anxiety wasn't just tied to specific events but had a cumulative effect on her mental state. In the same vein, her feelings of being misunderstood by others, including her parents, deepen the emotional impact of these experiences. Edith recounts in the interview excerpts,

> *Interviewer: " Looking back, is there any point in the past, or even more recently, where you can clearly recognise that what you were experiencing was depression?"*
>
> *Edith: "At home, living in a Nigerian household, I'm a British Nigerian, and we live with Nigerian parents. Of course, when you're living with your parents as an adult, you clash a lot with your parents. Feeling like you're not being heard or understood can put you in a bad mental place. You just feel like [if] they don't get me, who can get me then?" (Ed: 72)*

The recurring sense of not being heard resonates in her words. Edith's longing for someone to *"get"* her reflects a pervasive feeling of isolation in social circles and within her family dynamics. Her frustration with this lack of understanding becomes a source of distress, contributing to her feelings of alienation and the emotional struggles tied to her mental health.

For Osas, she expresses a deep sense of loss and isolation resulting from her experience with meningitis and its impact on her mental health. The illness marks a significant before-and-after moment in her life, especially concerning her cognitive abilities. Her words,

> *When I was younger, I had an illness called meningitis, and that did affect my work, the movement of my brain, and just how I can recollect things in general (…) I felt like before my illness, I was the most intelligent person, and then after my illness (…) I'm the only person feeling it and feeling the changes (…). After my illness during school and education, I did find it quite hard, and I felt like I had to work like three times as hard (Osas: 178).*

Osas recounts a painful awareness of the perceived decline in her intellectual capacity. There is an apparent mourning for her former self, a self that she associates with high intelligence and confidence in her abilities. This sense of personal loss is compounded by her feeling of being the *"only person feeling it and feeling the changes,"* suggesting a profound isolation in her experience. Osas feels alone in her struggle, as if no one else can truly understand or empathise with the changes she perceives in herself. This creates a sense of alienation, not just from others but also from her pre-illness self. Her accounts that *"I had to work like three times as hard"* convey the emotional and physical exhaustion she experiences post-illness. This reflects not only a struggle to meet academic expectations but also an internal battle with her new reality. There is a sense of frustration and fatigue in having to compensate for something she feels she has lost—her previous ease with learning and intellectual tasks. The use of *"three times as hard"* emphasises the extent of this struggle, highlighting how deeply the illness has affected her sense of self-worth and her daily functioning. Moreover, she also recounts how the family added to her trauma, captured in her words,

> *It was more pressure from family than schoolmates (...) they just expect everything [my academic success] to just carry on as it [was before the illness] (Osas: 179)*

The pressure from her family to "just carry on as it [was before the illness]" adds an additional layer of emotional strain. This expectation minimises her experience of the illness and its aftermath, leaving her feeling unsupported in her need for understanding and

compassion. The family's expectations exacerbate her sense of failure and inadequacy, as she is unable to meet the implicit standards, though palpable, set for her prior to her illness. This creates a dynamic of internal conflict—between wanting to live up to her family's expectations and coming to terms with her own limitations, which she feels acutely.

Nkiru describes feeling overwhelmed by the weight of her traumatic experience, which culminated in suicidal thoughts. In her words,

> *I was at a place where I was having suicidal thoughts (Nk: 142).*
>
> *When I first got very anxious and depressed, I was in a very controlling relationship with my child's father. So I think being controlled and not being able to be myself or being open (...) that kind of triggered it (Nk: 157).*

The intensity of these feelings suggests a profound sense of despair, where she may have felt trapped or without escape from her emotional pain. Her accounts indicate how deeply the trauma affected her mental state, pushing her to the brink of contemplating ending her life. She also highlights how her anxiety and depression were *"triggered"* by being in a *"controlling relationship"* with her child's father. The use of the word *"controlling"* conveys her sense of restriction, both emotionally and personally. This loss of autonomy and the inability to be herself created a profound inner turmoil. The connection between her loss of freedom and the onset of her mental health struggles emphasises how deeply her circumstances impacted her, leading to a sense of helplessness and despair. Nkiru's traumatic experience seems to reflect a layering of distress—from the external control imposed on her to the internal emotional consequences. This combination left her feeling disconnected from her authentic self, intensifying her anxiety and depression. Her reflections reveal how the traumatic relationship stripped her of her sense of agency and contributed to the deterioration of her mental health.

Kofi's traumatic experience is saturated with a profound sense of fragmentation and loss that extends beyond the immediate emotional response. The depth of his suffering reveals not just the weight of individual events but the cumulative effect they had on his entire being, shaking the core of his identity. Here is an excerpt from his interview:

Interviewer: “Can you reflect on the factors or experiences that you believe contributed to the onset of your depression?”

Kofi: "I was going through a lot personally. I lost my brother and ended a relationship with someone I intended to marry. Plus, I had just returned from a family member's funeral. Everything hit me at once, and I needed time to think and analyze, but my usual coping mechanisms weren't working. I was constantly in a state of distress" (Ko: 132)

"I was thinking suicidal, and I was like, wow, this has never been me. It's a whole different concept (…). Everyone who saw me said it wasn't me because I lost a significant amount of weight. I was never the same; I didn't want to socialise." (Ko: 136)

When Kofi speaks of losing his brother and ending a significant relationship, he connotes that these were not just losses in isolation; they represent a collapse of foundational aspects of his life—family and future. The relationship was something he had attached long-term meaning to, and the death of his brother cut into the very fabric of his familial connections. This dual loss may suggest that the future Kofi had envisioned for himself was torn apart, leaving him adrift without a sense of direction or stability. Another layer was added to the mix regarding a family funeral overstretched his emotional threshold. Kofi’s expression, *"everything hit me at once,"* conveys a sense of emotional overload where his ability to process and make sense of his feelings is overrun by the sheer volume of grief and turmoil. His statement that he *"needed time to think and analyse"* suggests that he sought a way to regain control or make sense of his situation, yet his usual coping mechanisms—perhaps the mental strategies or routines he relied on—failed him. This inability to cope reveals a feeling of helplessness and disorientation, where the familiar no longer offers comfort or solutions. Even to the point where:

"I was thinking suicidal, and I was like, wow, this has never been me. It's a whole different concept (…) Everyone who saw me said it wasn't me because I lost a significant amount of weight. I was never the same; I didn't want to socialise." (Ko: 136)

Kofi's admission of suicidal thoughts reflects the most intense rupture in his self-perception. His exclamation—*"Wow, this has never been me"*—indicates that this mental space was entirely alien, representing not just despair but a complete departure from how he understood himself. This shift is more than emotional distress; it's a deep crisis of identity. Kofi had never seen himself as someone who could feel this way, and the *"whole different concept"* suggests that he is grappling with a profound internal change. The suicidal ideation signifies an existential questioning of whether he can continue to endure, further deepening the sense that he no longer recognises the person he has become. Kofi's feelings about his traumatic experience reveal a multi-layered disintegration of self. He is not only grieving the losses he has experienced but is also mourning the loss of his former self. The trauma fractures his sense of identity, his ability to cope, and his social connections, leaving him in a space of deep isolation and existential questioning. This narrative is one of profound emotional, physical, and psychological rupture, where the familiar is no longer recognisable, and the future feels uncertain.

Adjua's account reveals an emotional impact from the combination of the COVID-19 lockdown and the loss of her father. Adjua recounts,

> *I think it's a combination. So when [the Covid-19] lockdown first started, I think that triggered it. Being inside all the time not really seeing anyone. And then my dad passed away (Ad: 4). I would say I was very, very depressed. I didn't want to go anywhere. I didn't see anyone I was, yeah, I wasn't happy (Ad: 6).*

She expresses feeling overwhelmed by depression, describing how it affected her desire to engage with life. The experience led her to withdraw, avoid social interaction, and lose interest in activities. Adjua's sense of unhappiness was pervasive, manifesting in a complete disconnection from others and a lack of motivation to go anywhere or see anyone. The weight of her emotions created a space of isolation, where her mental health deteriorated significantly, leaving her feeling trapped in sadness and depression.

In Efia's world, the overwhelming nature of her traumatic experiences and the impact on her mental health was evident. She reflects,

I think I got way too overwhelmed that I just randomly started crying in a lesson and broke down (Ef: 86)

She speaks of a feeling of losing control over her emotions, where the burden of her distress surpasses her capacity to manage it. The use of *"randomly"* suggests that her emotional response felt sudden and out of her control, emphasising the unpredictability and intensity of her reaction. This sense of being overwhelmed appears as an involuntary release of pent-up emotions, surfacing at an unexpected time and place. Efia continues with,

I felt so defeated and useless that I just broke down (…) It felt like I couldn't breathe, and my airways were closed up because I was just crying too hard (Ef: 87)

Efia captures the emotional weight of her trauma, revealing a deep sense of powerlessness. Her use of the words *"defeated"* and *"useless"* evokes profound feelings of inadequacy, as if the situation has stripped her of her ability to cope or maintain a sense of worth. This breakdown, I described as a complete collapse, not just physically but emotionally. *"It felt like I couldn't breathe… crying too hard"* powerfully conveys the suffocating nature of her emotions, highlighting how her feelings manifested physically. The intensity of her crying, to the point of feeling as though her *"airways were closed up,"* suggests an overwhelming emotional and physical experience, as if her body was responding to the emotional overload by shutting down, cutting off her ability to breathe. Efia reflected on what she thought was the stressors,

Maybe it's just I'm quite insecure sometimes about my intelligence or not wanting to be a failure (…) I'm really scared of disappointing everyone who worked so hard to bring me here. I wouldn't want all their hard work to go to waste (Ef: 101)

Efia's admission that she feels insecure about her intelligence and fear of failure introduces another dimension to her trauma. Her insecurity seems to compound her emotional struggle, heightening her fear of disappointing those who have supported her. Efia's words, *"I'm really scared of disappointing everyone who worked so hard to bring me here"* reveal a burden she feels to succeed explicitly linked to familial expectations. This fear of letting

others down deepens her sense of emotional isolation, as the pressure she feels is internal and tied to her expectations. This leaves her feeling that her failure would nullify the hard work and sacrifices of those around her, making her own emotional state even more distressing.

Akua's reflections focus specifically on her feelings surrounding the trauma of losing her father and its impact on her mental health.

> *I lost my dad when I came here. It was hard, so it really made me depressed (...) Because I wouldn't get to see him anymore, talk to him, take advice from him (Ak: 30).*

Akua's words reveal a profound sense of loss. Her grief seems deeply tied to the inability to maintain the father-daughter relationship that once offered her guidance and emotional support. The use of *"wouldn't get to see him anymore"* encapsulates her permanent disconnection from her father, amplifying the finality of his death. The phrase she used, like *"talk to him, take advice from him"* suggests that her father was a key figure in her life, offering both practical and emotional support. Losing access to that guidance has left her feeling unsupported and emotionally adrift. Her description of depression, *"it really made me depressed",* underlines the depth of her emotional struggle. The word *"really"* suggests an intensity of feeling, as though the grief became an overwhelming and consuming force in her life. For Akua, depression is not just a feeling of sadness—it represents a profound disruption in her sense of security and connection. When Akua says,

> *I wasn't myself again. No friends you may talk to. My lifestyle changed. So I started (...) I think I turned all my attention to shopping and going out (Ak:30 & 32)*

she expresses a loss of self that stems from her traumatic experience. She felt a disconnection from her previous identity, suggesting a profound internal shift in how she viewed herself and interacted with the world. It implies that the loss of her father not only impacted her emotionally but also altered her sense of self. She no longer feels like the person she was before the trauma, reflecting a fragmentation of identity. The mention of *"no friends you may talk to"* points to social isolation, which likely exacerbated her depression.

Aku highlights the absence of supportive relationships, reinforcing the feeling of being alone in her grief.

Parents Perspectives

Kemi, a Nigerian mother's account, reveals a deeply emotional and personal struggle as she reflects on her daughter's traumatic experience. She provides insight into her feelings of helplessness, frustration, and sorrow as she navigates her daughter's pain and the impact on her mental health. Kemis' excerpt,

> *One of them used my daughter's name to open an account on Facebook, pretending to be my daughter, using her details to bully people. So those who were being bullied thought it was my daughter (…). That's why they were always fighting her. My daughter was innocent. I don't know how they managed to use my daughter's details to create an account and start doing what they were doing. I went to the police station. The police asked me whether there was an injury. I said no. They told me to tell my daughter to leave Facebook (…). All these things as she was going through them contributed to her depression (Ke:206-207)*

Kemi's sense of injustice is apparent when she describes how her daughter's identity was stolen and used to bully others, leading to her daughter being unfairly targeted. Her repetition of the word *"innocent"* emphasises her belief in her daughter's integrity and the confusion she feels about how such a violation of her daughter's identity could have happened. This confusion is mixed with a sense of powerlessness as she recalls her efforts to seek help from the police, only to be dismissed. It heightens Kemi's frustration, as the authorities did not take the emotional harm seriously, reinforcing her sense of helplessness in protecting her daughter from further harm. Her emotional burden is also expressed when she describes the toll the bullying took on her daughter. Kemi's words,

> *She came home to tell me she was no longer going to school (...) My daughter was always coming home to tell me how people at her school were bullying her (Ke: 203).*

I knew she spoke to (...) a counsellor, but from there, they never paid attention to her complaint (Ke_210).

Kemi recognises the bullying as a persistent, unrelenting source of stress for her daughter, which compounded Kemi's distress as a mother. As her daughter expressed feelings of depression, Kemi felt the gravity of the situation but also the inadequacy of external support. The counsellors' disregard deepens Kemi's frustration, as she perceives that her daughter's cries for help went unheard. Kemi's grief and anger become more pronounced when she reflects on the potential her daughter had before the bullying began. Kemi recall,

I shed tears myself because this child, especially (...) I knew how intelligent this child is (...) It makes me feel so bad because they were just trying to spoil this child's destiny to frustrate her. And I could not do anything." (Ke: 215)

Her use of the word *"destiny"* conveys a profound sense of loss, as though the bullying and subsequent depression have derailed her daughter's future. Kemi's belief that her daughter's future was being *"spoiled"* highlights the emotional weight she carries, as she sees her daughter's mental health struggles as not only a present issue but one that threatens her daughter's long-term well-being. Perhaps the most striking aspect of Kemi's reflection is the deep sense of guilt she conveys,

I felt bad, and at the same time, it was not my fault, but the situation made it look as if it was my fault (...) If not for the circumstances, why would I haphazardly allow a little child to struggle alone? (Ke: 237)

Kemi's self-blame is a recurring theme as she grapples with the tension between knowing that she is not responsible for the trauma her daughter endured and feeling as though she could have, or should have, done more to protect her. This guilt intensifies in the use of the word *"haphazardly"*, which suggests a feeling of chaos and lack of control in the situation, and her acknowledgement that her daughter *"struggled alone"* points to her deep regret and sorrow. The image of her daughter facing this pain in isolation haunts Kemi, as she feels that she should have been able to shield her child from such suffering.

Osazie, another Nigerian mother, expresses a profound sense of sadness and helplessness as she witnesses her children's trauma following the loss of their father and its impact on their mental well-being. Osazie reflects,

> *When my children first lost their dad, they struggled. They were quiet; you could see that the joy was no longer there. They spoke quietly, and another major thing I noticed as a practitioner [all parents in this study have a direct relationship with HSC] was that I had also come through anxiety myself (...) One of the symptoms I saw was bed wetting. The sadness, the pain, I can't explain it (…) I was talking to them, trying to understand their feelings (Osa: 273).*

Her description of their quiet demeanour conveys her deep emotional connection to their pain as she observes a visible change in their behaviour and energy. The use of *"quiet"* and *"joy was no longer there"* signifies a stark contrast to how her children may have been, and this shift deeply affects her. Osazie's reflection on her own experience with anxiety—*"I had also come through anxiety myself"*—adds a layer of personal understanding to her interpretation of their behaviour. It suggests that she empathises with her children's suffering, perhaps recognising the signs of distress because she, too, has been in a similar emotional state. Her mention of bed wetting as a symptom—*"one of the symptoms I saw was bed wetting"*—demonstrates how Osazie tracks these tangible manifestations of trauma, which she links to her children's inner turmoil. The bed-wetting becomes symbolic of unspoken, deep-seated anxieties that are otherwise difficult for them to articulate. Ultimately, Osazie feels their pain intensely, describing it as something she cannot fully explain—*"the sadness, the pain, I can't explain it"*—which suggests a level of emotional exhaustion or helplessness.

Chike, a Nigerian father's reflections on his child's traumatic experience and its impact on his mental well-being reveal a deep sense of realisation and regret. He recounts,

> *My own child grew up extremely withdrawn. He had a broken leg (…), which took him four months to recover from. Since then, he hasn't fully recovered from what I now think was depression and anxiety (Ch: 181)*

He recalls the impact of the injury, noting how his son became *"extremely withdrawn."* Chike now interprets this withdrawal as an early manifestation of depression and anxiety, emotions he did not fully recognise at the time. His admission suggests an expressive acknowledgement that he missed the emotional and psychological depth of his son's suffering, focusing instead on the visible, physical recovery. Initially, Chike's primary focus was on survival and the physical aspect of his son's injury.

> *Survival was the main focus (...) Honestly, I do, especially with the experience I have now. I tried to reach someone I thought could help him later on, but the boy was not very cooperative (Ch:185)*

Chike's singular focus on his son's immediate physical health possibly reflects a father's instinctive drive to ensure his child's safety and healing in a tangible sense. However, in hindsight, Chike expresses a shift in understanding, realising that mental health was also critically at stake. The statement, *"Honestly, I do, especially with the experience I have now,"* suggests Chike's growing awareness of the psychological aftermath, and it conveys a sense of regret or guilt for not recognizing the signs sooner. Chike's feelings are further complicated by his attempts to reach out for help later on, but his son's resistance—*"the boy was not very cooperative"*—adds to his sense of helplessness. This resistance from his son seems to amplify Chike's frustration and perhaps a lingering guilt that he did not seek mental health support earlier. Chike's narratives suggest a father grappling with the limitations of his ability to intervene in his son's mental health struggles, reflecting both a deep concern and a sense of powerlessness in the face of his son's withdrawal.

Summary of the Shared and Unique Features of Participants' Experience.

Participants highlight trauma as a root of anxiety, depression, and isolation, with young people feeling unsupported and parents expressing helplessness amid challenges like bullying, bereavement, and academic pressures.

On the distinct features, each participant's experience carries unique aspects. Agnes struggles with the lasting effects of racial discrimination, while Chichi feels overwhelmed by academic pressures and family expectations. Daba reflects on the emotional toll of lost relationships and university stress, while Edith's experience centres on loneliness during a

summer without friends. Osas mourns the cognitive decline after meningitis, compounded by family pressure to maintain academic success. Nkiru's controlling relationship led to suicidal thoughts, and Kofi grappled with profound grief from the loss of a brother and the end of a significant relationship. Adjua's depression was triggered by her father's death during the COVID-19 lockdown, and Efia's anxiety and breakdown were rooted in fear of failure and disappointing her family. Among the parents, Kemi speaks of her daughter's bullying and the injustice of being wrongfully blamed, feeling helpless as authorities dismissed her concerns. Osazie describes her children's quiet suffering after the loss of their father, and Chike regrets not recognising his son's withdrawal as a sign of depression after a leg injury. These parental reflections reveal a deep emotional burden in witnessing their children's trauma and their own struggles.

Are There Differences In How Young Ghanaians And Nigerians Make Sense Of Their Traumatic Experience?

For Nigerian youths like Agnes, Chichi, and Daba, social disconnection emerges prominently. Agnes describes withdrawing after racist comments at school, fostering fear and isolation, while Daba reflects on university stress and repeated relationship losses, resigning to a cycle of disconnection. In subtle contrast, Ghanaian youth such as Adjua and Akua often tie isolation to family dynamics, as seen in Adjua's deep sadness during the COVID-19 lockdown, compounded by her father's death. Familial expectations differ subtly between the groups. Nigerian participants like Chichi and Edith face overt pressure to meet family expectations, intensifying their stress. Chichi feels obligated to continue her studies despite feeling overwhelmed, while Edith struggles with feeling misunderstood by her parents. Ghanaian youth, such as Efia, internalise familial expectations, with Efia's fear of disappointing her family adding an emotional burden, even without explicit pressure. Identity and personal loss further delineate their experiences. Nigerian youth like Osas mourn the loss of their former selves, grappling with changes in cognitive abilities after illness. Conversely, Ghanaian youth like Kofi confront broader identity crises, where cumulative losses—such as a sibling's death and a relationship's end—create a deep rupture in their sense of self. Though united by themes of isolation, family expectations, and identity struggles, the lived experiences of Ghanaian and Nigerian youth reflect perceived distinct cultural and social influences.

5.5.2. Sub GET 3.2: Just Man Up And Accept

This sub-GET is a build on the previous one, which highlights participants making sense of their traumatic experience and its impact on their mental health and well-being. In this section, I explore the silence that characterises participants' responses to their traumatic experiences. Some aspects of the issues around silence were captured in Sub-DET 2.3: Family Expectations; however, this section only focuses on silent responses. The contributing participants are all young people. Ghanaians: Adjua (Ad), (Ak), Efia (Ef), and Kofi (Ko). Nigerian: Agnes (Ag), Chichi (Ch), Daba (Da), Edith (Ed), Nkiru (Nk) and Osas (Os).

Young People's Perspectives

Agnes, a Nigerian female, withdrawal from speaking to others, *"I was not talking to people because of what I experienced" (Ag: 18),* which seems to be an instinctive reaction to the emotional and psychological pain she endured. This silence is not a passive response but, in a sense, a form of self-preservation—an attempt to protect herself from further disappointment or rejection. Agnes implicitly conveys that talking about her experiences was futile, saying

> *I was really upset because I knew that there was no one that was going to help me at all because no matter what I said, no matter what I did, they would just say, ohh, get on with your work (Ag: 24).*
>
> *They told me to just deal with it myself. They didn't really give me any help in any way (Ag: 19)*

She emphasises a profound sense of invalidation, as if her pain was rendered invisible by those who were supposed to support her. The repeated instruction to just deal with it herself reinforces the notion that she was left to manage overwhelming emotions on her own, fostering a sense of abandonment. This dismissal was in her school environment, where the lack of intervention worsened the situation:

> *In the London school, they didn't give me much help. They told me to get on with what I was doing and just ignore everything (Ag: 23).*

Here, Agnes encounters a system that fails to protect her and perpetuates her isolation by silencing her experiences. Her silence is not chosen but imposed—her attempts to speak out are dismissed and trivialised, leading her to retreat further into herself. Agnes's comment,

> *Because I was ignoring it, they were doing it even more and more (Ag: 23). My parents they try and like (…) want me to stay strong (Ag: 19)*

It reflects the cyclical nature of her trauma. Her silence, which might have been a way to cope or avoid conflict, paradoxically exacerbated her suffering. The more she remained quiet, the more emboldened her tormentors became, feeding into a vicious cycle where her silence reinforced her vulnerability. The expectation from her family to *"stay strong"* adds another layer to her struggle. While intended as encouragement, this sentiment carries an implicit demand to suppress her emotional pain, reinforcing her isolation. Her parents' desire for her to *"stay strong"* reflects a cultural norm of emotional stoicism, which can be particularly pervasive in immigrant families where resilience is often valorised. Yet, for Agnes, this cultural expectation translates into a silencing of her emotional needs, leaving her with no outlet for her trauma. Agnes's silence, therefore, can be a response to the cumulative effects of neglect, dismissal, and cultural expectations. It can also be a reflection of her internal struggle between the need for help and the reinforced belief that help will not come. Her words show a young person who is aware of her isolation but feels powerless to change it. The silence possibly becomes both a symptom of her trauma and a protective shield against the further pain of being disregarded.

Chichi, a Nigerian female, excerpts

> *I don't have the motivation to tell anyone (Ch: 44).*
>
> *We don't discuss it just because of the pressure I was receiving from them" (Ch: 46)*
>
> *There was so much I had not done (...) I felt like the pressure of my family members telling me that I couldn't leave uni and I had to finish even while I was stressed added to it (Ch: 42-43)*

Chichi reveals a profound sense of isolation and emotional suppression. Her feeling of being emotionally drained, where reaching out for help feels like an insurmountable task. I interpret this lack of motivation as an internalised response to cultural stoicism—she feels the burden of having to handle her struggles independently. Chichi silence is not just an avoidance of communication but an embodiment of the expectation that one should endure pain privately. The inability to express her trauma outwardly suggests feelings of resignation and perhaps shame, reinforcing the cultural narrative that vulnerability is a weakness. The phrase *“we don’t discuss it”* indicates that emotional expression is collectively discouraged within her family, reinforcing the expectation that struggles should be faced quietly. The *“pressure”* from family reflects cultural expectations, where personal difficulties are overshadowed by the demand to conform, perform, and meet external standards, such as academic success. Chichi’s silence is not just personal but imposed by her family dynamics, creating feelings of entrapment. The cultural script of stoicism demands endurance, and by not voicing her struggles, Chichi remains locked in a cycle where emotional support feels inaccessible or inappropriate.

Nkiru, a Nigerian female, offers a profound insight into the silent processing of traumatic experiences, reflecting both the emotional suppression imposed by cultural norms and the personal struggle that comes with it. She reflects.,

> *I didn't open up to anyone about it. I was very closed off (...) Growing up, it wasn't the norm; it wasn't something that was spoken about in our household, especially coming from a Nigerian background with highly religious views. So it's almost like they kind of pair mental health with religion in terms of 'Oh if you're depressed, go and pray to God about it' when you know there are other steps and other things that you need to do as well as praying to God (Nk: 147)*

Nkiru repeatedly emphasises being *"closed off"* and not opening up to anyone about her struggles. This reflects an internalised expectation to remain silent, a common aspect of cultural stoicism. The phrase *"I didn't open up to anyone about it"* suggests a deep sense of isolation, where emotions and pain are kept internal as a method of self-protection or conformity to cultural norms. Nkiru's silence is not just an individual choice but is shaped by

her upbringing in a context where emotional vulnerability is discouraged. This silence can be interpreted as a coping mechanism ingrained in cultural expectations of strength, where admitting to emotional pain might be seen as a weakness. Nkiru's mention that mental health *"wasn't something that was spoken about in our household"* suggests a broader cultural framework in which personal suffering is not acknowledged openly. Her feelings of being "closed off" may have developed not from a lack of desire to speak but from the absence of a culturally acceptable space to express her pain. She experiences the cultural imperative to suppress emotions and deal with her mental health privately. The *"highly religious views"* in her background further deepen this stoic attitude, pairing mental health with religious solutions rather than emotional expression, reinforcing the message that one should *"pray it away"* rather than seek external support. Nkiru's continued reflection that,

> *A lot of people bottle it up (...) and I did for a long time, yeah. Until I actually opened up. And I think a part of the long time for me is because of my cultural background, and I didn't really know much about depression and anxiety* ***(****Nk: 158)*

She captures the weight of emotional suppression that illustrates the internal pressure of carrying unspoken trauma, where the passage of time only deepens the emotional burden. Nkiru's admission that she *"bottled it up"* for an extended period reveals the psychological strain of cultural stoicism. In her words, we can sense the buildup of emotional tension, a feeling of being overwhelmed by her unspoken struggles. There is also a sense of resignation in the phrase *"and I did for a long time yeah,"* suggesting a kind of learned helplessness, where she silently complied with the cultural expectation of dealing with mental health alone.

Daba, a Nigerian male, narrative about silently dealing with his traumatic experiences offers an expressive insight into how emotional suppression becomes a way of life—his account.

> *I feel like I just learned to shrug it off, if that makes sense. Maybe it's the type of person that I am; I don't like to dwell on things a lot. So with me, it's like life goes on because I'm still young (Da: 57)*

Daba reveals a learned behaviour of detaching from his emotions, choosing silence overexpression. He expresses a sense of inevitability in how he processes his pain. The phrase "*shrug it off*" suggests that emotional discomfort is something to be dismissed rather than acknowledged, reflecting a stoic response to trauma. His justification that *"life goes on"* speaks to a deeper internalisation of this mentality, where confronting emotional struggles is not seen as necessary. This sense of emotional isolation is further emphasised when Daba admits,

> *I don't really talk about it (…) When I stop talking. Even like from a few years ago I used to be so much more of a talker a person that used to talk so much more. I used to be happy. I mean I'm still happy now, but as I grow up, it's like when your mental health kind of plays out, I kind of went much more quiet, so I've become much more quiet now (Da: 58)*

The repetition of this admission: *"I don't really talk about it... In general, yes, I don't really talk about it."* Highlights how silence has become his default response to trauma. He chooses not to talk about his emotions, reflecting the internal conflict that comes with the expectation of self-reliance. By opting for silence, Daba reinforces the belief that emotional challenges should be handled alone, with minimal outside support. The extent to which Daba's silence has shaped his response to trauma is powerfully captured in his statement,

> *"I'm definitely much more quiet now, I have kind of blocked myself out from everyone, and I just don't talk. That's probably a symptom (Da: 58)*

His description of blocking himself out reflects a profound sense of isolation, where disengaging from others feels like a necessary way to cope. By cutting himself off from those around him, Daba possibly shields himself from the vulnerability of emotional expression. His admission that this silence is likely a *"symptom"* of his trauma shows self-awareness; he understands that his withdrawal is a manifestation of his emotional distress. Yet, even with this recognition, he continues to hold back, suggesting that enduring this silence is part of the coping process embedded in a stoic and "Man Up" mentality. His silence becomes a protective barrier, allowing him to manage his emotions privately without the perceived burden of opening up.

For Edith, a Nigerian female, how she dealt with her traumatic experiences silently was captured in her statement,

> *"I probably just won't be talking well. Me personally, I probably just won't be speaking with them" (Ed:* 80).

Her withdrawal from communication suggests that she internalises emotional pain rather than vocalising it, which can also be linked to cultural expectations where expressing vulnerability is often seen as a weakness. In choosing silence, Edith adheres to a form of stoicism that prioritises endurance over emotional openness. However, this silence may also result in feelings of isolation, as her emotions remain unspoken and unacknowledged. While this coping mechanism helps her avoid potential misunderstanding or dismissal from her family. She had said,

> *Feeling like you're not being heard or understood can put you in a bad mental place. [If my family does not], who can get me then?* (*Ed:* 72)

Edith acknowledged how this deepens her internal struggles, leaving her to silently navigate her distress within the confines of cultural and familial expectations.

Osas, a Nigerian female, reveals a deep struggle with the silent internalisation of emotions, masking her true feelings behind a disguise of normalcy. In her words,

> *I could just go completely quiet because, naturally me, as a person, I'm quite bubbly... I could be doing that to cover up my own emotions (...) Outside, it's like, 'Oh, you know, she's all happy with everything.' And then, on the inside, it's like I'm a little bit sad (Os: 171)*

Her emphasis on being *"bubbly"* yet feeling sad inside highlights a profound dissonance between her external presentation and inner emotional world. This dissonance seems to be a coping mechanism, where outward cheerfulness serves as a barrier to confronting or sharing her pain. Osas saying, *"I could be doing that to cover up my own emotions"* signifies a conscious awareness that her external behaviour is a protective shield against vulnerability, stemming from a learned expectation to manage distress without burdening

others. Moreover, the transition from being outwardly cheerful to becoming completely silent marks a critical shift. Osas narrates,

> *When I'm not doing any of the laughings and the joking and just nothing. I'm just completely silent. I think that's when it's more noticeable for people [to say], 'Oh, she's actually really going through it, and she's quite depressed, yeah (Os: 171)*

This contrast implies that silence becomes her way of both preserving and revealing her pain. The quietness, though isolated, is when her struggle is most authentic and perhaps even visible, yet unspoken. The sense of isolation intensifies as she describes being someone who rarely opens up:

> *Honestly speaking, I would say, and my family would say that as well, I'm probably the one that doesn't speak about when I'm going through [depression] the most. Like I just go through it myself, and I just like to do it by myself. I would say there's literally been one particular time, like literally one out of the so many, that I've ever opened up to a few members in my family. But yeah, that's it really. I don't really talk about stuff (Os: 175)*

The rare instance of Osas sharing her emotions with family members, described as *“literally one out of the so many,”* stresses how deeply ingrained this silence is in her experience of trauma. Even in moments of distress, the preference for dealing with things *“by myself”* reflects an internalised pressure to manage emotions alone, a manifestation of cultural expectations to endure suffering quietly.

In Kofi’s words, a Ghanaian male expression,

> *We're often taught to be brave and hide our emotions, but everyone experiences emotions. We're conditioned to suppress our feelings and just carry on (Ko: 132)*

He conveys a tension between external expectations and internal realities. The instruction to *"be brave"* implies a societal and cultural demand to suppress vulnerability, equating emotional expression with weakness. The phrase *"We're conditioned to suppress our feelings and just carry on"* encapsulates a learned behaviour—an ingrained response to emotional struggles. Kofi's use of the word *"conditioned"* suggests a habitual, automatic reaction

shaped by cultural and social forces, where feelings are buried rather than explored. By adding *"just carry on,"* Kofi conveys the pressure to maintain external functionality despite any emotional turmoil. This reflects a sense of internal conflict—emotions persist but have to be hidden, contributing to a silent endurance of trauma. Kofi further deepens this theme with the statement,

> In our society, nobody talks about it. Everybody bottles it up (...) You wouldn't know. Nobody knew I was going through that *(Ko: 137-138)*

It suggests a forced containment of emotions as though they are to be stored away out of sight. This metaphor, "*bottles it up",* implies emotional suppression under immense pressure, where feelings are not expressed but tightly held within, waiting to explode. The lack of dialogue around these issues reinforces this isolation, suggesting that the silence is not merely personal but also communal. For Kofi, the *"In our society"* connotes a sense of an unwritten collective norm of emotional suppression, where acknowledging one's internal state is rare if not outright discouraged.

Moreover, Kofi's words, *"You wouldn't know. Nobody knew I was going through that"* point to the invisibility of his emotional struggle. He implies that his silent suffering went unnoticed by those around him, revealing the extent to which the expectation to *"man up"* had led him to mask his pain. The silence here is not just about refraining from verbal expression but about a deeper, more pervasive invisibility of emotional distress. It shows how Kofi's internal world was effectively hidden behind a façade of coping, highlighting the personal cost of this cultural stoicism.

Together, Kofi's reflections reveal a layered understanding of his trauma—he acknowledges the weight of societal expectations to suppress emotions, even as he recognises the futility of this suppression. His silence is both a survival mechanism and a source of isolation, bound by the cultural script of stoicism that demands endurance without expression. The feelings of invisibility and internal conflict that arise from this silence define his experience of trauma.

Efia reveals a complex emotional landscape of how she handled her traumatic experiences silently. Her statement,

I tend to just sleep it off or just keep on doing my work (...) Honestly, I'm used to bottling up my emotions. When I feel upset, I just tend to sleep it off, so I don't really think much of it, and I just pretend it's not there (Ef: 87-88)

Efia conveys a habitual pattern of emotional suppression. This also reflects a learned response where her feelings are internalised, likely influenced by the belief that expressing emotions is a sign of weakness. Her use of *"sleep it off"* indicates an attempt to escape or distance herself from her emotions rather than confront them, highlighting the silent endurance of her distress. Her words, *"I just pretend it's not there," c*onvey a deeper sense of avoidance. By pretending her emotions do not exist, she minimises their significance in her life, which can be interpreted as a protective strategy. If she does not acknowledge the pain, it cannot harm her further. However, this also suggests a disconnection from her emotional self, where she feels compelled to silence her suffering rather than give it a voice.

Summary of the Shared and Unique Features of Participants' Experience

Participants from Ghanaian and Nigerian backgrounds share a cultural stoicism that fosters silent coping with trauma. Societal expectations discourage emotional expression, leading to internalised struggles that shield but deepen loneliness and emotional suppression.

Each participant uniquely navigates the silence surrounding their traumatic experiences: Agnes felt invalidated by her school's neglect, where silence was imposed by systemic failure. This deepened her vulnerability and sense of abandonment. Chichi internalised intense academic pressure from her family, leading to an emotional shutdown. She embodied the cultural belief of enduring pain quietly. Nkiru, influenced by her religious upbringing, equated mental health struggles with spiritual issues, relying on prayer and private coping rather than external support. Daba adopted silence as a learned behaviour, "shrugging off" emotional pain to move forward, reflecting a belief that struggles should not be dwelled upon. Edith avoided expressing emotions due to a lack of familial understanding, using withdrawal as a coping mechanism to prevent further pain. Osas masked her sadness with a cheerful demeanour, maintaining normalcy outwardly while intensifying her inner isolation. Kofi was conditioned to suppress emotions due to societal expectations of bravery, which left him feeling invisible and unsupported. Efia escaped emotions by sleeping or

pretending they didn't exist, creating disconnection from her emotional self. Adjua experienced cultural stoicism but uniquely described the compounded emotional toll of her father's death during COVID-19, intensifying her isolation and depression.

5.5.3. Sub-GET 3.3. Prayer And Faith Were My Refuges

After exploring Sub-GET 3.1 to amplify the voices of these young people and parents, allowing them to share their traumatic experiences and their impact on their mental health, I utilised Sub-GET 2 to highlight the silence that often characterises their responses to these traumatic experiences. In this sub-GET 3.3, I make sense of how participants were making sense of their experiences of cultivating strength and resilience through their traumatic experiences, particularly in the context of anxiety and depression. The contributing participants are four young Ghanaians – Ajua (Aj), Akua (Ak), Efia (Ef), and Kofi (Ko). Six young Nigerians – Agnes (Ag), Chichi (Ch), Daba (Da), Edith (Ed), Osas (Os) and Nkiru (Nk). Including three Nigerian parents – Chike (Ch), a father, Osazie, and Kemi, a mothers.

Young People Perspectives

The question asks.

"Can you describe in detail what you feel has been most helpful for you in managing or overcoming your challenges?"

Kofi, a Ghanaian male, highlights a multifaceted coping strategy. Kofi reflects,

> *When I was in a depressive state, I didn't know how to cope. Prayer and faith in God were my refuge. I believe it's about tuning your mindset to find ways out of depression, not just accepting being stuck (Ko: 123).*

For Kofi, faith is not only a form of emotional support but also a cognitive framework that provides meaning during times of distress. By positioning prayer and faith as *"refuges,"* Kofi emphasises the protective and restorative function that his spirituality serves. In this sense, faith is both an anchor and a guide, offering him a sense of purpose and security amidst emotional turmoil. The notion of faith as a refuge also speaks to Kofi's belief in the existence of a higher order, which helps him reconcile the uncontrollable aspects of his life. His

spiritual beliefs provide a framework for understanding and navigating his depression, demonstrating how faith becomes a cognitive reorientation tool. Here, for Kofi, faith is positioned as both an immediate source of comfort and a long-term strategy for resilience. Kofi's mindset about *“not just accepting being stuck”* reflects an active agency where faith propels him towards action rather than passivity, aligning with cultural norms of endurance but evolving into a proactive process of overcoming. Kofi also reflects on how he used therapy to build resilience. He states,

> *Therapy was immensely helpful. It allowed me to express myself and get advice and daily guidelines for recovery. One impactful concept was whether I would remain imprisoned by my mind or break free to explore future possibilities. This helped me realise I needed to better myself and move forward in life (Ko: 123)*

Here, Kofi contrasts the often-portrayed reluctance to seek therapy within African communities, as discussed in Sub-GET 3.2, with the cultural conditioning to ‘man up’. Kofi's initial struggles with depression were compounded by his difficulty in expressing emotions due to this conditioning. However, therapy provided an alternative space for expression, challenging his earlier belief that coping alone was the solution. The term *"immensely helpful"* signifies the profound impact therapy had on his ability to manage his mental health, suggesting a shift from isolation to shared understanding. Therapy enabled Kofi to externalise his internal struggles and engage in a dialogue that gave structure to his recovery. The *"daily guidelines for recovery"* point to the practical, solution-focused nature of therapy, which, in contrast to the abstract solace of prayer, offered Kofi tangible steps to take control of his mental state.

The phrase *"whether I would remain imprisoned by my mind or break free to explore future possibilities"* illustrates a pivotal moment in Kofi’s journey—his realization that recovery requires more than passively waiting for change. This moment of clarity represents the duality of resilience, where strength is both a personal resolve and an actionable, forward-thinking process. For Kofi, therapy allowed him to see beyond his immediate state of suffering, offering a narrative of hope where his future was no longer confined to his present mental state. This insight resonates with broader therapeutic goals in cognitive approaches

like CBT, where clients are encouraged to challenge self-defeating beliefs and cultivate a more expansive view of their potential.

Kofi captured a synergy between faith and therapy in his building resilience. His words,

> *I believe prayer works because God operates in mysterious ways. He may not appear directly but works through others. I believe my prayers were answered by being guided to a therapist who understood my situation. So, both prayer and therapy were effective (Ko: 130-131).*

Kofi synthesises his experience of integrating spirituality with psychological interventions. His belief that God works through others, such as the therapist, reveals a conceptual blending of spiritual and secular tools for healing. This synthesis allows Kofi to maintain his spiritual beliefs while benefiting from therapeutic practices, avoiding the common dichotomy where faith and therapy are seen as incompatible. This integration suggests that for Kofi, resilience is not cultivated in isolation but through a dynamic interaction between external support systems (such as therapy) and internal belief systems (such as faith). His worldview embraces the idea that both divine intervention and human expertise can coexist and complement each other in the healing process. This perspective may resonate with many individuals in religious communities who find strength in both faith and medical or psychological assistance, demonstrating that the pathways to resilience are not singular but multifaceted.

Kofi's experience also reflects the wider cultural theme of communal healing within African traditions, where individuals rely not only on internal strength but also on the collective wisdom and support of spiritual and community leaders. His mention of being *"guided to a therapist"* speaks to the providential nature of this support, framing therapy as an extension of divine care.

Adjua, a Ghanaian female, describes how spending time with friends and getting out of the house provided emotional relief, even though she didn't openly discuss her mental health challenges. Adjua reflects,

> *I'd say maybe seeing my friends more, going out more (...) It helped even though I didn't talk about it with anyone. Just being around people, getting out of the house, it made a difference (Ad: 8). I say I'm a religious person, so that helps a lot (...) praying, speaking to God is helpful (Ad: 13)*

This suggests that the simple act of being around others—without necessarily engaging in deep conversations—helped her feel less isolated and more connected to the world. This kind of social interaction, even in its more subtle forms, played a key role in building resilience by providing her with a sense of normalcy and distraction from her inner struggles. In addition to her social connections, Adjua's faith served as a crucial anchor during her experiences with anxiety and depression. She finds strength in prayer, noting that *"praying, speaking to God is helpful."* For Adjua, religion offers a personal and ongoing source of comfort and stability, allowing her to make sense of her emotional experiences through spiritual reflection. This aspect of her resilience is more internal, providing a private space for her to process her struggles and seek solace. Together, external social interactions and internal spiritual practices shape Adjua's multifaceted resilience. Her experience illustrates how individuals often draw from various sources to navigate mental health challenges, finding strength in both their relationships with others and their relationship with faith. This dual approach combines social and spiritual support.

Akua, a Ghanaian female, makes sense of cultivating strength and building resilience through her depression. Akua accounts,

> *I think because sometimes, when we are depressed, we pray to God (Ak: 34).*
>
> *I wasn't myself again (…) My lifestyle changed. So I started (...) I think I turned all my attention to shopping and going out (Ak: 32).*

Akua highlights the role of faith as a deeply embedded source of spiritual resilience, providing solace and a sense of control through prayer. This practice aligns with her cultural and religious background, offering hope and comfort in the face of emotional turmoil. On the other hand, her turn to external activities, like shopping and going out, reflects a different strategy, where she seeks temporary relief and distraction from her pain. These activities serve as a way to maintain functionality and regain some control over her

disrupted life, even if they do not directly address the root of her emotional struggles. Together, these coping mechanisms illustrate how Akua navigates both spiritual and material avenues of resilience, depending on internal reflection with external actions to manage her depression.

Efia, a Ghanaian female, in her account of cultivating strength and building resilience, she initially describes how she copes with her emotions captured in her statements,

> *Honestly, I'm used to bottling up my emotions. When I feel upset, I just tend to sleep it off, so I don't really think much of it (...) I don't have a lot of space to be able to cry (...) Sometimes I have to wait until the end. When I'm alone (...) if I'm really upset, I'll just cry to my friend, or I'll just call up my best friends (Ef: 88-89)*

The imagery of *"bottling up"* emotions and her mention of needing to *"wait until the end"* to cry highlights the constraints she feels in expressing her feelings openly, discussed in Sub-GET 3.2. Instead, Efia turns to trusted friendships for emotional release, often crying alone or confiding in her best friends. This reliance on solitude and close friendships as emotional outlets signifies both her resilience and the limitations imposed by cultural or family dynamics, where crying is seen as a private matter, as discussed earlier. Efia's reflections on her cultural and religious context further illuminate how she navigates the intersection of these factors in her mental health journey. Efia points out,

> *As a Christian, I don't believe God thinks you're crazy for going through this. We should be able to listen and talk it out, not just run straight to the church saying, 'My child is crazy' (...) I think sometimes we Africans believe that you have to struggle through it and that it will pass; you just have to be strong-minded. I think that's not very helpful (Ef: 92-93).*

Efia challenges the belief held in some African communities that faith alone can resolve mental health issues. She critiques the tendency within her community to view mental health through a spiritual lens, where prayer is seen as the primary solution. Efia emphasises the importance of talking openly about mental health rather than relying solely on religious intervention. Her rejection of the *"crazy"* label highlights the stigma associated with mental health issues in her culture, where seeking help can be perceived as a sign of instability, as

discussed in Sub-GET 3.2. This creates a tension between her faith, which she continues to value, and the broader cultural beliefs about mental health that she resists. Moreover, Efia reflects on the pervasive "struggle mindset" in African communities, which posits that enduring hardship without complaint is a sign of strength. She articulates the cultural expectation to *"struggle through it and that it will pass; you just have to be strong-minded."* However, she challenges this notion, stating, *"I think that's not very helpful,"* recognizing that such stoicism often prevents individuals from seeking the help they need. This tension between cultural stoicism and the need for emotional expression is central to Efia's experience. She critiques the belief that resilience is solely about enduring difficulty, instead advocating for the importance of vulnerability and seeking support as a form of strength. Her rejection of the *"just get through it"* mentality highlights her evolving understanding of resilience, which now, for Efia, includes openness and self-care rather than suppression. In addition, Efia's journey toward self-awareness is a key aspect of her resilience. She states,

> *You have to surpass that and realise it's OK to talk about your problems. I'm open with my problems. When I'm upset, I talk it out with people. I've been told I'm quite self-aware. I know my problems and what I need to change in how I operate in this world, especially as a Black woman (Ef: 99-100).*

Here, Efia describes a shift from silence and suppression to openness and self-advocacy. Her sense of resilience is not tied to traditional notions of stoic strength but rather to her ability to recognise her emotional needs and seek support. Efia's self-awareness as a *"Black woman"* navigating mental health challenges is significant, as she acknowledges the specific cultural and societal pressures that shape her experience. Efia's resilience, therefore, is not only about individual strength but also about resisting cultural norms that stigmatise vulnerability and mental healthcare.

Agnes, a Nigerian female making sense of how she cultivates strength and builds resilience, highlights her parents' role in encouraging her to *“stay strong”* phenomenon. As discussed earlier, this underlines a common cultural narrative of resilience through personal fortitude, particularly within African families. She states, *“My parents, they try and like… want me to stay strong” (Agnes, p. 19),* revealing the tension between external expectations and internal

emotional struggles. Agnes appears to internalise this message from her parents, who may be responding to their own cultural perceptions of strength, where enduring hardship silently is often the norm. This reflects a form of *cultural stoicism*, where parents, perhaps unconsciously, push the notion that adversity should be borne without complaint. For Agnes, this message may contribute to feelings of isolation, as her parents' well-meaning encouragement could be perceived as downplaying the severity of her emotional distress. However, this also becomes a source of resilience as it compels her to find alternative methods of coping, such as seeking help through her school's Step Therapy Program.

The Step Therapy Program serves as a pivotal turning point for Agnes, allowing her to rebuild her sense of self-worth and confidence. Agnes recounts,

> *I got help from my school's Step Therapy Program, and it really helped me to find that confidence again to interact with people and not be scared about what they're going to say to me (Ag: 20).*

Through therapy, Agnes is able to explore and process her fears and anxieties in a safe space, which leads to tangible behavioural change—she regains the ability to interact with others without fear. The therapy program offers a counter-narrative to her previous experiences of isolation, where neither her school nor her family provided sufficient emotional support. This shift from isolation to professional support highlights how resilience can be cultivated internally and through access to external resources. The fact that the program helped her *"find that confidence again"* points to a restoration of self, suggesting that Agnes previously had this confidence but lost it due to prolonged negative experiences such as racist comments. The therapeutic process serves to revive this latent sense of self, which is foundational to her developing resilience. With the success of the school's therapy program, Agnes advocates for its broad access. Her words,

> *I think it should be rolled out for every school because there's always going to be someone who really needs that extra help but doesn't have access to it, like how I was when I was a lot younger. I didn't have access to the help that I really needed (Ag: 24)*

For Agnes, this is not just personal; she has developed a broader social awareness, recognizing that the systemic lack of support she experienced is likely a widespread issue. Her advocacy for broader access to mental health support demonstrates her maturity and insight. It also suggests that Agnes has not only cultivated personal resilience but also grown into a position where she can think about the well-being of others. By calling for wider availability of therapeutic services, Agnes transforms her individual experience into a collective call for action, highlighting how resilience can extend beyond personal survival to communal empowerment.

Chichi, a Nigerian female, reflects on how she cultivates strength and builds resilience also offers a nuanced understanding of the evolving nature of coping mechanisms. Initially, her approach to stress and mental health challenges involves a form of self-protection through avoidance. Chichi narrates,

> *I think removing myself from what has stressed me, but I feel like what I did is like running away from the issue rather than tackling it head-on. So, I wouldn't say it exactly helped. I would say it more like kind of pushed it to the side (Ch: 53)*

By removing herself from the stressful environment of the university, Chichi demonstrates agency, but she simultaneously recognises that this method feels incomplete. She perceives her actions as a temporary relief from overwhelming pressures rather than a long-term solution to her struggles with anxiety and depression. This tension between self-preservation and perceived avoidance forms the foundation of her early understanding of resilience. As her narrative progresses, Chichi's sense of resilience begins to shift. She then acknowledged IAPT and said,

> *The only thing I would do differently is now that I have been informed of the help available; if it comes back, I would seek help faster than before (Ch: 53).*

The knowledge about mental health resources, like IAPT, redefines her approach to managing her well-being. While she initially distanced herself from the stressor, she now expresses a proactive stance, emphasizing that she would seek help faster if she encounters similar difficulties again. This transition from avoidance to engagement demonstrates her evolving understanding of strength—resilience is no longer just about enduring in isolation

but about seeking support and addressing challenges head-on. This marks a significant development in her journey of resilience-building.

Daba, a Nigerian male, has a multifaceted journey of cultivating strength and building resilience. It emerges from his reflection on personal growth through adversity. Daba reflects;

> *Before university, I wasn't as mature as I am now, but for me to be mature, I have had to go through experiences that shape the kind of person you are, and a lot of those experiences may be negative experiences (Da: 56-57).*

He acknowledges that to become mature, he had to navigate challenging and often negative experiences, which shaped him into the person he is today. This understanding reflects a transformative view of hardship, where Daba perceives these experiences as essential to his development. By situating adversity as a necessary path to maturity, he redefines negative events not as obstacles but as opportunities for growth. This perspective highlights how Daba's resilience is possibly rooted in his ability to reframe difficult circumstances as instrumental in shaping his character. A significant source of Daba's strength is his faith, particularly his relationship with God. Daba acknowledges.

> *First and foremost, my relationship with God (Da: 60). In our culture, we're very priderful (Da: 65). Praying about things is a kind of therapy for me. So yeah, it's just good to seek help from God. So that definitely helps, yeah (Da: 59).*

Daba emphasises that prayer acts as a form of therapy for him, offering solace and support in times of mental distress. His statement, *"Praying about things is a kind of therapy for me,"* reveals how he intertwines his spiritual practice with his emotional well-being. By turning to God in moments of vulnerability, Daba demonstrates how faith becomes a key pillar in his resilience. In addition to his spiritual practices, Daba incorporates physical fitness as part of his routine, further enhancing his mental health: "*Gym as well, like just fitness in general. Definitely, yeah, (…) definitely help you" (Da: 60).* Daba's cultural context also plays a pivotal role in how he navigates resilience. He acknowledges that his culture is *"very prideful,"* which shapes how emotions, particularly those linked to vulnerability, are expressed or withheld. While cultural pride can foster a strong sense of identity, it may also act as a

barrier to openly discussing mental health challenges. This tension reflects a common theme in many communities where pride and resilience are intertwined, but emotional openness is often stigmatised, as discussed earlier. For Daba, resilience also extends into his social relationships. Daba recounts,

> *Just surrounding yourself with good people and just relationships in general. Like you know, day-to-day life you're socializing with people who are going to affect your mood, so you (…) want to make sure that they are people to help you stay in [a good mood] all the time (Da: 60).*

For Daba, surrounding himself with positive, supportive individuals is crucial to maintaining his mental well-being. He recognises that the people in his life significantly influence his mood and mindset, suggesting that resilience is not an isolated endeavour but one bolstered by a strong community. Additionally, Daba's resilience is deeply connected to a form of stoicism and emotional detachment. His approach to adversity is pragmatic, as he explains that he has learned to "shrug it off" rather than dwell on negative experiences:

> *I just learned to shrug it off, if that makes sense. Maybe it's the type of person that I am. I don't like to dwell on things a lot. So with me, it's like life goes on because I'm still young (Da: 57).*

This attitude reflects a cultural and perhaps personal inclination to avoid being weighed down by emotional struggles, preferring instead to move forward. While this form of stoicism allows him to maintain a sense of strength and control, it may also serve as a defence mechanism that prevents deeper emotional engagement with his challenges, as discussed in Sub-GET 3.2. Nonetheless, Daba's assertion that *"life goes on"* points out his forward-looking resilience, where his ability to detach from emotional distress enables him to focus on the future rather than be consumed by past difficulties. This approach to well-being, combining prayer, fitness, stoicism and social relationships, illustrates how he actively engages in practices that strengthen both his mind and body, cultivating resilience from multiple dimensions.

Edith, a Nigerian female, reflects on cultivating strength and building resilience also reveals a multifaceted approach to managing her mental well-being. Her view that;

> *I see watching TV and talking to friends and stuff like that as a form of therapy for me (Ed: 73). I don't feel like [using professional services] (...) because my friends can give me that therapy" (Ed: 74)*

This highlights her reliance on informal networks for emotional relief. For Edith, these interactions provide a therapeutic outlet that negates the immediate need for formal mental health services. Her assertion that *"my friends can give me that therapy"* demonstrates a strong sense of agency, where she leverages personal relationships to alleviate emotional distress. This informal form of care plays a significant role in her resilience, allowing her to manage her emotions in ways that feel accessible and effective within her everyday life. Religion also emerges as a crucial source of strength for Edith, who describes it as a form of therapy.

> *So, it doesn't matter where you're from and what religion you are. Obviously, you can believe what you believe in terms of, like 'God can see me' and whatever. But everybody needs help. And even religion can be a source of therapy (Ed: 75)*

By integrating faith into her coping mechanisms, she expands the concept of therapy beyond its clinical definition, aligning it with her cultural and spiritual beliefs. For Edith, religion serves not only as a guiding principle but as an emotional refuge that offers solace during difficult times. This reflects her ability to draw on culturally grounded sources of strength, further enhancing her resilience by creating a spiritual dimension to her mental healthcare. Despite her reliance on informal support and religion, Edith also discusses her family's role in her emotional well-being, emphasizing the need for parental involvement in her happiness. Edith's message to parents

> *to my parents, If we're not happy, they should ask what it is and how they can make us happier (…) My parents should prioritise our comfort (Ed: 79)*

Edith expresses a desire for her parents to prioritise her comfort and engage in open communication about mental health. This expectation reflects a tension between traditional family dynamics and her own evolving understanding of emotional care. Edith's critique of her parents' communication skills highlights a gap in the support she receives at home, which challenges her resilience in certain aspects. However, her ability to articulate this need

also suggests a form of emotional intelligence and self-awareness, which contributes to her overall strength. By seeking understanding from her family while simultaneously building resilience through other means, Edith navigates a complex emotional landscape that seemingly balances familial expectations with her personal needs.

Osas, a Nigerian female, reflects on cultivating strength and building resilience and reveals a multifaceted coping process. The spiritual dimension of her resilience is central, where prayer and scripture provide a foundation for her strength. Osa explains,

> *When I do go through it and when I am feeling a bit low, I just turn to God. I pray. I read my Bible. I do have a lot of (...) friends who are also Christians, which helps because when I do go through it and I feel like I can't even pray at the moment, I would call a friend, and we'll talk through it, pray about it. And it does make me feel better in the moment (Os: 163)*

Osas makes sense of her resilience by turning to God during low moments, seeking solace and guidance through her faith. This act of prayer becomes a moment of release and emotional regulation, enabling her to face her difficulties with renewed strength, even when she feels overwhelmed. Her reliance on friendships, particularly those rooted in shared religious beliefs, is equally significant. By involving her Christian friends when she feels unable to pray alone, Osas constructs a communal approach to resilience. This sense of shared faith reinforces her strength, as the prayers and support from friends provide spiritual encouragement and foster a collective sense of coping. Osas' comments suggest that her friends reflect her values, influencing her positively during hardships and emphasizing how her social environment directly impacts her resilience. Osas' experience reflects an active process of meaning-making where resilience is not simply an internal trait but is cultivated through faith and reinforced by her social network. She emphasised friendship and relationships:

> *Friendships really help in general because the type of people you carry around with you is going to reflect on you yourself (Os: 173).*

Osas highlights the reflective aspect of resilience. She acknowledges that the company she keeps significantly impacts her own strength and emotional well-being, suggesting that her

resilience is partly shaped by the positive influences of those around her. In essence, Osas' resilience is an interplay of spiritual, social, and self-reflective processes, all contributing to her ability to navigate and grow from difficult experiences.

For Nkiru, a Nigerian female, deliberate choices marked her journey of cultivating strength and building resilience. She states,

> *I knew that I wanted to live. I needed a space to heal. I needed something to get myself better (Nk: 142).*

This reflects a critical moment of self-determination. At this moment, Nkiru consciously chooses life and healing, marking the beginning of her resilience-building process. The need for a *"space"* to heal suggests that she views strength not merely as an internal characteristic but also as something nurtured in the right environment. This space for healing is both physical and emotional, emphasizing the importance of creating a supportive context

for recovery. For Nkiru, the decision to pursue healing is the first step in developing resilience, demonstrating that strength begins with an active choice to survive and thrive. Her journey continues with the realization that resilience requires continuous self-advocacy. Nkiru's persistence in seeking mental health services is evident when she states,

> *I had to advocate for myself more, so I had to constantly go to these appointments and constantly be on them for me to get signposted to a mental health service (Nk: 141).*

This highlights how resilience is cultivated through action, particularly in navigating complex mental health systems. Nkiru's need to advocate for herself illustrates the barriers she faced as she sought care, highlighting that resilience involves enduring these challenges and actively working to overcome them. The strength she draws from this process is tied to empowerment—learning how to advocate for her own needs becomes a critical aspect of her growth. Her narrative positions resilience as something earned through persistent efforts to access and maintain the care necessary for her well-being. Also, Nkiru links her mental well-being to her physical health, recognizing the role of activity in her overall resilience. Nkiru notes,

I found that when I've been the most active, my mental health has improved a lot more than when I haven't been active at all (Nk: 148).

Here, she reflects on the connection between physical and mental health, recognizing that taking care of her body plays a significant role in managing her mental state. This perceived holistic approach suggests that for Nkiru, resilience is multi-faceted, involving both physical self-care and mental fortitude. By engaging in physical activity, she experiences tangible improvements in her mental health, reinforcing the idea that resilience is about emotional strength and maintaining a balance between mind and body. Her reflections illustrate that cultivating resilience involves integrating various aspects of self-care to build a foundation for long-term well-being. Nkiru's reflections offer a nuanced understanding of resilience as something actively cultivated through deliberate choices, self-advocacy, and physical activity. Her experiences highlight that strength is not inherent but is developed.

Parents' Perspective'

I now explored how parents understand and interpret the ways they support their young person in cultivating and building resilience through anxiety and depression.

Chike, a Nigerian father, reveals a deep reliance on prayer as a primary coping mechanism for supporting his son through adversity. He recounts,

When my son had all these problems, I devoted a lot of time to prayer. I know that it works. What I didn't do would have been to add this dimension to it because then the prayer would have been more focused, and maybe we would have had a more lasting solution. All that we know as Africans is about prayer (...) we haven't balanced our life well. We just focus on one area of prayer and we don't balance (Ch: 194-195).

Chike expresses a firm belief in the power of prayer, which highlights the culturally rooted practice in many African communities, where prayer is viewed as the main source of strength during difficult times. Chike interprets resilience as being strongly tied to spiritual engagement, where faith becomes not just a way to cope but a tool for enduring and overcoming adversity. For him, prayer is synonymous with building inner resilience, a crucial

component in facing his son's struggles. However, Chike also reflects on the limitations of relying solely on spiritual support. His admission, *"What I didn't do would have been to add this dimension to it because then the prayer would have been more focused,"* suggests an evolving understanding that resilience might require more than just spiritual practices. He begins to acknowledge the potential benefit of combining prayer with other forms of care, such as psychological therapy. This shift reflects a growing awareness that resilience, particularly in the context of mental health, could be more effectively cultivated through a balanced approach that includes both spiritual and medical or psychological interventions. Chike's reflections indicate a realization that while prayer offers spiritual strength, it may not be sufficient to provide lasting solutions for his son's mental health challenges.

Moreover, the cultural dimension of Chike's experience is critical to his understanding of support. He notes, *"All that we know as Africans is about prayer... we haven't balanced our life well,"* conveying the cultural tendency to prioritise spiritual solutions over psychological care. His acknowledgement of an imbalance in life reflects his growing critique of this approach. He begins to question the adequacy of relying entirely on prayer and recognises the need for a more holistic strategy in supporting his son. This marks an important shift in how Chike interprets resilience—moving from a singular spiritual focus to considering a more integrated, multifaceted approach.

Chike's reflection on what he *"didn't do"* also demonstrates a process of critical self-awareness. As he revisits his actions, there is an evident tension between his initial focus on prayer and his current understanding of the need for a broader range of support. This self-reflection is crucial in the development of his interpretation of resilience as he moves toward a more comprehensive view of how to support his son. His sense of regret over not adding *"this dimension"* to prayer suggests that he now believes resilience requires a combination of spiritual, emotional, and psychological resources. Chike's evolving perspective on resilience points to an important personal growth in understanding mental healthcare, where spiritual practices remain vital but are complemented by other forms of support.

Osazie, a Nigerian mother, has experiences supporting her children in cultivating resilience, which is impactful. She recalls,

> *I was talking to them not just as their mother but also as [who is aware of issues around depression]. How are you struggling with what has happened to us? You know, how are you doing? Are you keeping up? Are you OK? And I'm generally checking in on them all the time." (Os: 273)*

She engages in active emotional monitoring, not simply asking her children how they feel but framing these questions through a lens of therapeutic awareness. By continuously checking in on their emotional well-being, Osazie demonstrates that she understands resilience as something that has to be actively nurtured through open communication. This ongoing dialogue contrasts with traditional norms in her Nigerian cultural background, where emotions are often suppressed. Her dual identity enables her to bring a more therapeutic approach to supporting her children, encouraging them to address their feelings rather than internalise them. Osazie's professional background allows her to recognise the potential dangers of unaddressed grief, understanding that it can lead to depression if not carefully managed. Her statement,

> *I tried to do everything to support them and help them see that even with Dad not around, we can still live life. OK, we won't die (...) because that's the direction of sadness that breeds depression." (Os: 274)*

She relies on a proactive approach to fostering resilience by helping her children maintain a sense of forward momentum despite their profound loss. This emphasis on continuing to engage with life aligns with her awareness that unchecked sadness can spiral into depression, particularly within the context of familial grief. Her support is emotional and practical, as she encourages her children to re-engage in everyday activities, thus demonstrating that for Osazie, resilience is about emotional expression and the capacity to move forward.

Culturally, Osazie's approach to resilience intertwines traditional narratives of survival with a modern therapeutic sensibility. While African cultural expectations often emphasise stoicism and endurance in the face of hardship, Osazie's approach combines these elements with an active engagement in mental health. By teaching her children that *"we won't die"* despite their father's absence, she frames resilience as both survival and a forward-looking process

that demands ongoing emotional and practical support. Osazie's reflections show that resilience is not an automatic outcome but something that needs to be cultivated through continuous support and encouragement in the face of life's challenges.

In Kemi's account, a Nigerian mother,

> *I purposely allowed her to stay out of school for about a year now so that she can air out everything that was going on in her mind (…) She's healed now because I gave her the space to process it all (Ke: 228).*

Her decision to allow her daughter to stay out of school for a year to *"air out everything"* highlights a key aspect of how Kemi understands the process of building resilience. By stepping back and providing her daughter with the time and space to process her emotions, Kemi demonstrates an intuitive understanding that healing cannot be rushed. Rather than pushing her daughter to immediately return to school, Kemi frames resilience as something that involves internal reflection and emotional processing, not just external actions. This reflects a broader view of resilience as a gradual, self-directed process, where individuals need time to regain emotional stability before taking on life's challenges again. Kemi's reflections also reveal how shared emotional struggles can shape the ways parents support their children. Her statement,

> *I couldn't put my eye on her because both of us were depressed (…) So, this is the thing, (...) she's ready to see a professional because she just called me today asking if she could go back to school" Ke: 231)*

Kemi points to the interconnectedness of her and her daughter's experiences. Kemi's own mental health challenges impacted her ability to fully support her daughter, creating a situation where both were navigating their individual battles with depression. Possibly, each supporting the other. In Kemi's account, their shared journey shows that resilience-building is not just the young person's responsibility but is a relational process where both the parent and the child influence each other's emotional recovery. Kemi's daughter's eventual decision to seek professional help marks a turning point, signalling a shift towards empowerment and readiness to re-engage with life, reinforcing Kemi's view of resilience as a collaborative effort.

Furthermore, Kemi's understanding of resilience is also shaped by the non-linear nature of recovery. Her acknowledgement that both she and her daughter were struggling with depression shows how resilience is often a slow, evolving process rather than a straightforward path. Allowing her daughter time away from school reflects Kemi's recognition that resilience might not be achieved through immediate action but requires moments of retreat and self-care. This understanding challenges conventional views of resilience as bouncing back quickly, offering instead a perspective that values gradual recovery and the importance of emotional space in cultivating long-term resilience.

Cultural and familial dynamics play a crucial role in how Kemi supports her daughter's resilience. Her narrative reflects a tension between cultural expectations and the reality of her daughter's mental health struggles. Kemi's eventual encouragement for her daughter to seek professional therapy represents a significant departure from traditional cultural norms that may stigmatise mental health issues, as discussed in Sub-GET 3.2. In this way, Kemi supports her daughter's resilience by recognizing the need for external help and navigating and challenging cultural assumptions about mental health.

Summary of the Shared and Unique Features of Participants' Experiences

Participants cultivated resilience through faith and social support. Prayer and relationships with God offered solace. Social connections, like friendships and supportive environments, also provide emotional relief and strength during struggles.

Each participant demonstrated unique approaches to cultivating resilience during traumatic experiences. Ghanaian Participants: Kofi combined faith and therapy, viewing prayer as a refuge and his therapist as an instrument of God's healing, blending spiritual and psychological recovery. Adjua found relief in social interactions, spending time with friends and leaving the house to alleviate emotional strain, alongside prayer for solace. Akua balanced faith and external distractions like shopping and outings to regain control and cope with depression. Efia critiqued cultural stoicism, advocating for open discussions about mental health and emphasising vulnerability as a source of strength. The Nigerian youth participants: Agnes regained confidence through her school's therapy program while navigating the tension between cultural expectations of stoicism and her emotional

struggles. Chichi initially avoided addressing her mental health but later embraced seeking help. Daba combined prayer and fitness to cope, drawing resilience from cultural pride and a forward-looking mindset. Edith leaned on informal networks, finding solace in friends and therapeutic activities like watching TV. Osas relied on prayer, Christian friends, and supportive social circles. Nkiru prioritised self-advocacy and found physical activity essential for improving her mental health.

The Nigerian Parents: Chike blended prayer with psychological interventions, evolving to appreciate the balance between spiritual and professional support. Osazie actively monitored her children's well-being, emphasising emotional support and engagement. Kemi gave her daughter space for emotional processing, valuing self-care over rushing into responsibilities.

Are There Differences In How Young Ghanaians And Nigerians Cultivate Strength And Resilience?

Young Ghanaians and Nigerians share common strategies for cultivating strength and resilience, particularly in their reliance on faith, social support, and self-advocacy. However, subtle differences emerge in how these elements are prioritised and expressed. For Ghanaians, faith often serves as a private refuge. Participants like Kofi and Adjua highlight the central role of prayer and spirituality in managing mental health challenges. Their approach tends to combine faith with subtle social interactions, such as spending time with friends without discussing personal struggles. This quieter, internally focused resilience is further reflected in Efia's preference for "bottling up" emotions, revealing feelings only in trusted friendships. Ghanaian participants often integrate faith with personal coping strategies while navigating cultural expectations of stoicism.

In subtle contrast, Nigerians appear to adopt a more multifaceted and communal approach. Faith remains vital, as seen in Daba and Osas's reliance on prayer and Christian friendships for emotional support. However, they also emphasise the importance of positive social connections and professional help. Nkiru's proactive pursuit of therapy and Chichi's emphasis on self-advocacy highlight a shift toward combining traditional faith-based

practices with modern mental healthcare. This openness to communal and professional support reflects a broader network of resilience-building.

5.5.4. Main GET 3 Summary:

In Main GET 3, the focus is on how participants cope with trauma, emphasizing three sub-GETs. Sub-GET 3.1: Traumatizing Experiences - This sub-GET highlights the profound impact of trauma, including loss, external pressures, and the resulting anxiety and depression. Participants' experiences illustrate the weight of these events, such as Agnes' struggle with racism, Chichi's stress from academic pressures, and Kofi's grief from significant losses. Each narrative reveals how trauma affects mental health, leading to isolation, fear, and the feeling of being unsupported. Sub-GET 3.2: Silent Struggles - This section explores the internalised responses to trauma, where participants often dealt with their struggles silently. Cultural norms and family expectations of resilience frequently contributed to this silence. For example, Nkiru discusses the cultural expectation to rely on prayer rather than seek external help, while Daba describes "shrugging off" emotions to cope. The silence reflects a form of cultural stoicism, leading to further isolation as emotional expression is discouraged. Sub-GET 3.3: Cultivating Strength and Resilience - Participants describe how they built resilience through spiritual practices like prayer, support from social connections, and personal growth. Kofi, for instance, finds solace in faith and therapy, seeing both as complementary in his recovery. Similarly, Osas draws on friendships and prayer for support, while Adjua emphasises the importance of being around friends, even without discussing her struggles. These narratives illustrate a blend of spiritual, social, and self-reflective strategies that help participants navigate their emotional challenges.

5.6. Chapter Summary

In this Chapter, I have analysed young Ghanaian and Nigerian individuals' experiences regarding care for anxiety and depression in Inner London, revealing the intricate ways in which cultural factors intersect with mental health services. The analysis, rooted in IPA, offers a nuanced view of how these young people, along with their parents and

practitioners, navigate the mental health landscape, shedding light on the gaps and potential areas for improvement within the current care model.

A key theme that emerges is the sense that *"The Model Itself Isn't Made for Diverse People."* Participants frequently voiced concerns about the cultural disconnection they experienced when seeking mental health support. Significantly, interactions with therapists from different racial backgrounds posed challenges to effective care, revealing the limitations of a perceived one-size-fits-all approach in a culturally diverse setting like London. Practitioners, too, recognised this shortcoming, noting the low engagement levels among Black clients and the need for a more adaptable, culturally sensitive model of care. This feedback highlights the systemic issues within existing mental health frameworks and points to the necessity of reforms that better accommodate diverse communities.

Building on this, the theme *"I Have Not Heard of This Before"* highlights a pervasive lack of awareness around mental healthcare within the communities of these young participants. Many described the absence of open dialogue about mental health issues in their families and communities, where cultural and religious beliefs often take precedence over professional care. This lack of awareness is compounded by generational dynamics, with younger people feeling caught between the expectation to "stay strong" and their desire for more open conversations about their struggles. Practitioners emphasised the importance of outreach efforts to bridge this gap, suggesting that services need to be more visible and accessible to the populations they aim to serve.

The third theme, *"Coping with the Weight,"* shifts focus to how these young people and their families manage the burdens of trauma and adversity. Participants shared their experiences with racism, loss, and the pressures of cultural expectations, which often led to a reliance on inner strength, faith, and community support. While these coping strategies helped some navigate their challenges, others highlighted the emotional toll of managing such burdens in isolation. This theme not only emphasises the resilience within these communities but also emphasises the need for mental health services that recognise and integrate these cultural coping mechanisms into care plans.

Together, these themes paint a complex picture of the mental healthcare experiences of young Ghanaian and Nigerian individuals in Inner London. They reveal the disconnect between the structured, evidence-based approaches of services like CBT and the lived realities of those they aim to support.

5.1. What Next?

The chapter calls for a reimagined model of care that blends cultural humility with clinical expertise to create a more inclusive, effective mental healthcare system for diverse populations. This reimagining involves adapting therapeutic approaches and building stronger connections between mental health services and the communities they serve, ensuring that care is accessible and culturally relevant. The next chapter will discuss these results in the context of relevant theory and existing research and explore the findings' implications.

Chapter 6: Phase II: Research Impact Workshop

This chapter showcases the impact of the research and answers the research question.

How can the views and preferences of Ghanaians and Nigerians towards the care for anxiety and depression inform the mental healthcare and practice design?

Initially, I planned to conduct a focus group for this phase; however, receiving the IOE Early Career Impact Fellowship allowed me to design a broader, sponsored workshop as an integral part of the research process. Rather than being limited to dissemination, the workshop served as a participatory research method, creating a platform for co-production and knowledge exchange. The workshop facilitated the generation of new insights by bringing together young Ghanaians and Nigerians aged 16-25, parents, community and faith leaders, healthcare practitioners, and policymakers/service designers. Through structured participatory activities—such as facilitated discussions, collaborative action planning, and anonymous contributions—the workshop validated the findings and extended the research by capturing diverse stakeholder perspectives to inform actionable recommendations.

During the workshop, I presented my findings from Phase 1, the interviews, which highlighted the specific mental health challenges faced by Ghanaian and Nigerian youths in London (Chapter 5). The event included facilitated discussions between youth participants and mental health professionals, reflecting on these challenges and collaboratively developing action plans to integrate cultural humility into mental health practices (see the published Executive Summary of the Impact Workshop in Appendix A, Isiwele, 2024).

6.1. Background

This research impact workshop was conceptualised as a platform to disseminate the findings from Chapter 5 and aims to advance the practice of cultural humility among mental health professionals working with Black youth. Drawing on key frameworks (Hook et al., 2013; Royal College of Psychiatrists, 2021; Tervalon & Murray-García, 1998), this workshop highlights the importance of cultural humility as an approach that fosters equitable, non-hierarchical relationships between healthcare providers and service users from diverse cultural backgrounds. In this context, cultural humility is essential for addressing the unique

challenges faced by Black adolescents, particularly Ghanaian and Nigerian youth, whose mental health needs are often overlooked or misunderstood within conventional healthcare systems (CQC, 2018; Devonport et al., 2023).

The motivation for this workshop is grounded in the broader understanding of research impact, which is increasingly recognised as a critical outcome of academic inquiry. According to the Research Excellence Framework (REF), "impact" is defined as the "effect on, change or benefit to the economy, society, culture, public policy or services, health, the environment, or quality of life, beyond academia" (REF, 2014). It emphasises the tangible contributions that research makes to the broader community, not just within academic circles. This can include a wide range of positive effects, such as influencing policy, improving public services, enhancing quality of life, or fostering cultural understanding and transformations (Davies et al., 2007; Morton, 2015; Nutley, 2007; UKRI, 2022). As succinctly put in the Bartlett Manual of Impact (2024, p. 2), research impact can be simply understood as “the difference you or your work makes.” This workshop is thus an integral part of ensuring that the findings from this study make a meaningful and measurable difference in the lives of the populations studied and in the policies and practices that shape mental health services for Black youth in Inner London.

In the realm of health and social research, the notion of research impact has evolved significantly. Two key criteria—*reach* and *significance*—may be employed to evaluate the extent and depth of research impact. *Reach* refers to the breadth of the influence, such as how widely research outcomes are disseminated and adopted across different sectors, communities, or regions. *Significance*, on the other hand, focuses on the magnitude of change or transformation brought about by the research, assessing how deeply it impacts the target audience or field (UKRI, 2022).

Both “reach” and “significance” are crucial dimensions in this workshop. *Reach* in the sense that the research findings on the mental health experiences of Ghanaian and Nigerian youth have the potential to influence mental health policies, professional practices, and service delivery models across Inner London and beyond. Given the historically marginalised position of Black communities within mental health research and care (Devonport et al.,

2023; Littlewood & Cross, 1980; Rwegellera, 1977), the *significance* of these findings lies in their capacity to drive systemic change and foster more inclusive, culturally sensitive approaches to mental healthcare.

I align with the collaborative approach with the understanding that impact is most effective when it is built on mutual understanding and respect between researchers and the communities they engage with (Bayley & Phipps, 2019; Reed, 2016). Morton (2015) advocates for collaborative, participatory approaches that engage stakeholders directly to enhance the relevance and applicability of research findings. In line with these principles, this workshop has been developed through collaboration with key groups, including the youths, families, and mental health professionals who are most directly affected by the issues explored in the research.

6.2. The Planning

I adopted a thoughtful and structured approach in planning the impact workshop, as suggested in the Bartlett Manual of Impact (2024), used in the Fellowship training program, and by Reed (2016). I attended seven essential Fellowship sessions fundamental to the planning stage. These provided valuable insights into the comprehensive nature of research impact activities. The sessions also focused on using co-production principles to engage under-represented groups in research, building an audience and communicating research effectively, delivering inclusive and practical events, crafting written evidence for policy audiences, tracking and demonstrating engagement and impact success and developing an impact narrative.

With the learning from the sessions and drawing from Reed (2016), I focussed on participant engagement and clear impact pathways. I identified the needs of participants—youth, parents, and practitioners—and co-produced knowledge through discussions to ensure relevance. Using the *Theory of Change* (Reed, 2016), I mapped out how sharing research findings could promote cultural humility and influence practice. The workshop included tailored presentations and activities, emphasising storytelling to make the research relatable. I evaluated its impact through participant feedback, gathering evidence of changes

in awareness and understanding. This approach ensured a meaningful, well-targeted dissemination of findings.

The key components include:

- Defining the purposes and goals for which I articulated the ultimate impact or change I aim to achieve.
- Mapping backwards to identify intermediate outcomes and short-term changes that will lead to the long-term goal.
- Identifying activities and outputs to determine what research activities and outputs (e.g., workshops, reports) are needed to achieve these outcomes.
- Engaging relevant participants in shaping the process ensures the research is relevant and actionable.
- Evaluating progress by establishing indicators and metrics to measure progress towards the intended impact.

This helps ensure that research efforts are purposeful, strategically aligned with the needs of participants, and able to generate measurable societal benefits. The steps are in the project's "impact and communication strategy," discussed in Section 6.2.2, with full details in Appendix H.

6.2.1. Objectives.

The workshop objectives were:

1. Sharing research findings on the mental health challenges specific to Nigerian and Ghanaian adolescents in London.
2. Facilitating discussions between youth participants and mental health professionals to reflect on these challenges.
3. Developing joint action plans aimed at incorporating the principles of cultural humility into mental health practices.

These objectives addresses the research question highlighted above.

6.2.2. Developing an Impact and Communications Strategy

Following the seven IOE ECR Fellowship training sessions, I developed a living document titled "Impact and Communications Strategy" to record and track my research impact opportunities during and after the research project. An Impact and Communications Strategy is a structured plan that outlines how to maximise the societal impact of research by strategically engaging with participants and effectively communicating research findings. It involves setting specific goals for the desired impact, identifying key audiences, developing targeted messages, choosing suitable communication channels, and evaluating the success of these efforts. This strategy helps ensure that research reaches and influences relevant decision-makers, practitioners, and communities, translating findings into real-world changes (Bastow et al., 2014; Watermeyer & Chubb, 2019). It emphasises defining purpose, considering processes, acknowledging progress, tailoring messages, embedding evaluation, upholding research integrity, being flexible to change, and utilising available resources for an effective impact and communications strategy. In the document, I meticulously outline a comprehensive plan to achieve the goals in my research impact proposal. I focused on structuring a multi-faceted approach that aligned with both the objectives of disseminating the research findings and fostering practical change in mental health practices. The Impact and Communications Strategy was detailed and comprehensive. I will only discuss the elements relevant to this write-up. In Box 2, are examples of what is included in the Impact and Communications Strategy.

Box 3: The Key Messages

The key messages to communicate are:

1. **Importance of Cultural Humility:** Cultural humility is essential in mental healthcare, especially for addressing the unique needs of Black youth in London.
2. **Community-Centred Care:** Effective mental healthcare for Black youth involves listening to their experiences and incorporating their perspectives into care practices.
3. **Collaborative Solutions:** By collaborating with Black youth and their communities, mental health professionals can develop more relevant and effective strategies.
4. **Commitment to Action:** Stakeholders, including policymakers and healthcare providers, are urged to commit to actionable plans that promote cultural humility in their practices.

5. **Ongoing Engagement:** The project emphasises the importance of sustained engagement and adaptation of mental health practices to reflect evolving community needs and feedback.

Defining Purpose and Goals.

This workshop aims to create a collaborative platform that bridges research findings with actionable outcomes aimed at improving mental healthcare for Ghanaian and Nigerian youth in Inner London. I seek to disseminate key insights from my study on the lived experiences of these youth as they navigate anxiety and depression care in a culturally diverse urban setting (published protocol: Isiwele et al., 2022, in Appendix I). The core objective is to promote cultural humility among mental health professionals by engaging them in meaningful discussions with the youth, their families, and community stakeholders.

Cultural humility is crucial for addressing the unique needs of Black youth in mental healthcare. By foregrounding this principle, I aim to encourage professionals to reflect on their practices, develop more equitable patient-provider relationships, and implement care models that respect the cultural contexts of Black youths. This approach is supported by research that advocates for more inclusive and culturally sensitive healthcare models, which can mitigate disparities in mental healthcare for marginalised communities (Hook et al., 2013; Royal College of Psychiatrists, 2021).

Through this workshop, I also aim to co-create strategies with participants—youth, families, and professionals—that address systemic barriers in mental health service provision for Black youth, particularly those of Ghanaian and Nigerian descent. By involving key individuals in the design and implementation of culturally responsive care, this workshop seeks to integrate cultural humility into clinical practices and institutional policies in a way that is sustainable and scalable (Morton, 2015).

In the end, my goal is to initiate systemic change that ensures mental health services are accessible, culturally responsive, and tailored to the needs of underserved communities (Rivas, 2024). By fostering a space for collaboration and co-creation, this workshop will

potentially contribute to addressing the mental health disparities faced by Black youth in Inner London and beyond (UKRI, 2022).

The workshop's goals were clearly delineated, ensuring that participants understood the relevance of the discussions and activities to improving mental health outcomes for Black youth. This was clearly stated in the invitation letters; see Appendix J.

Audience Mapping and Tailored Messaging:

I meticulously mapped out the communities and individuals relevant to the workshop. Recognizing that each group had different expectations and interests, I crafted bespoke invitation letters for each group via email to young people aged 16-25, parents/carers, and professionals/practitioners (including IAPT practitioners, now NHS Talking Therapy), service designers, policymakers, academics/researchers, faith leaders, and media representatives (Appendix J for all letters). For example, the youth participants were invited to engage directly in discussions that affected their mental healthcare, while professionals were encouraged to reflect on how cultural humility could enhance their practice. This tailored communication strategy was key to ensuring active participation and meaningful engagement from all participants, aligning with the principles of participatory research (Cacari-Stone et al., 2014; Minkler, 2010; Page-Reeves, 2019).

Table 10 shows examples of other relevant direct and indirect stakeholders in addition to the primary participants, which included young people, parents, and practitioners.

Table 10: Excerpt of the audiences and key stakeholders engaged and invited

Prioritised audiences (most research investments will need to target government/parliamentarians; business/private sector; civil society; media/public)	**Details (which government departments, which sectors specifically?)**	**Overview of engagement activities and communication channels**
Government/Parliamentarians	. (1) NHS England (London Region) (2) **Greater London Authority** (3) Local Councils/Talking Therapy (formally IAPT): Each London borough has a public	. (1) Host regular workshops for healthcare providers to train them in cultural humility. (2) Organise seminars where policymakers can hear directly

	health department responsible for local mental health services. **(4) Public Health England** (5) Mental Health Recovery Plan (6) Office for Health Improvement and Disparities (OHID)	from affected youth and community leaders
Business/Private Sector	. (1) Priory Group (2) UKAT London Clinic (3) Psymplicity Healthcare (4) Themindworks	(1) Write articles for major newspapers and appear on (2) community and health-related radio and (3) TV programs to discuss the importance of cultural humility in mental healthcare.
Civil Society Entities	Partner with NGOs like 1. Mind 2.Black Minds Matter 3. 100 Black Men of London 4. BME Youth 5. 4FRONT 6. Black Thrive 7. Growing Minds And any other which focus on mental health and Black communities, respectively	Send out regular newsletters to stakeholders summarising recent developments, upcoming events, and case studies of successful community engagement.
Media/public	.(1) The Guardian's health section, (2)The Voice (3) BBC community programs, and influential healthcare blogs	Attend national mental health conferences to present findings and network with potential allies. Hold public speaking events in community centers to educate and gather support from the local population.
		Establish regular communication channels with government officials and business leaders through personalised emails, briefing sessions, and face-to-face meetings

Collaborative and Participatory Communication

Collaborative participatory communication empowers communities by actively incorporating their perspectives, ensuring that the communication process is not solely directed from the top down but instead fosters a collaborative creation of meaning. It facilitates an environment where participants can openly share their concerns, hopes, and ideas, resulting in more enduring and effective outcomes (Figueroa, 2002). I facilitated an environment where participants—whether youth, parents, or professionals—were co-creators of the

workshop program and outcomes. For example, a section was created in the online registration form to capture their input on areas of interest, see Box 3. Also, the development of joint action plans during the event exemplified this participatory communication approach. By fostering dialogue and mutual understanding among different participants, I ensured that the communication of research findings was not a one-way dissemination but an interactive process that encouraged collective ownership of the outcomes.

Box 4: Example of participants' input

Utilizing Multiple Channels of Communication

I employed multiple communication channels to enhance the reach and engagement of the workshop. In addition to the in-person interactions during the workshop, I also used digital platforms such as Microsoft Forms for registration (Appendix K) and feedback collection (Appendix L). Others include social media and WhatsApp. This digital engagement ensured that participants who might not have been able to attend in person could still provide input and engage with the content. The executive summary output has been published in UCL Discovery and has been receiving significant downloads. For example, it has been downloaded 73 times between July and October 2024. These various mediums reflect the Manual's guidance on respecting stakeholder time and preferences in communication,

ensuring that information is disseminated effectively without overwhelming the audience (Greenhalgh & Wieringa, 2011).

Evaluation and Follow-Up (Discussed in Section 6.5)

Finally, an evaluation process was embedded in the communications strategy. Feedback was collected from all participant groups via a structured evaluation form (Appendix L), allowing for both quantitative and qualitative assessments of the workshop's impact. This evaluation data was crucial for assessing immediate outcomes and planning future workshop iterations, as the manual suggested. Additionally, I ensured that the findings and feedback from the workshop would inform subsequent communication strategies, enhancing the long-term sustainability of the project's impact.

6.3. Ethical Considerations:

I discuss the ethical considerations of this research in Section 3.5. In addition, due to the sensitive nature of the topic of mental health and the vulnerable group participants, amendments were necessary to the existing IOE ethics approval to accommodate the Impact Fellowship event. In organising this workshop, I integrated key ethical considerations to ensure that my research and its dissemination and co-creation (the workshop) maintain the highest standards of integrity, respect, and care. I recognise that fostering meaningful change through research impact demands a deep commitment to ethical practices throughout the process. I now discuss some key considerations in addition to those in Section 3.5.

A critical component of this workshop was addressing the **power dynamics** inherent in research partnerships, particularly when working with marginalised communities. Power imbalances between researchers, professionals, and community members have been well-documented (Cornwall, 2008; Femdal & Knutsen, 2017). In this workshop, I sought to create an equitable space where youth and families were not merely seen as subjects of research but as active participants in co-creating solutions to systemic mental health challenges. This approach aligns with advocates for collaborative, community-driven methodologies in mental health research (Bergold & Thomas, 2012).

Unintended consequences are an inherent risk in impact activities, and ethical researchers must remain vigilant to avoid reinforcing inequalities or causing harm (Macfarlane, 2008). Continuous reflection and adaptability are key strategies in managing such risks. By embedding flexibility into the workshop design, I was able to respond to emerging issues and ensure that the focus remained on fostering positive change. Flexibility in research methods is particularly important when dealing with complex social issues, such as mental health in marginalised communities, where unexpected challenges often arise (Israel et al., 2013)..

Reciprocity and acknowledgement of contributions are core ethical principles in this workshop, ensuring that participants benefit from their involvement. The workshop aimed to offer immediate value through the sharing of findings and through co-developing solutions to enhance culturally sensitive mental healthcare. Participants' insights were acknowledged as vital to shaping the recommendations and strategies discussed, ensuring they felt their contributions were valued and impactful (Cornwall, 2008).

Cultural sensitivity and humility were emphasised, given the focus on Ghanaian and Nigerian communities. This required the facilitators at each table to acknowledge the limits of their understanding and to approach the young participants and parents with respect for their cultural backgrounds and experiences (Tervalon & Murray-Garcia, 1998). Creating culturally safe spaces where participants could discuss the intersection of culture, mental health, and systemic challenges was crucial to the workshop's goals (L. T. Smith, 2021). This approach aimed to foster mutual learning and respect among all participants, making the findings and discussions more relevant to the needs of the community.

Finally, **amplifying the voices** of Ghanaian and Nigerian youth and their families was a core ethical commitment of this workshop. Research has increasingly recognised the importance of engaging marginalised communities as equal partners in research (Israel et al., 2013; Stoll et al., 2022). These communities are often excluded from conversations about mental health, and their perspectives are crucial to shaping culturally responsive care (Stoll et al., 2022). The workshop promoted inclusive, culturally sensitive mental healthcare by centring lived experiences and involving participants in action plan development.

By embedding these ethical principles into the workshop, I advanced my research and ensured that the process reflected my commitment to trust, equity, and respect for all participants.

6.4. The workshop

Thirty-six people registered, and 24 (66.7%) attended the event. The workshop began with a brief welcome, housekeeping announcements, and the coordinator's overview of the day's program (Table 11).

Table 11: The Workshop Program

Welcome and Introduction	A brief introduction by the workshop coordinator and housekeeping
Keynote Presentation	Presentation of research findings on mental health challenges specific to Nigerian and Ghanaian adolescents in London.
	The findings implicate the principles of cultural humility and its significance in enhancing mental health services.
Interactive Discussion:	**Activity 1** Facilitated discussion where youth participants share their experiences and challenges in accessing mental health services.
	Mental health professionals reflect on these insights and discuss how they can implement cultural humility practices in response to the needs expressed by the youth.
Comfort Break	
Collaborative Action Plan Drafting:	**Activity 2** **Developing Joint Action Plans**
	Youth and professionals work together in small groups to develop actionable strategies that promote cultural humility.
	Each group focuses on creating practical, youth-centred initiatives that can be implemented within the community and healthcare settings.

Commitment to Action	**Activity 3** Summary of key action plans and commitments made by both youth and professionals.
Rapid feedback	**Activity 4** Rapid feedback session to evaluate the workshop and plan for future sessions that further involve youth participation.
Refreshments and Networking	**Activity 4** This event focuses on cultivating a mindset of cultural humility, essential for effectively addressing the diverse needs of Nigerian and Ghanaian communities and other diverse youth in London and fostering a more inclusive and understanding mental health environment.

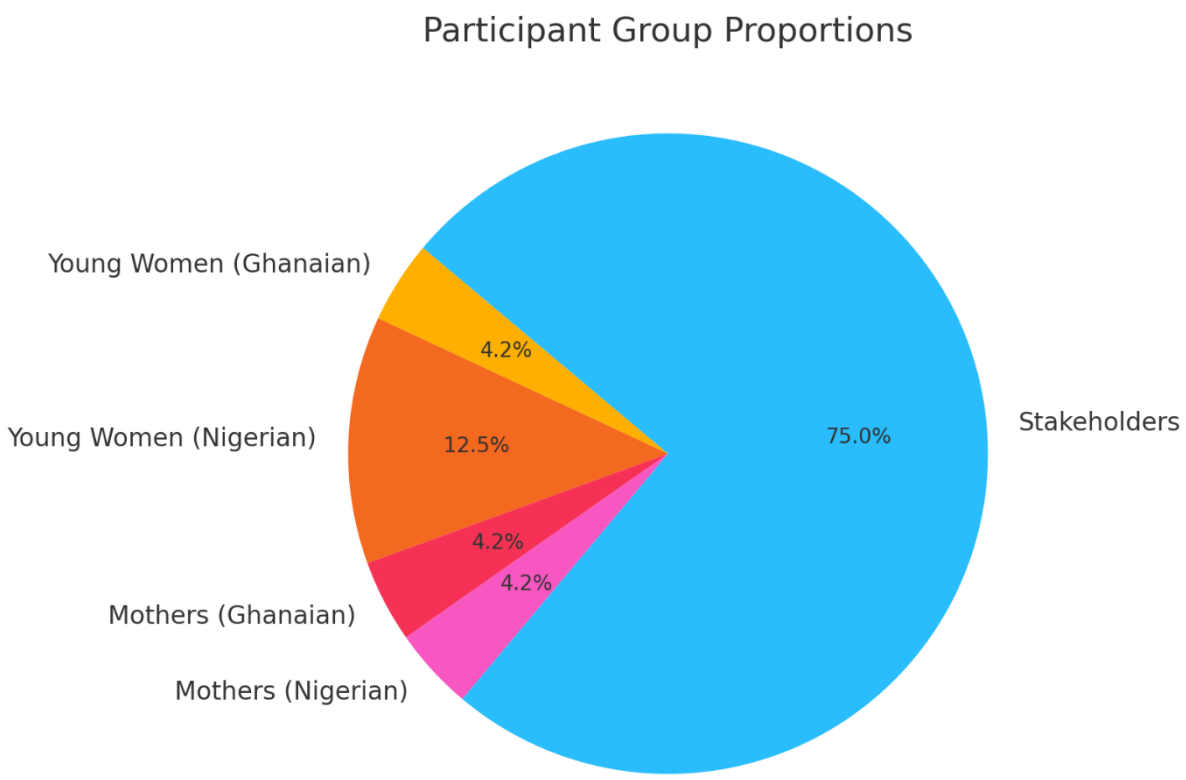
6.4.1. Sharing my research findings

The first agenda item was a plenary session where I shared the preliminary results of my research findings. To ensure the content was accessible to a non-academic audience, I simplified the language and incorporated visual aids to help explain complex concepts. The aim is to tailor communication strategies to meet the needs of non-specialist individuals, ensuring that even complex research is approachable (Cartwright & Hardie, 2012; Creswell & Poth, 2018; Lincoln & Guba, 1985). Creswell (2018) discusses how narrative approaches and visual tools can effectively bridge the gap between academic and public audiences, while Cartwright & Hardie (2012) emphasise using clear and persuasive communication. This approach aligns with the naturalistic inquiry paradigm, which emphasises studying phenomena in their natural settings (Guba, 1978). Guba also highlights the value of engaging participants in real-world contexts, a strategy particularly effective in non-academic workshops (Lincoln & Guba, 1985). They further stress the importance of understanding the context and perspectives of participants to successfully disseminate research findings, advocating for interactive and participatory techniques that resonate with broader audiences.

While simplifying complex research for non-specialist audiences is crucial for effective science communication, it is not without its challenges. Critics argue that oversimplification can risk undermining the accuracy and integrity of the information presented. These considerations were carefully weighed during the planning and delivery of my presentation. Latour (1993), for example, critiques the oversimplification of scientific facts, warning that it can distort the nature of scientific inquiry. Pinker (2015) advocates for clear, direct communication but cautions against excessive simplification that could misrepresent complex ideas.

The context in which I presented these findings included a diverse group of participants. This included four young women of Ghanaian (n=1) and Nigerian (n=3) descent, aged 17 to 21 (mean age = 19.5), as well as two mothers (one Ghanaian and one Nigerian) and 18 formal stakeholders, including practitioners, faith leaders, and politicians. In the session, we also explored the role of cultural humility in improving mental health services, followed by a Q&A session that facilitated audience interaction.

Figure 6: Participant Groups



Subsequently, the attendees were divided into four tables, equally mixed groups to encourage active participation and engagement, ensuring young Ghanaians and Nigerians were represented at each table. Each group had a designated note-taker who recorded the discussion on a flip chart (see Figure 7), while participants who were hesitant to speak could write their thoughts on Post-it notes. Each group's findings were then summarised and presented by a representative, and all notes were collected, transcribed, and analysed for further insights.

6.4.2. Participatory Method of Data Collections

Participatory methods were integral to the event's structure and outcomes (Heron & Reason, 1997). My aim was not only to disseminate the findings from my study but also to engage the participants—youth, parents, and professionals—in co-creating actionable solutions to improve mental healthcare for Black youth. This focus on participation ensured

that the discussions were rooted in the lived realities of the very communities the research intended to impact.

Participatory methods, in this case, were especially vital for promoting cultural humility in the dialogue around mental healthcare, co-creating knowledge, empowering participants, and being transformative, democratic research processes (Heron & Reason, 1997). Scholars like Israel et al. (2013) and Vaughn et al. (2017) observe that participatory research within immigrant communities allows participants to bring their cultural perspectives and lived experiences to the forefront, providing more meaningful insights. In the workshop, this was particularly important because issues surrounding mental healthcare for Black youth often involve cultural misunderstandings or gaps in service provision (Devonport et al., 2023). Using these methods, I aimed to empower the participants to shape the discussion and the resulting action plans, ensuring that their voices were centred on developing culturally sensitive solutions.

A key benefit of this approach was the emphasis on inclusivity. In the workshop, young people and their families were given the opportunity to express their concerns about accessing mental health services. Their focus was on cultural stigma, lack of representation, and systemic biases in healthcare. This participatory approach enabled me to access deeper insights into these communities' specific challenges beyond what might have been captured through more conventional, top-down research methods.

One limitation of the participatory method is the potential for power dynamics within groups to affect the outcomes of discussions. According to Cornwall (2008, p. 279), participation may be dominated “by more powerful voices or fear of reprisals. It can be because people feel that they have nothing to contribute, that their knowledge and ideas are more likely to be laughed at than taken seriously”, which can marginalise quieter or less confident participants. This can skew the findings, as not all voices are equally represented in the data collection process. In some cases, participants who are uncomfortable speaking in group settings may not fully express their thoughts, even with mechanisms like post-it notes, limiting the depth of insight gathered (Bergold & Thomas, 2012).

Additionally, the participatory approach can be time-consuming and resource-intensive (Bergold & Thomas, 2012). For example, bringing everyone to one hall for a workshop also required some financial commitment. My Impact and Communication Strategy contains a budget for hall hire, refreshments, free vouchers, stationery (including pens, post-it notes, flip charts, etc.) and £30 voucher incentives for the young people in attendance. UCL Research Culture and the IOE Early Career Impact Fellowship funded these. This participatory approach delivered through the workshop requires considerable preparation, facilitation, and analysis time. This can be a challenge, particularly in larger or more diverse groups where achieving consensus or ensuring that all perspectives are heard takes longer.

For this workshop, the resources used for data collection included Post-it notes, a flip chart for visual documentation, presentations by group representatives and empirical observations during group discussion.

1. **Post-it Notes**

   The Post-it note method proved to be a highly effective tool for encouraging participation, especially in a diverse group that included both adolescents and adults. In the context of the workshop, Post-it notes allowed participants to jot down their thoughts on mental health services and experiences with anxiety and depression care in a low-pressure, anonymous manner. For the younger participants, this method created a space for self-expression without the need to confront the often intimidating task of speaking in front of others. However, while the notes provided rich snapshots of individual perspectives, they were often brief, limiting the depth of the information, and some were difficult to read. I found that using Post-it notes as an entry point into more detailed group discussions was necessary to contextualise these responses (Figure 8).

2. **Flip Chart**

   The flip chart was instrumental in capturing the collaborative thinking of participants in real-time. As the discussions unfolded, an appointed member (volunteer) on each table used the flip chart to map out key themes, such as systemic barriers to care and the need for culturally competent mental health professionals (Figure 7). This visual representation of the group's thoughts was particularly helpful in identifying

recurring concerns, such as the lack of Black therapists and more unique perspectives on improving access to care. The flip chart helped ensure that no contribution was overlooked, but it also presented challenges in managing the louder voices in the room. As the facilitator, I was mindful of giving equal weight to all contributions, especially those from more reserved participants, who might not have been as vocal.

3. **Group Presentations by Representatives**

   The group presentations were a vital element of the workshop, where each smaller group shared the collective ideas they had developed. In this context, the presentations were not only a summary of discussions but also a means of empowering participants to take ownership of the data being generated (Heron & Reason, 1997). I observed that having representatives present on behalf of their groups gave a sense of agency to the participants, reinforcing the idea that they were not merely responding to pre-set questions but actively shaping the workshop's direction. However, one limitation I encountered was the potential for some voices to be sidelined, as group representatives tended to reflect the majority view. To counter this, I encouraged participants to ask clarifying questions and offer additional insights during and after the presentations (Heron & Reason, 1997).

4. **Empirical Observations**

   Throughout the workshop, my role as a researcher was to facilitate and observe the dynamics at play. Empirical observation gave me invaluable insights into the interpersonal and cultural subtleties often not explicitly discussed. For instance, I noticed moments where participants hesitated to engage with sensitive topics, such as the cultural stigmatization of mental health, which was particularly evident among the non-practitioner participants. These observations helped me to understand the unspoken tensions around mental health in these communities. Angrosino & Perez (2000, p. 673) emphasise that

   > *Even studies based on direct interviews employ observational techniques to note body language and other gestural cues that lend meaning to the words of the persons being interviewed. Social scientists are observers*

both of human activities and of the physical settings in which such activities take place.

Observations can add a rich layer of context to participatory research, especially in understanding body language, group dynamics, and the socio-cultural context. However, I recognise that observations are inherently subjective, and my own positionality influenced my interpretation of these behaviours (Guba & Lincoln, 1994). Therefore, I relied on triangulation—comparing my observations with the data from Post-it notes, flip charts, and presentations—to ensure a balanced and accurate interpretation of the data in Sections 6.4.3.

Conclusion: In this workshop, participatory methods were essential in ensuring that the voices of Ghanaian and Nigerian youth and their families were heard in discussions about mental health services. These methods not only democratised the process of data collection but also enabled the participants to contribute actively to shaping the outcomes. Each of the data collection tools—Post-it notes, flip charts, group presentations, and empirical observations—had specific strengths and limitations. For instance, while Post-it notes allowed for anonymity and candid responses, they lacked depth. Similarly, group presentations fostered collective ownership but sometimes reflected dominant perspectives. My empirical observations added valuable context but were subjective and required cross-referencing with other data. Ultimately, these methods helped facilitate a dialogue grounded in cultural humility, which is critical for improving mental health services for Black youth in Inner London.

Figure 7: Flip chart and Post-It Notes documentation

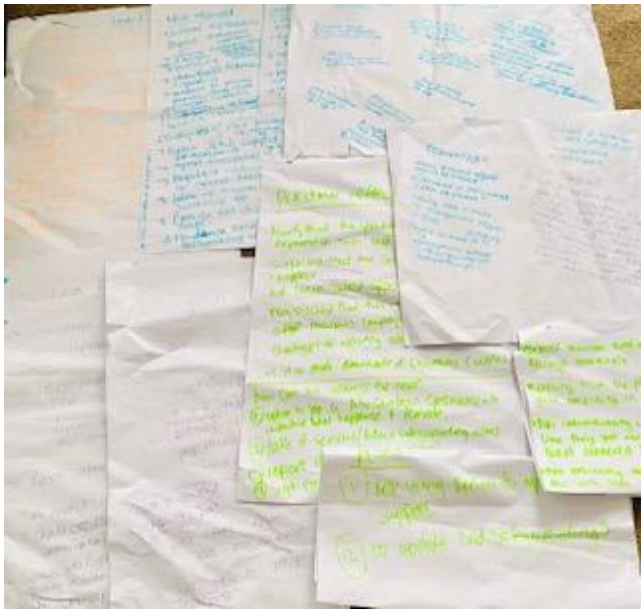


Figure 8: Workshop group activities

6.4.3. The Impact Workshop Activities and Outcomes

After I presented the key research findings, interactive activities followed promptly.

1. A facilitated discussion where youth participants share their experiences and challenges in accessing mental health services.
2. The mental health professionals reflect on these insights and discuss how they can implement cultural humility practices in response to the needs expressed by the youth.
3. Developing Joint Action Plans: Youth and professionals work together in small groups to develop actionable strategies that promote cultural humility. Each group focuses on creating practical, youth-centred initiatives that can be implemented within the community and healthcare settings. Each group nominated one participant to present their summarised points to the whole group, which elicited further reflexive discussion (Finlay, 2002).
4. A rapid feedback session to evaluate the workshop and plan for future sessions that further involve youth participation.

The resources for these findings were the Post-it notes, the flip chart, the presentation by each group representative and my empirical observations.

6.4.3.1. Youth Participants' Experiences and Challenges in Accessing Mental Health Services

Youth participants in the workshop highlighted numerous challenges in accessing mental health services. There was input from the practitioners at their table. However, other Table members were encouraged to listen to the youth as they recounted their experiences for this activity. Their narratives account for over 90% of the discussion. The insightful discussion reveals systemic deficiencies and gaps in care that disproportionately affect young people. One primary concern they highlighted was the “infrequent and limited support” provided, often reduced to “just once a month”, which is grossly insufficient for effective mental healthcare. Furthermore, consultations with ‘general practitioners and psychiatrists were frequently brief’ and superficial, typically resulting in “premature medication prescriptions

without a thorough discussion of potential side effects". This approach might undermine the quality of care and jeopardise patient safety.

In their own words, a significant barrier to effective treatment was the "inability to establish a therapeutic rapport with health providers". The youths reported difficulty in forming meaningful connections with their therapists, which is crucial for successful mental health outcomes. The issue was exacerbated by "long waiting lists", particularly after transitioning from children's services (CAMHS), which starkly contrasted with the immediate and intensive support previously available. The transition phase often involved "repetitive appointments" where the same information was circulated without any progression in treatment, coupled with a "lack of peer discussions and family involvement", which further isolated the youth.

Additional complications shared included a pronounced lack of diversity among mental health professionals, with very few African or Black therapists available. This might potentially contribute to cultural and relational disconnects. The "long wait times" for therapy—up to ten months for a therapist, usually not of the same ethnic background—compounded feelings of neglect and unimportance. Issues such as the stigma associated with being a teenager seeking mental health help within their community, societal pressures to conform, and the financial burdens of private mental health services further discourage young people from seeking or continuing treatment.

6.4.3.2. Mental Health Professionals' Reflections and Cultural Humility Practices

Based on my presentation and the youth's narrative in the workshop in Activity 1, mental health professionals reflected on the importance of cultural humility in their practice, acknowledging the profound influence of cultural backgrounds on mental health outcomes. They lack relevant skillsets in addressing cultural preferences, which are crucial for building trust and rapport between therapists and youth. Professionals emphasised the need for "increased dialogue around cultural differences and specific preferences to improve the therapeutic relationship", which might potentially facilitate more "personalised and effective care".

Furthermore, there was a consensus on the necessity to enhance service “accessibility and diversity” within the mental health workforce. This includes “targeted recruitment to increase the number of Black professionals and other underrepresented groups in the field”, which can help build rapport, particularly with clients from similar cultural backgrounds. Initiatives such as “reducing wait times for assessments”, improving “transition communications”, and conducting “follow-up sessions in community settings” were suggested to foster a more inclusive and responsive mental health service environment. Additionally, professionals called for changes in “diagnostic terminology” and the “integration of cultural considerations in referrals” to ensure that services are not only accessible but also resonate with the diverse identities and experiences of the youth they aim to support.

6.4.3.3. Collaborative Action Plan Drafting

In the collaborative action plan drafting phase, youth and mental health professionals joined forces to develop joint action plans centred on cultural humility. Together, they strategised to request a workforce that is enhanced by an appropriate representation of diverse backgrounds among health professionals. This effort aims to reflect the community's demographics better and ensure that the therapeutic workforce mirrors the diversity of its clientele.

The collaborative groups also requested a refining “communication methods” to align more closely with the cultural and personal needs of the youth, which might result in building “trust and the effectiveness” of mental health interventions. Another significant focus was on the implementation of “community and school-based initiatives”. To build a more supportive and inclusive environment, these initiatives include follow-up sessions and proactive mental health discussions within schools and community groups.

Each subgroup dedicated itself to “creating practical, youth-centred initiatives” that could be realistically implementable both within community settings and healthcare environments. Their main quest is for solutions grounded in the actual needs and cultural circumstances of the youth they aim to support. These plans mark a strategic move towards a more culturally

sensitive approach to mental healthcare, which emphasises “inclusivity” and “active participation” from the affected community.

6.4.3.4. Commitment to Action:

In this phase, participants demonstrated a robust commitment that might potentially enhance key aspects of mental health services. Three commitments to actions were highlighted: First, central to these improvements were efforts to strengthen “*confidentiality and trust”*, which are pivotal elements in building a secure therapeutic environment. This included stringent measures to keep patient information confidential and anonymous and a focus on building trust through consistent and genuine interactions. This resonated with the main findings, where participants were vehemently cautious about participating in my study, fearing that whatever they said might go into the system, which could haunt them. Even though I tried to persuade them that whatever they said in the course of the semi-structured interview would be anonymised and their names pseudonymised, some did not believe, and neither did they participate (see Chapter 3, Section 3.4).

Second, there was a concerted effort to enhance “*cultural and individual considerations”* within mental health practices. This involved improving cultural disposition conceptualised in cultural humility among health professionals, integrating cultural needs into referral processes, and maintaining a person-centred approach that respects individual service user needs and backgrounds. Such initiatives might be crucial for addressing communities' diverse needs and fostering an inclusive service environment.

Third, “enhanced *support and preparedness”* are prominent in the commitment to action. Professionals resolved to implement better preparatory measures for counsellors and improve safeguarding practices to protect vulnerable youth. They emphasise the need for more accessible school services and the promotion of mental health awareness, especially about Child and Adolescent Mental Health Services (CAMHS) and online platforms. They highlighted an ongoing concern about the adequacy of support provided to young people. This comprehensive approach to action underpins the importance of a multi-faceted and responsive mental health service framework that is prepared to meet the evolving needs of the community it serves.

These points reflect a concerted effort by youth, professionals and other participants to address the gaps in mental health services through culturally sensitive and youth-centred approaches, aiming for systemic improvements and better mental health outcomes.

6.5. Feedback and Measuring Impact

I embedded a rapid feedback session to assess its effectiveness and help plan future sessions to enhance youth and stakeholder engagement. Drawing on formative assessment principles (Lewis, 1974) and recent insights from Dobson & Fudiyartanto (2023), who emphasise real-time feedback's importance. This process allowed me to gather insights quickly during the real-time workshop content and impact. One challenge of this approach is the concern of its fast pace, which is that rushed feedback can sometimes lack depth (Boud & Molloy, 2013). However, I alerted participants that there was a feedback session towards the end of the workshop, which allowed participants to distil their thoughts without feeling too pressured.

I collected the feedback using a Microsoft form, which participants could access via a QR code displayed on the electronic whiteboard. The evaluation form was divided into three sections, detailed in Appendix L. The first section, comprising questions Q1 to Q5, targeted responses from youth participants. The second section, with questions Q6 to Q10, was intended for professionals, practitioners, faith leaders, politicians, parents, and others. The third section contained three general questions, Q11 to Q13, meant for all participants. I analysed participant comments within each section in the form, as outlined below, and the resource for this was the participant's responses in the evaluation form. My observation and understanding of the rich interactive discussion from the other activities during the workshop also informs my interpretation of participants' qualitative feedback. I draw from Angrosino and Perez (2000, p. 673), who emphasise that “Social scientists are observers both of human activities and of the physical settings in which such activities take place”.

6.5.1. Section 1: For Youth Participants:

For the question,

> *Q: ‘Did you feel heard and understood during the workshop?’*
>
> *Ans: All responded “Yes” (100%).*

Q: 'Would you recommend a similar workshop to your friends or peers?'

Ans: All participants who responded said, "Yes" (100%).

Q: 'How likely are you to use the information or strategies discussed in your own life or community?'.

Ans: It was average rated for 4.89 out of 5 (97.8%).

Q: 'What was the most valuable thing you learned or experienced?'

P1: "Talking about my mental health". P2: "About cultural Humility and cultural competence".

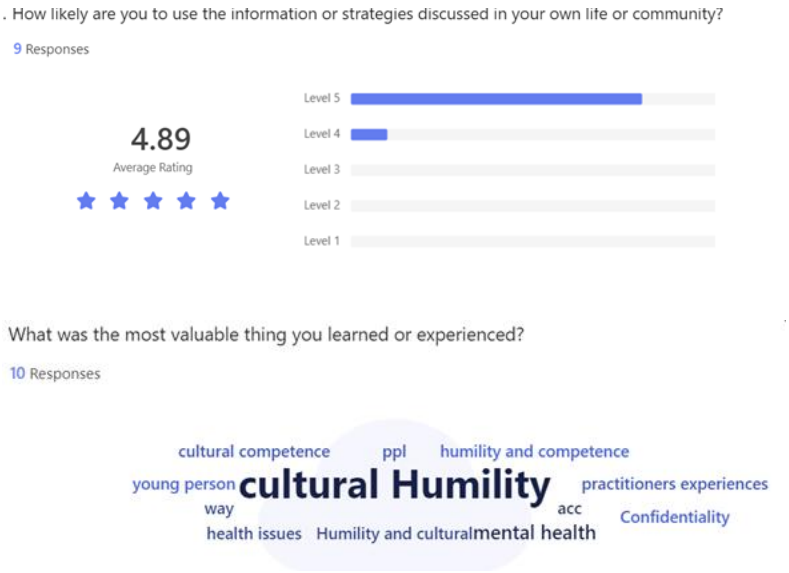
P3: "That there are people that would actually try to help and not just write you off", P 4: "Embracing cultural humility as the way forward".

The unanimous *"Yes"* response to the question, "Did you feel heard and understood during the workshop?" (100%) suggests that the young participants felt acknowledged and that their perspectives were valued. This indicates that the environment encouraged open dialogue, allowing participants to express themselves without feeling ignored or misunderstood. In response to, "How likely are you to use the information or strategies discussed in your own life or community?" participants gave an average rating of 4.89 out of 5 (97.8%) (Figure 9). This high score suggests that most found the workshop content relevant and useful to their personal lives or communities. Additionally, when asked, "Would you recommend a similar workshop to your friends or peers?" all participants (100%) said *"Yes,"* reflecting a shared perception of the workshop's benefits, although the data does not specify the reasons for their endorsement, possibly due to the limited time allocated for such rapid feedback.

The qualitative responses to "What was the most valuable thing you learned or experienced?" reveal different individual takeaways. P1 emphasised "Talking about my mental health," suggesting the value of open mental health discussions. P2 highlighted "Cultural humility and cultural competence," indicating the importance of these concepts in their learning. P3's comment, "That there are people that would actually try to help and not just write you off," suggests a shift in their perception of mental health services. P4 similarly focused on "Embracing cultural humility as the way forward," which aligns with Participant 2's takeaway and may reflect optimism about future interactions with mental health professionals who adopt these principles.

While these responses offer valuable insights, the limited number of participants makes it difficult to generalise the findings. Overall, the data shows that the participants felt positive about the workshop, particularly regarding mental health and cultural humility. However, the feedback lacks detail, making it hard to assess the depth of understanding or the workshop's long-term impact. I explore this in the REF research output in Section 6.5.4 below.

Figure 9: Young Participant's Feedback



6.5.2. Section 2: For Professionals, Faith Leaders, Politicians, Parents & Others

The question, *"did the workshop deepen your understanding of cultural humility and its importance in mental healthcare for Black youth?"* All participants reported *"Yes"* (100%). "How confident are you in your ability to apply cultural humility principles when working with Black youth? They average rate is 4.26 out of 5 (85.2%) (Figure 10). "Would you be interested in participating in future workshops or training on this topic?" All respondents said, *"Yes"*.

For the qualitative question, 'What specific insights or strategies do you plan to implement in your practice?" below are the practitioner's response

Q: What specific insights or strategies do you plan to implement in your practice?

P1: "Importance of the language". P2: “Give young people [the choice] to select what practitioners they would like to work with potentially”. P3: "The concept of cultural humility in general and taking into consideration people’s preference", P4: “Discuss with the team the importance of cultural humility. Raise awareness of the importance of confidentiality and how that is managed in client-practitioner relationships”. P5: "Effective communication and method"

P6: "Making adaptations to practice that signify cultural humility and not cultural competence."

P7: "Better advocacy for young people". P8: "Follow up" P9: "Cultural humility and competence."

P10: "Change the power dynamic and listen more, learn more" P11: "Culture care" P12: "More in-depth questions before referring" P13: "Yes, it helped to hear a young person's view."

P14: "Cultural humility" P15: Effective communication" P16: "Change referral criteria and nationality data to reflect Nigerian and Ghanaian and other African countries." P17: "Cultural humility" P18: "All" P19: "All the strategies"

The participants’ reflections highlight a transformative awareness of culturally responsive mental healthcare for Ghanaian and Nigerian adolescents. P1 emphasises the “importance of language” in fostering meaningful connections, recognising that culturally resonant communication builds understanding and respect. P2 highlights the value of personal agency, advocating for young people to choose practitioners they feel comfortable with, fostering trust and improving outcomes. P3 and P4 focus on “cultural humility” and confidentiality, emphasising a client-centred approach that respects individual backgrounds and safeguards trust. P5 and P15 stress the need for effective, culturally appropriate communication to better engage adolescents. Similarly, P6 distinguishes between static cultural competence and the dynamic, reflective practice of cultural humility, highlighting the importance of continuous learning.

P7’s commitment to “better advocacy” demonstrates a resolve to address systemic barriers that marginalise youth, while P8 highlights the need for continuity in care through consistent follow-up. P9 sees cultural humility and competence as complementary, prioritising flexibility and reflection to connect with clients. P10’s focus on “changing the power dynamic” shows a shift toward collaborative, client-centred care, empowering young people by valuing their voices. P11 highlights the importance of integrating “culture care” into core services, treating cultural identity as essential to effective care. P13 values hearing adolescents’ perspectives, reinforcing the need to listen actively to inform relevant support. P16 calls for improved “referral criteria and nationality data,” advocating for structural changes to better address the needs of Ghanaian, Nigerian and diverse communities. Finally, P18 and P19’s decision to adopt “all the strategies” reflects the workshop’s comprehensive

impact, indicating their commitment to implementing holistic approaches for these youth's multifaceted challenges. Collectively, these insights emphasise the necessity of culturally tailored, empathetic, and proactive care for Ghanaian and Nigerian adolescents in mental health services.

Figure 10: Feedback: Practitioners and others

For the question: What additional resources or support would be helpful for you to continue learning and growing in this area?

> *P1: "More reading", P2: "More training.", P3: "The research resources cited", P4: "Recommended action from young black people with steps that could have been done to make their experience*

easier [in therapy]", P5: "Information on services", P6: "More workshops", P.7: "More lectures like these", P8: "A follow-up (…) [workshop] to reflect on how this practice [cultural humility] changed outcomes", P9: "Trust", P10: "Update information", P12: "To organise more workshops of this kind", P13: "Another workshop may be longer with an opportunity to meet with more youth, particularly young males", P14: "More workshops in applying cultural humility in practice",

A clear need emerges for continued learning and deeper engagement in addressing mental healthcare for Black youth. Participants identified personal growth opportunities and systemic gaps requiring collective action. Suggestions like "more reading" (P1) and "research resources" (P3) highlight a thirst for accessible, evidence-based literature to empower informed practices. Calls for "more training" (P2) and "hands-on workshops" (P5, P6) accentuate the importance of experiential learning in applying cultural humility principles. Participants also valued structured lectures (P7) and iterative follow-up workshops (P8, P12) to foster reflection and sustained progress. Youth-centred approaches were emphasised, with P4 advocating for young Black voices in shaping mental health interventions. Trust (P9) emerged as a cornerstone for therapeutic relationships, highlighting the need for culturally sensitive care to overcome historical discrimination. Practical resources, such as updated service information (P10), and longer, in-depth sessions on applying cultural humility in practice (P13, P14) were also suggested. These insights underline the necessity for sustained, inclusive learning processes that integrate trust, youth voices, and cultural humility to make mental healthcare in Inner London more effective for Ghanaian, Nigerian, and diverse Black youth.

6.5.3. Section 3: General Questions for All Participants:

The question, 'How would you rate the overall effectiveness of the workshop in achieving its goals?' the 20 who answered, average, rated it 4.65 out of 5 (93%). 'Did the workshop create a safe, inclusive space for open dialogue and learning? The 22 respondents said *'Yes'* (100%).

Q: 'What suggestions do you have for future workshops on this or related topics?'

P1: "More time to have longer discussions [of the workshop activities]." P2: "I would love to have the PowerPoint slides prior to attending!" P3: "More talk about the different mental health issues and ways to reduce stigma surrounding it." P4: "More time, table facilitators, give young people guidance (…), more lead in (…) the session." P5: Introduction of people in the room, if they are practitioners and what type". 6: "More yourhs [to be invovled]." P7: "Understanding the barriers to accessing mental health." P8: "Possibly social topics/sociological topics exactly like this (culture)." P9: "Around questioning methods." P10: "Cultural humility." P11: "More information

needed." P12: "More professional awareness and get organisations involved." P13: "Working with African young people to address mental healthcare, barriers to accessing services, how religion plays a part in managing mental health, can you provide a certificate for this workshop?" P14: "None." P15: "Nothing." P16: "All the topics discussed."

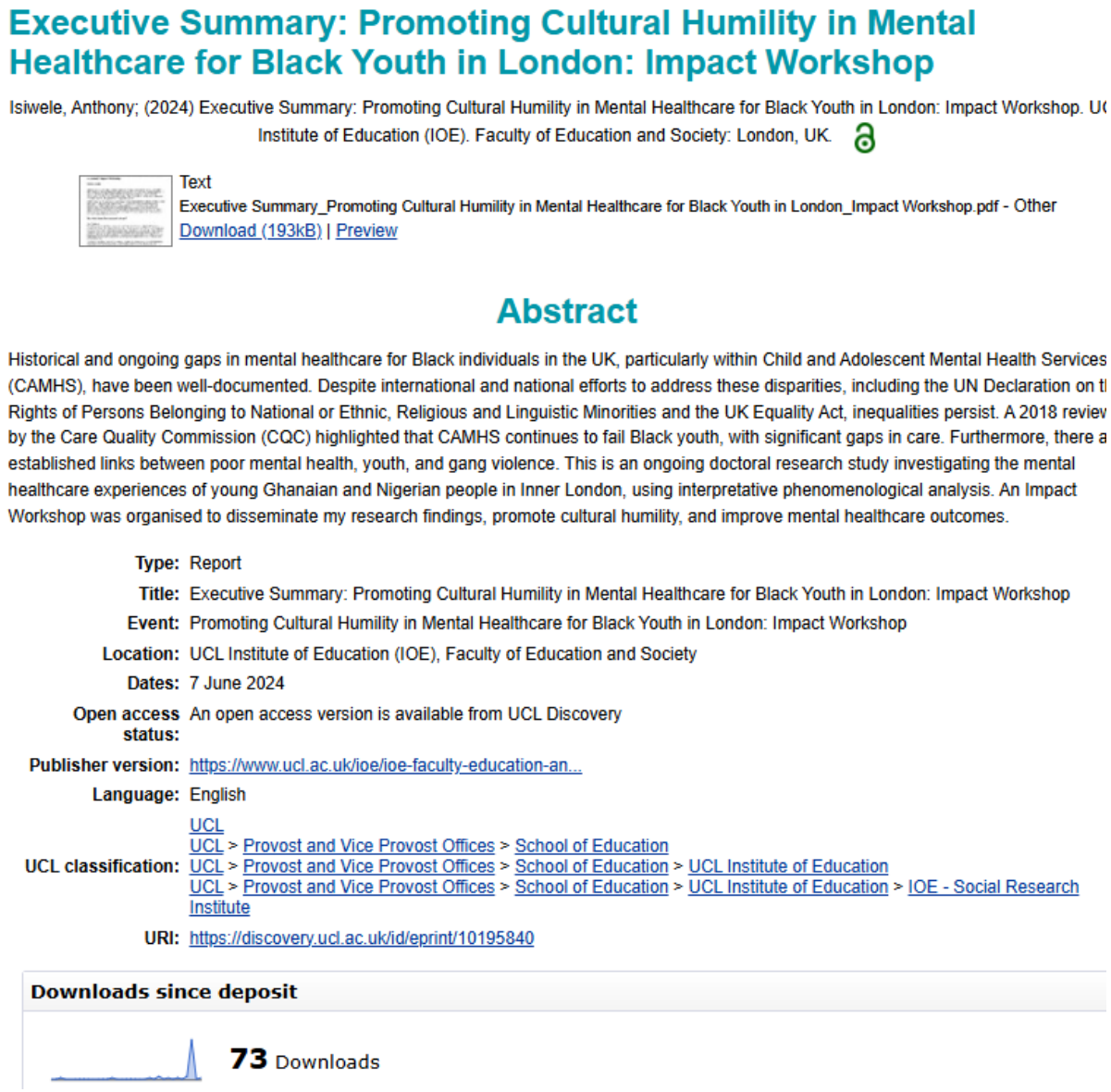
The qualitative responses reveal several key themes and areas for improvement in future workshops. A recurring theme is the need for more discussion time (P1, P4), as participants desired deeper exploration of topics and more meaningful interactions. Extending the workshop duration or adding open-ended discussion periods could enhance reflection and engagement. Participants also requested advance access to PowerPoint slides (P2), suggesting a need for better preparation and interactive engagement. Providing materials beforehand could enrich discussions and allow participants to contribute informed perspectives. Stigma reduction around mental health (P3) emerged as a critical topic. Participants emphasised the need to address societal misconceptions and provide practical strategies to combat stigma, which remains deeply ingrained in many African cultures. Another suggestion was increasing youth involvement and structured guidance (P4, P6). Empowering young people through leadership roles, such as facilitators or speakers, could foster engagement and centralise their voices in the conversation. Participants also highlighted the importance of understanding barriers to accessing mental health services (P7) within the cultural contexts of Ghanaian and Nigerian youth in London. Introducing practitioners and their roles (P5) could enhance collaboration and transparency. Professional awareness, organizational involvement (P12, P13), and the intersection of faith and mental health (P13) were also emphasised. Religion often shapes mental health perspectives in these communities, highlighting the need for faith-based discussions. In summary, incorporating these insights—extended discussions, practical strategies, youth leadership, cultural sensitivity, and interdisciplinary focus—can make future workshops more inclusive and impactful.

6.5.4. Research outputs

The REF assessed research impact beyond academia, including benefits to society, economy, culture, policy, and health (UKRI, 2022). The societal and cultural impact of the workshop aligns with REF's focus on assessing societal dimensions, such as changes in healthcare practices and policies, while academic impact is evaluated through research outputs (UKRI,

2022). Bibliometric analysis, including citation counts, h-index, and journal impact factors, provides a scalable method to assess scholarly influence (Donthu et al., 2021; Goodwin, 1980). However, it faces criticism for oversimplifying impact and favouring English-language publications, marginalizing global contributions (Sugimoto & Larivière, 2018). Recognising these limitations, qualitative assessments are essential. Notably, the workshop's executive summary has seen significant downloads globally, particularly in the UK and US, within weeks (Figure 11).

Figure 11: Research Outputs-Downloads



Executive Summary: Promoting Cultural Humility in Mental Healthcare for Black Youth in London: Impact Workshop

Isiwele, Anthony; (2024) Executive Summary: Promoting Cultural Humility in Mental Healthcare for Black Youth in London: Impact Workshop. UC Institute of Education (IOE). Faculty of Education and Society: London, UK.

Text
Executive Summary_Promoting Cultural Humility in Mental Healthcare for Black Youth in London_Impact Workshop.pdf - Other
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Abstract

Historical and ongoing gaps in mental healthcare for Black individuals in the UK, particularly within Child and Adolescent Mental Health Services (CAMHS), have been well-documented. Despite international and national efforts to address these disparities, including the UN Declaration on t Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities and the UK Equality Act, inequalities persist. A 2018 reviev by the Care Quality Commission (CQC) highlighted that CAMHS continues to fail Black youth, with significant gaps in care. Furthermore, there a established links between poor mental health, youth, and gang violence. This is an ongoing doctoral research study investigating the mental healthcare experiences of young Ghanaian and Nigerian people in Inner London, using interpretative phenomenological analysis. An Impact Workshop was organised to disseminate my research findings, promote cultural humility, and improve mental healthcare outcomes.

Type:	Report
Title:	Executive Summary: Promoting Cultural Humility in Mental Healthcare for Black Youth in London: Impact Workshop
Event:	Promoting Cultural Humility in Mental Healthcare for Black Youth in London: Impact Workshop
Location:	UCL Institute of Education (IOE), Faculty of Education and Society
Dates:	7 June 2024
Open access status:	An open access version is available from UCL Discovery
Publisher version:	https://www.ucl.ac.uk/ioe/ioe-faculty-education-an...
Language:	English
UCL classification:	UCL UCL > Provost and Vice Provost Offices > School of Education UCL > Provost and Vice Provost Offices > School of Education > UCL Institute of Education UCL > Provost and Vice Provost Offices > School of Education > UCL Institute of Education > IOE - Social Research Institute
URI:	https://discovery.ucl.ac.uk/id/eprint/10195840

Downloads since deposit

73 Downloads

Societal and Cultural Impact

My workshop's societal impact could be evaluated by qualitative assessments examining shifts in healthcare practices within Inner London, such as the adoption of culturally humble approaches by mental health professionals. Moreover, any policy changes influenced by the workshop—such as the incorporation of cultural humility training in professional development programs—would be critical indicators of societal impact. Watermeyer (2019) emphasises the need for research to not only inform but also transform practices within communities, which aligns with the goals of this workshop. However, capturing such impact is complex and requires robust methodologies that can track long-term changes in practice and policy (Penfield et al., 2014).

Measuring Reach and Significance

Reach could be quantified by the number of interested parties involved in the workshop, the breadth of dissemination efforts, and the extent to which the workshop's outcomes are adopted across various sectors. For instance, partnerships with local mental health services and community organizations could extend the reach of the research, making it more impactful at a systemic level. While the published executive summary of the workshop is being downloaded outside the UK, the significance of this, on the other hand, would be assessed through qualitative measures, such as participant feedback, case studies of changes in mental health practices in the UK and elsewhere, and testimonials from workshop attendees. The research has also been presented at both local and international conferences, to mention a few:

- 20th Biennial European Society for Health and Medical Sociology (ESHMS) Conference at the University of Antwerp, Stadscampus, Belgium.
- The Association for Child and Adolescent Mental Health (ACAMH) Malta Conference
- Early Career Researchers in Children and Young People's Mental Health (CYP MH) at UCL
- Project meeting on Talking Therapy Invite by Newham CBT Therapist

The Role of Case Studies and Impact Narratives

Bayley & Phipps (2019) highlight the importance of narrative approaches to understanding significance, which can provide a richer, more nuanced picture of impact. In the context of this research, collecting case studies of specific healthcare providers or organizations that have implemented the workshop's recommendations could vividly illustrate the real-world impact of promoting cultural humility. These narratives would serve to highlight the specific challenges faced by Ghanaian and Nigerian adolescents in Inner London, the solutions proposed, and the outcomes achieved as a result of the workshop.

6.6. What Next

The impact workshop reveals some of the mental health challenges faced by Ghanaian and Nigerian adolescents in London and the importance of cultural humility in mental healthcare. In the short term, I will share the link to the published workshop report with all participants, including current research work in this area, to maintain the momentum. For the outcomes of this workshop, the following steps will be crucial:

1. **Enhance Diversity in the Mental Health Workforce**
    - Increase targeted recruitment to boost the number of Black professionals and other underrepresented groups in mental health services. This will help build rapport and trust between therapists and clients from similar cultural backgrounds.
2. **Improve Communication and Cultural Sensitivity**
    - Develop and implement training programs focused on cultural humility and sensitivity for mental health practitioners.
    - Refine communication methods to better align with the cultural and personal needs of the youth to enhance the effectiveness of mental health interventions.
3. **Community and School-Based Initiatives**
    - Implement follow-up sessions and proactive mental health discussions within schools and community groups to create a supportive and inclusive environment.

- Engage in regular outreach and awareness programs to reduce stigma and encourage open dialogues about mental health within the community.

4. **Policy Advocacy**
    - Advocate for policy changes that integrate cultural humility into mental health practices. This includes addressing systemic barriers such as long waiting times and the lack of diversity among practitioners.
    - Support a national campaign for raising awareness about the importance of culturally sensitive mental healthcare through social media and community outreach programs.
5. **Ongoing Training and Education**
    - Promote continuous professional development through workshops and training sessions focusing on cultural humility and sensitivity. These sessions should include practical applications and real-world scenarios to better equip mental health professionals.

In conclusion, by taking these steps, we can move towards a more inclusive and effective mental healthcare system that better serves the needs of Ghanaian and Nigerian and diverse youth in London. This initiative sets a foundation for broader efforts to promote mental health equity in diverse young people in diverse urban settings

Chapter 7: Discussion

7.0. Overview

The aim of this research was to gain a deeper understanding of the meanings Ghanaian and Nigerian young people attribute to their experiences with care for anxiety and depression and to develop insights into how best to support them in their care journey. I conducted semi-structured interviews and used Interpretative Phenomenological Analysis (IPA) to gather and analyse the data. The preliminary findings revealed significant gaps in culturally appropriate care. I emphasised the importance of cultural humility in bridging these gaps. I organised an Impact Workshop to disseminate the study's findings and promote cultural humility in mental healthcare, specifically for Ghanaian and Nigerian youths. The workshop event included presentations, discussions, and the development of action plans to integrate cultural humility into mental health practices. Participants, including youth, parents, and professionals, worked collaboratively to address the systemic gaps resulting from the findings and improve mental health services for these communities.

I acknowledge that the findings are relevant only to my small sample. As an IPA study, the intention is not to generalise to larger populations but rather to provide a detailed account of this specific group, serving as a foundation for further research (Smith et al., 2022).

In this Chapter, I aim to present a comprehensive interpretation of the study's findings in relation to existing literature and theoretical frameworks. I will begin by summarizing the key results, highlighting how they align or diverge from previous research on mental healthcare in the context of the experiences of Ghanaian and Nigerian young people in Inner London. The focus will centre on an in-depth examination of critical themes such as cultural humility, accessibility and systemic barriers, alongside an analysis of the limitations of Evidence-Based Practice (EBP) for diverse populations. I will also explore the influence of religious and spiritual beliefs and the role of intergenerational dynamics in shaping mental health perceptions. Furthermore, the discussion will cover resilience and coping mechanisms, drawing connections between the data and the broader socio-cultural context. Additionally,

the research's strengths and limitations will be acknowledged. The chapter will conclude by bringing together the main points discussed.

7.1. Summary of the Findings

My analysis uncovered several key themes that provide a nuanced understanding of the challenges these young people face within the mental healthcare system. First, I discovered that the current model of care often fails to meet the needs of diverse populations. Participants frequently expressed dissatisfaction, noting that the mental health system seemed ill-equipped to accommodate cultural differences. They recounted experiences with therapists from different racial backgrounds, emphasising the importance of cultural sensitivity and understanding. This theme, *"The Model Itself Isn't Made for Diverse People,"* highlights systemic issues within the mental healthcare framework that require urgent attention.

Second, I identified a significant lack of awareness about mental health issues among participants and their families. Many were unfamiliar with professional care for anxiety and depression, often relying instead on cultural and religious beliefs. This lack of awareness, compounded by stigma, created barriers to accessing appropriate care. Additionally, a generational gap in understanding mental health complicated family communication on these issues. These were captured in the theme, *"I HAVE NOT HEARD OF THIS BEFORE", which* highlights the pervasive lack of awareness about mental healthcare among participants.

Third, the *Research Impact Workshop* highlighted how these challenges are perpetuated at a systemic level. Participants, including young people, parents, and practitioners, engaged in discussions that validated the need for culturally attuned interventions. This participatory element reinforced the findings, bridging the gap between research and action.

Finally, I explored how participants coped with trauma and adversity, revealing a reliance on prayer, faith, and community support. While these coping mechanisms provided some relief, they were often insufficient for addressing deeper struggles. This theme, *"Coping with the Weight,"* captures the silent emotional burden participants carried.

These findings illustrate the impact cultural relevance and sensitivity have on effective mental healthcare. They call for a flexible, culturally responsive model of care informed by diverse lived experiences to address systemic shortcomings effectively. The following sections will revisit the study's theoretical underpinnings and explore how care models might be improved.

7.2. Revisiting the Theoretical Frameworks Underpinning the Study

In the results section, I presented an exploration of individual experiences, but I want to refocus on the core objective of this study and, particularly, this discussion section, which is guided by the theoretical frameworks that underpin this research. My approach is primarily rooted in the constructivist-interpretivism paradigm, supported by several key theories.

My belief in a *Relativist Ontology* shapes this discussion, which suggests that reality is socially constructed, subjective, and varies across different individuals and cultures (Guba & Lincoln, 1994). This aligns with my *Interpretivist Epistemology,* where I emphasise understanding how individuals young Ghanaians and Nigerians interpret and make meaning of their experiences of the phenomena (Schwandt, 1994). Within the construct of meaning-making, although IPA has its roots in psychology, I find it highly valuable in social work education and practice because it provides a framework for deeply understanding the subjective experiences of individuals within their social contexts (Eatough & Smith, 2017; Vicary & Ferguson, 2024).

I also drew on the frameworks of *Intersectionality* and *Critical Race Theory (CRT)* to explore how various social identities and systemic factors intersect to shape the experiences of the participants, especially in the contexts of race, culture, and mental health (Crenshaw, 1989; Delgado, 2023). Additionally, the *Social Model of Mental Health* informs my discussion by focusing on the social, economic, and cultural factors that influence mental health rather than viewing mental health issues solely as individual pathologies (Armstrong et al., 2005; Pilgrim, 2017).

These frameworks collectively guide my exploration of the lived experiences of Ghanaian and Nigerian young people receiving care for anxiety and depression in Inner London, using IPA, which allows an in-depth exploration of personal lived experiences within their specific

socio-cultural contexts. They provide me with a comprehensive lens to understand the complex interplay of cultural, social, and individual factors in their mental healthcare experiences.

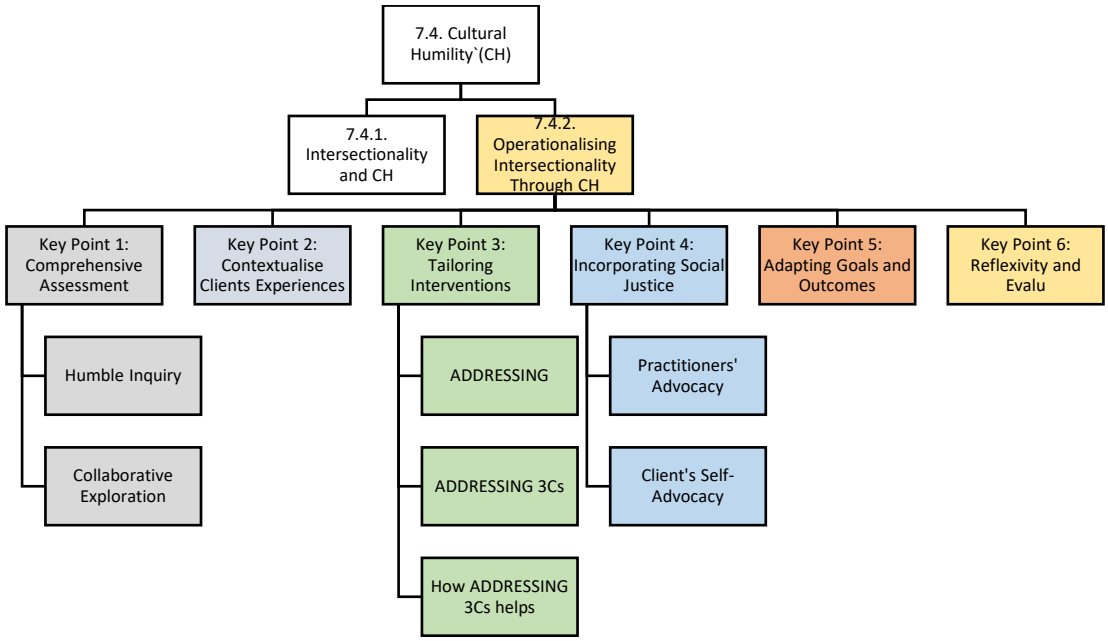
7.3. Focus of the Discussion

The findings from the study have significant theoretical implications for the effectiveness of the current mental healthcare model in serving diverse communities, particularly Ghanaian and Nigerian youth. These will be discussed under six emerging themes: (1) Cultural Humility, (2) Accessibility and Systemic Barriers, (3) Evidenced-based Therapy (EBP), (4) Faith and Spiritual Influences, (5) Intergenerational Dynamics and Mental Health, and (6) Resilience and Coping Mechanisms.

7.4. Cultural Humility

Due to the nature of cultural humility's prominence as an emerging theme in my findings and its complex discussion in its application in this thesis, I have illustrated how I organised this in Figure 12

Figure 12: Overview of Cultural Humility Discussions



My findings suggest that the prevailing mental healthcare model often marginalises individuals by neglecting their intersecting cultural identities and specific needs, leading to feelings of alienation and frustration. This observation aligns with Bansal et al. (2022), who identified current statutory mental healthcare models as significant barriers to effectively serving ethnic minorities. They noted that the dominance of monocultural, overly simplistic frameworks in assessment and treatment fails to account for the nuanced needs of diverse groups, thereby hindering person-centred care. This historically insufficient care model, particularly for Black children and young people, remains unaddressed, as highlighted in both recent and longstanding studies (Devonport et al., 2023; Littlewood & Cross, 1980; Rwegellera, 1977).

The Care Quality Commission's (CQC) 2018 review reveals the same mental health system's continued inadequacy but is now actively promoting culturally appropriate care, which they referred to as 'culturally competent' care (CQC, 2024). This promotion is underpinned by the principles outlined in the Health and Social Care Act 2008, Regulated Activities, 2014, Regulations 9 and 10, which emphasise the importance of person-centred care and respect for cultural identity, respectively—elements notably absent from the experiences of the young people involved in this study. Despite regulatory frameworks designed to ensure culturally sensitive care, participants expressed dissatisfaction with mental health services, indicating a clear gap between policy and practice.

Historically, cultural competence has been emphasised as a key approach to addressing this gap (Cross et al., 1989; P. A. Hays, 2016a; Iwamasa & Hays, 2019; Rathod et al., 2010). However, cultural humility may offer a more effective model for advancing Black mental healthcare. Tervalon and Murray-García's (1998) concept of cultural humility calls for practitioners to continuously self-reflect, acknowledge their biases, and foster respectful partnerships with clients rather than merely acquiring static knowledge about different cultures. This approach moves beyond the limitations of cultural competence, which is often reduced to a checklist of cultural facts, as seen in culturally competent CBT (Hays, 2016; Iwamasa & Hays, 2019). Instead, it promotes an adaptive, dialogical process where the client's nuanced cultural experience is centred.

The testimonies of study participants highlight the importance of this shift. Efia expressed frustration with counsellors who failed to understand the unique experiences of African youth. Nkiru found therapy helpful only after switching to a therapist with a solid cultural understanding, someone she could genuinely connect with. Reflecting on her first therapy experience, she felt a deep disconnect, stating, "It didn't really work well for me. I didn't find it useful. I found it very white-focused." Such disconnects are prevalent, as documented by Bhui et al. (2018), where cultural misalignment in therapy often leads to feelings of distrust and emotional withdrawal among minoritised clients. This sense of alienation undermines the therapeutic process, inhibiting the development of trust and openness, which are foundational to effective mental healthcare. Sue et al. (2007) stressed that therapists who fail to address their own biases risk creating therapeutic impasses, where progress is impossible for clients of colour. This reinforces the urgency of embedding cultural humility into mental healthcare practices, as it emphasises the ongoing need for practitioners to engage with their clients' cultural realities in a way that transcends mere knowledge acquisition.

Practitioners' insights also emphasise the limitations of the current system. Uwase, an NHS IAPT practitioner, candidly noted that "the model itself isn't made for diverse people," highlighting a critical flaw in the design of mental health services. While culturally adapted therapies, such as culturally competent CBT (Hays, 2016; Iwamasa & Hays, 2019; Rathod et al., 2010), have been proposed as potential solutions, these interventions will only succeed if rooted in a framework of cultural humility (Hook et al., 2013; Isiwele, 2024; Tervalon & Murray-García, 1998). Cultural humility ensures that therapists remain open and responsive to the specific needs of their clients rather than adhering to rigid, predefined therapeutic models that may not resonate with diverse minoritised populations. Table 12 shows the key difference between cultural competence and cultural humility.

Shelly, a community-based practitioner, emphasised the value of lived experience in therapy. She shared that her project's success was partly due to all practitioners being of African Caribbean heritage, allowing them to bring their lived experiences into their practice. This approach aligns with Sue et al. (1992), who found that ethnic matching between therapists and clients builds trust, reduces cultural barriers, and enhances therapeutic outcomes.

Similarly, Cleary and Armour (2022) highlighted that practitioners use self-disclosure to strengthen the therapeutic relationship by fostering a sense of connection. By sharing personal experiences, therapists may offer clients a deeper understanding, helping them feel validated and providing a safe environment to explore their own experiences without fear of judgment, encouraging a more open and honest therapeutic process. This approach resonates with the concept of cultural safety in healthcare, attributed to Irihapeti Ramsden and Māori nurses in the 1990s (Ramsden, 2018) and adopted by New Zealand nursing and midwifery education in 1992 (Papps & Ramsden, 1996). Cultural safety involves creating an environment where patients feel respected, understood, and free from discrimination, acknowledging and addressing cultural differences to ensure equitable, effective, and compassionate care (Ramsden, 2018). Williams (1999) emphasises the need for environments that respect and empower cultural identities and avoid assimilationist practices. Assimilationist practices encourage minority groups to abandon their cultural identities and adopt the dominant culture's values, norms, and behaviours, often erasing diversity and reinforcing social conformity over inclusion (Berry, 1997). These are encapsulated in cultural humility.

Hook et al. (2013) found that therapists practising cultural humility were more successful in building therapeutic alliances with their clients, particularly those from culturally diverse backgrounds. These alliances are critical for improving therapeutic outcomes, as they create a space where clients feel heard, respected, and understood. By prioritising cultural humility, practitioners can more effectively listen, engage, and adapt to the intersecting cultural needs of their diverse clients.

Table 12: Key Differences of Cultural Competence and Cultural Humility

Features	Cultural Competence	Cultural Humility
Emphasis	Acquiring knowledge and skills	Self-reflection and openness to learning

Approach	Specific cultural practices and beliefs	Acknowledging limitations and avoiding assumptions
Goal	Expertise in working with diverse populations	Respectful relationships and empowering individuals
Focus of Power	Reinforce power imbalances if not combined with humility	Address power imbalances and equitable dynamic
Potential Limitations	Oversimplification or stereotyping of cultures	Ongoing self-reflection and learning may be challenging for some individuals.
Application	Important in healthcare, education, social work, and other fields where professionals interact with diverse populations	Relevant in any setting, including those in cultural competence, personal relationships, workplaces, and community

I used the following two sub-sections to demonstrate how intersectionality-based cultural humility can be operationalised for this demographic and diverse youth in the context of my findings.

7.4.1. Intersectionality and Cultural Humility

Cultural humility, as a practice of openness, reflexivity, and respect toward a client's cultural identity, is vital in creating effective therapeutic relationships. When this concept is viewed through an intersectional lens (Crenshaw, 1989), it becomes even more essential, as it allows healthcare providers to account for the various intersecting identities that shape a young person's experiences with mental healthcare. Hook et al. (2013) expand on this by operationalizing cultural humility and demonstrating its measurable impact on therapeutic outcomes, particularly in the context of diverse clients. They argue that therapists who adopt a stance of cultural humility—characterised by respect, "curiosity and interest about

the client's cultural worldview" (p. 361), and the rejection of superiority—are more likely to develop strong working alliances with clients, which leads to better therapeutic outcomes.

My findings for Ghanaian and Nigerian youth in Inner London showed their identities are shaped by a range of intersecting factors, not limited to but including:

- **Race**: As Black youth, they face systemic racism and may experience microaggressions in schools, community and healthcare settings.
- **Nationality and Immigration**: Their status as migrants or children of migrants adds layers of complexity, such as navigating immigration status and cultural adaptation.
- **Gender:** Boys and girls may experience mental health stigma in different ways. In some cultures, boys are often discouraged from showing vulnerability, while girls are expected to demonstrate emotional resilience, particularly in caregiving roles (Gough & Novikova, 2020; McKenzie et al., 2018). However, the findings in this study suggest that the phrase "man up" was applied to both boys and girls, indicating a shared pressure to conform to masculine ideals. This metaphor reflects a cultural stigma that links vulnerability and seeking help for mental health issues, such as anxiety and depression, with feelings of guilt and weakness associated with masculinity. I note that other self-declared genders other than male and female participated.
- **Cultural Stigma**: Within these African communities, mental health issues are often stigmatised, which can influence how youth perceive and seek care for anxiety and depression.

These intersecting identities make it necessary for therapists to engage in cultural humility. Providers need not only to recognise the presence of these various identities but also to understand how they interact to create unique challenges for the individual. A rigid, competency-based approach that relies on generalised African or Black culture knowledge would be insufficient. Instead, practitioners need to approach each client with humility, acknowledging that they cannot fully understand the intricacies of each individual's lived experience without collaboration.

7.4.2. Operationalizing Intersectionality-based Cultural Humility

Here, I unpack how the principles of intersectionality and cultural humility can be integrated into therapeutic settings to empower the Ghanaian and Nigerian young people whose mental health struggles are shaped by systemic inequalities and cultural pressures. Drawing on intersectionality and critical race theory, I advocate for a therapy model that respects the uniqueness of each client's identity and actively challenges the structural forces that contribute to their distress.

This approach aims to create a healing space that fully honours the humanity of marginalised youth. The discussion is organised around six key points: See Table 13 and Figure 13. (1) conducting a comprehensive assessment of multiple identities with humility, (2) contextualising the client's experiences, (3) tailoring interventions based on intersecting identities with humility, (4) integrating social justice principles in therapy through the lens of cultural humility, (5) adapting therapeutic goals and outcomes, and (6) engaging in ongoing reflexivity and education to maintain cultural humility.

Figure 13: Operationalizing Intersectionality-Based Cultural Humility Frameworks

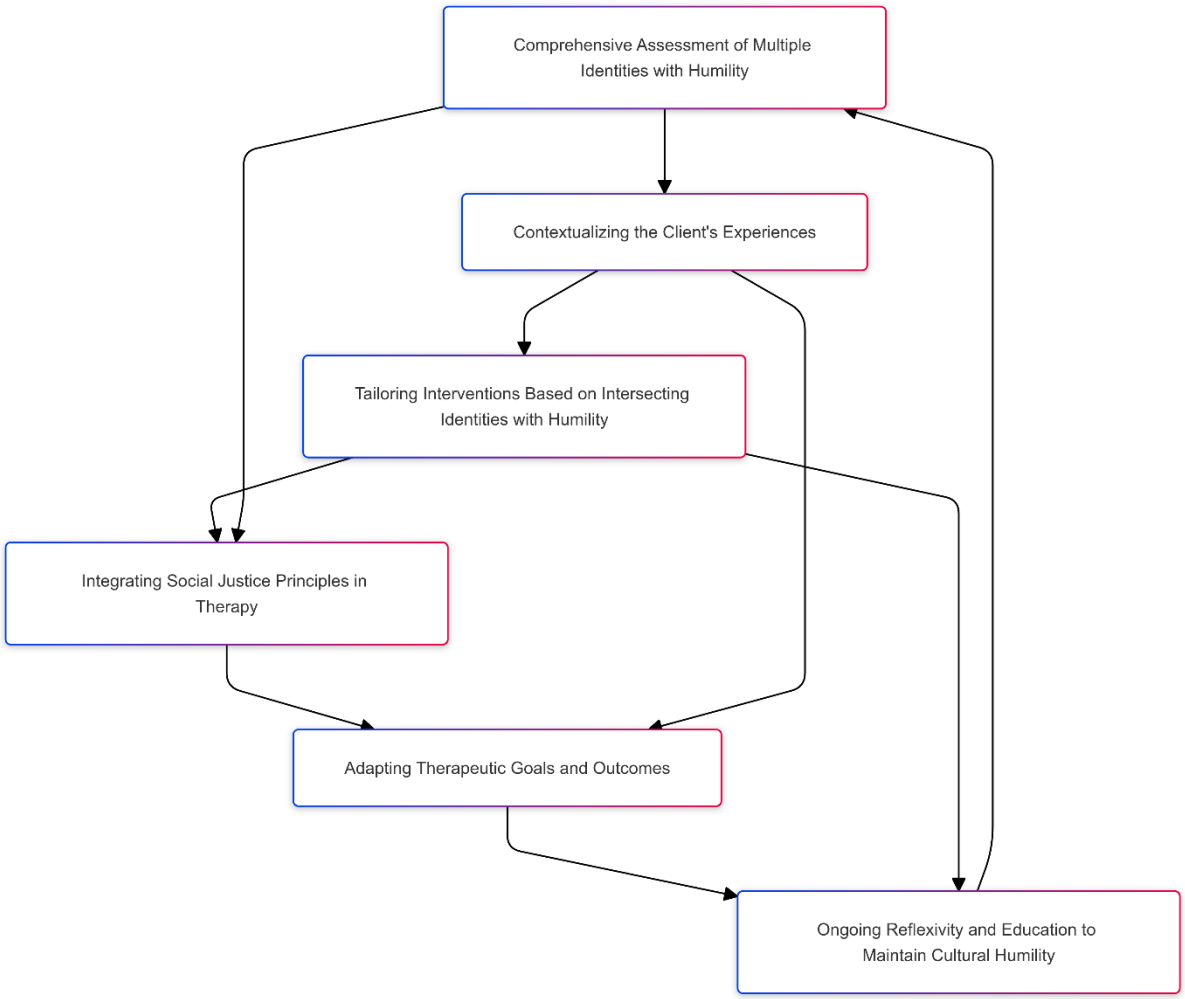


Table 13: Operationalising Intersectionality in Engagement through Cultural Humility

Key Point	Description
Key Point 1. Comprehensive Assessment of Multiple Identities with Humility	Practitioners conduct ongoing, non-assumptive assessments of clients' intersecting identities (ethnicity, socioeconomic status, racism). They practice humble inquiry, respecting the client's expertise on their own experiences.
Key Point 2. Contextualizing the Client's Experiences	Practitioners contextualise clients' mental health issues within systemic oppression (racism, discrimination). They apply Critical Race Theory to validate and address these experiences.

Key Point 3. Tailoring Interventions Based on Intersecting Identities with Humility	Interventions are culturally adapted and specific to the client's identities (ethnicity, religion, etc.), avoiding one-size-fits-all models. Therapists use frameworks like the ADDRESSING 3Cs model to guide treatment.
Key Point 4. Integrating Social Justice Principles in Therapy	Practitioners advocate for clients inside and outside therapy, addressing systemic issues (e.g., discrimination in schools) while empowering clients to develop self-advocacy skills.
Key Point 5. Adapting Therapeutic Goals and Outcomes	Practitioners' goals are co-created with the client to reflect cultural realities. Outcomes may include not only symptom reduction but also enhanced cultural identity and coping with racial discrimination.
Key Point 6. Ongoing Reflexivity and Education to Maintain Cultural Humility	Practitioners engage in continuous self-reflection and education to acknowledge their own biases and limitations, ensuring culturally competent care. They seek client feedback to adapt their practice.

Key Point 1: Comprehensive Assessment of Multiple Identities with Humility

My findings highlight the need for comprehensive, culturally attuned assessments (NICE, 2022) for Ghanaian and Nigerian youth in London, addressing multiple intersections such as ethnicity, immigration status, and systemic racism. Rooted in Tervalon and Murray-García's (1998) cultural humility and Crenshaw's (1989) intersectionality, practitioners need to integrate clients' lived experiences into care. I explore the approach through two concepts: "Humble Inquiry" for a person-centred assessment and "Collaborative Exploration" to foster participatory, culturally sensitive care strategies.

Humble Inquiry

A cornerstone of this approach prioritises respectful, open-ended questioning to place the client's perspective at the centre of care. Drawing on Carl Rogers' (1951) person-centred therapy, this method promotes client autonomy and expertise, practitioner humility, and the cultural adaptation of core therapeutic conditions. For example, Nkiru shared how the culturally sensitive assessment during her therapy fostered a sense of validation (Section

5.3.1). This highlights the power of culturally attuned questioning, which enabled her to feel seen and respected while guiding her toward appropriate care.

The first element of Humble Inquiry, **client autonomy and expertise in cultural contexts**, emphasises that clients are the foremost authorities on their own lives and mental health. Practitioners need to respect their narratives and avoid one-size-fits-all approaches (Purgato et al., 2021), which are difficult to actualise, as narrated by Nwase and Bindun, IAPT practitioners. Actualising this aligns with Rogers' person-centred therapy, which values the client's lived experience as the most valid source of information. For Ghanaian and Nigerian youth, this acknowledgement empowers them to actively shape their care, moving away from the systemic neglect or discrimination they may have experienced in other settings. Efia and Adjua, for instance, reflected on how his experiences were often overlooked, leading to feelings of invisibility and disconnection from available services. Empowering such clients through culturally humble engagement validates their experiences and fosters a sense of agency.

The second element, **empowerment through cultural humility**, involves fostering non-hierarchical relationships. Tervalon and Murray-García (1998) advocate for practitioners to view clients as experts of their own experiences. This approach is particularly significant for young people who may have faced systemic neglect or been silenced by cultural stigma around mental health. Nkiru and Kofi, for instance, reflected on how her therapist's willingness to listen without judgment made her feel empowered to share her struggles. Such therapeutic alliances create spaces for autonomy and growth.

The third element, **the practitioner's role as a humble facilitator**, calls for practitioners to create empathetic, supportive environments where clients feel safe to explore their cultural identities and mental health challenges. Rogers (1951) recommends that practitioners adopt a non-authoritative stance, acting as guides rather than prescriptive figures. This non-directive approach enables clients like Adjua to explore their experiences without feeling pressured or misunderstood. Kofi described how his therapist's empathetic and non-directive stance helped him articulate feelings of depression triggered by multiple losses.

The final element, **cultural adaptation of core therapeutic conditions**, involves embodying Rogers' (1961) unconditional positive regard, empathy, and congruence principles. Unconditional positive regard creates a non-judgmental space where clients feel valued, while empathy allows practitioners to deeply understand clients' perspectives. Congruence, or authenticity, fosters trust and connection. These conditions are essential for creating a therapeutic environment that aligns with the cultural realities of Ghanaian and Nigerian youth.

Collaborative Exploration

Complementing Humble Inquiry is **Collaborative Exploration**, which emphasises participatory care models (Archer et al., 2012) that integrate the perspectives of clients, families, and communities. Many African cultures, including those of Ghana and Nigeria, prioritise collective well-being over individualism (Wissing et al., 2020). Practitioners need to account for these values to avoid alienating clients with Westernised therapeutic frameworks (Hays, 2016). For example, Osas highlighted the role of family and faith in her mental health journey, highlighting the importance of integrating family and community support into care plans.

However, collaborative care has to balance family involvement with respect for client autonomy. Some clients, like Edith and the young people who participated in the workshop, expressed concerns about confidentiality. Practitioners need to navigate these tensions carefully, ensuring clients feel supported while maintaining privacy. Adhering to confidentiality principles outlined in GDPR and DPA 2018 is crucial, as it protects clients' rights regarding how much they want their family involved while fostering trust.

Collaborative care can also address stigma, a pervasive barrier in African communities where mental illness is often viewed as a family or communal issue. Practitioners can involve family members in therapy sessions as supportive figures to reduce stigma and contextualise clients' experiences. As Oye (2005) noted, mental illness is often stigmatised in African communities, making it essential for practitioners to align care with cultural expectations. For instance, involving Agnes' family in discussions about her struggles with racism at school

could help address the collective nature of her challenges while providing her with the support needed to rebuild confidence.

Key Point 2: Contextualizing the Client's Experiences within the Broader System

As the humble inquiry is ongoing, contextualising their struggles in a broader system context could be essential in alleviating self-guilt. Section 5.3, Sub-GET 1.1, participants experience systemic oppression. They express dissatisfaction with an inconsistent mental health support system, feeling forgotten and dismissed, and struggling with access to appropriate care. This will necessitate a therapeutic approach that situates their struggles within broader social contexts. Critical race theory (CRT), as developed by scholars like Bell (1992), Crenshaw (1995), and Delgado (2023), offers an essential framework for understanding how systemic racism exacerbates mental health issues in these populations, helping ensure that practitioners do not replicate or sustain these harmful dynamics.

In culturally humble practice underpinning CRT, practitioners are encouraged to critically question dominant cultural narratives that uphold racial privilege and perpetuate stereotypes about Black youth, particularly in the context of mental health models. These models often underestimate the impact of systemic racism on Black clients, failing to adequately account for the social determinants that influence mental health outcomes (Brown, 2008; Stoll et al., 2022). It also values the lived experiences of marginalised individuals, meaning practitioners need to validate and create space for Black youth's experiences of racism and discrimination rather than dismissing or downplaying them.

Furthermore, CRT in cultural humility calls for an active commitment to social justice, ensuring practitioners adopt an ongoing reflection on their own biases and advocate for systemic changes that support marginalised communities. To this end, practitioners would need to be mindful of the following: (1) Sue and Sue (2015) emphasise the importance of validating the client's lived experiences of racism and discrimination in therapy. Ghanaian and Nigerian young people may feel invalidated or misunderstood if their experiences are not adequately contextualised. Practitioners need to be attuned to the ways systemic racism impacts access to care and daily life. (2) Freire's (1970) critical pedagogy encourages practitioners to recognise and address power imbalances. Freire emphasises liberating the

oppressed through dialogue, reflection, and action, fostering critical consciousness and challenging systems of oppression. For Ghanaian and Nigerian youth, humility would require practitioners to be mindful of their positionality, as dismissing the realities of systemic oppression could replicate harmful dynamics within the therapeutic space.

Ket Point 3: Tailoring Interventions Based on Intersecting Identities with Humility

Practitioners emphasised that they have received minimal or no support in culturally adapting interventions, often left to modify rigid care models independently. Many highlighted the challenges of tailoring mental health interventions for culturally diverse youth, including Ghanaian and Nigerian, stressing the importance of embedding cultural humility within care practices to address these gaps effectively. Research supports the effectiveness of culturally specific interventions in addressing mental health challenges (Iwamasa & Hays, 2019; Mishu et al., 2023; Rathod et al., 2010). This approach necessitates an accessible framework that integrates ethnicity, religion, and national origin into care plans. However, as the London Assembly (2015) noted, the lack of subgroup data limits effective policy development. Current frameworks like the NHS Talking Therapy model lack detailed data collection, impeding understanding and resource allocation. To address this, I have modified the **ADDRESSING framework** (Hays, 2016),

1. **A**ge and Generational Influences
2. **D**evelopmental Disabilities
3. **Di**sabilities (Acquired)
4. **R**eligion and Spiritual Orientation
5. **E**thnicity and Racial Identity
6. **S**ocioeconomic Status
7. **S**exual Orientation
8. **I**ndigenous Heritage
9. **N**ational Origin
10. **G**ender Identity

Enhanced by additional cultural humility components, it offers a structured approach to incorporating identity factors into care plans, as illustrated in Box 6. Tailoring this framework for Ghanaian and Nigerian youth requires adding the "3Cs":

1. **Culturally Relevant Support Systems:** Recognising the influence of extended families and community leaders, such as pastors and elders, in decision-making. This aligns with cultural norms and reduces stigma.
2. **Collectivist Values:** Emphasising social cohesion and family involvement in therapy, addressing both support and pressure from family expectations regarding academic or financial responsibilities.
3. **Cultural Expressions of Distress:** Understanding non-verbal expressions, such as silence or stoicism, prevents misdiagnoses and ensures culturally appropriate care.

Incorporating these elements into mental healthcare demonstrates cultural humility by respecting clients' intersecting identities and contexts. For example, engaging pastors as community gatekeepers helps bridge gaps between families and professionals, fostering trust and reducing stigma. The **ADDRESSING 3Cs framework** may also encourage practitioners to integrate discussions about culture into care plans genuinely and efficiently.

Box 5: ADDRESSING 3Cs Assessment/Care Plan Form

Adapted for Ghanaian and Nigerian Communities with Cultural Humility

Not all fields will be relevant. Some might be more relevant than others. It would depend on the client's circumstance and what is vital to the young person, but it provides a sense of holistic exploration for diverse clients.

Client Information

- **Name:**
- **Age:**
- **Gender Identity:**
- **Sexual Orientation:**
- **Ethnic Group:**
- **Religion:**
- **National Origin:**
- **Current Residence (UK):**

Date:

1. Age and Generational Influences

Prompts:

- How does the client's age or era in which they grew up influence their worldview and mental health?
    - First-generation vs. second-generation dynamics:
        - Discuss differences between parent and child views on mental health (e.g., stigma around anxiety and depression in the African community).
        - How does the family handle mental health issues?
        - Explore how intergenerational conflicts affect the client's mental health.
- **Actions/Interventions:**
    - Educate the family on culturally sensitive mental health concepts.
    - Encourage open communication between generations to bridge understanding gaps.

2. Developmental Disabilities

Prompts:

- **Perception of developmental disabilities in the community:**
    - Are there stigmas or misunderstandings within the client's community about developmental disabilities (e.g., neurodiversity)?
    - Explore if the family views developmental disabilities through a medical lens or attributes them to supernatural causes.
- **Actions/Interventions:**
    - Provide culturally tailored educational resources for the family.
    - Address any potential resistance to mental healthcare due to traditional beliefs.

3. Acquired Disabilities

Prompts:

- **Community and family beliefs around acquired disabilities:**
    - How do traditional beliefs in the client's community view acquired disabilities (e.g., physical or mental health conditions)?
    - How do these views affect the client's or family's openness to receiving care?
- **Actions/Interventions:**
    - Use a culturally respectful approach to discuss disability and its impact on mental health.
    - Incorporate trusted community figures (e.g., elders or pastors) in discussions.

4. Religion and Spiritual Orientation

Prompts:

- **Religious influences on mental health:**
    - How does the client's religious background (e.g., Christianity, Islam, or traditional African spirituality) shape their understanding of mental health and help-seeking behaviour?
    - Does the client rely on faith, prayer, or religious leaders to cope with mental health issues?
- **Actions/Interventions:**
    - Collaborate with religious leaders to provide culturally congruent support for mental health.
    - Respect religious beliefs while introducing mental health interventions.

5. Ethnicity and Racial Identity

Prompts:

- **Cultural pride and experiences of discrimination:**
    - How does the client's Ghanaian or Nigerian ethnic identity contribute to their mental health resilience?
    - Has the client experienced racial discrimination in the UK, and how has that impacted their mental health?
    - Explore their connection to their ethnic heritage and the African diaspora.
- **Actions/Interventions:**
    - Validate the client's experiences of discrimination and explore strategies for coping.
    - Encourage the client to draw on cultural pride as a source of strength.

6. Socioeconomic Status

Prompts:

- **Financial and educational stressors:**
    - Does the client experience both local and transnational financial stress (e.g., supporting an extended family in Ghana or Nigeria)?
    - Are there high expectations for academic success from their family, and how does that affect their mental health?
- **Actions/Interventions:**
    - Support the client in managing financial responsibilities and educational pressures.
    - Provide resources for coping with stress.

7. Sexual Orientation

Prompts:

- **Cultural attitudes and family expectations:**
    - How do the client's sexual identity and traditional community views on LGBTQ+ issues interact?
    - Is there tension between family expectations of marriage and the client's sexual orientation?
- **Actions/Interventions:**
    - Provide support that is sensitive to the potential conflict between the client's sexual identity and cultural or family norms.
    - Explore safe spaces for expression and support.

8. Indigenous Heritage

Prompts:

- **Ethnic heritage within Ghana or Nigeria:**
    - Does the client's specific ethnic background (e.g., Yoruba, Igbo, Esan, Hausa or Akan) influence their mental health perception?
    - Explore the role of ethnic identity in both the client's cultural pride and potential stressors.
- **Actions/Interventions:**
    - Acknowledge ethnic-specific cultural values in care discussions.
    - Explore the influence of the client's heritage on their mental health needs.

9. National Origin

Prompts:

- **Acculturation and bicultural stress:**
    - How does the client navigate their dual identity between British and Ghanaian/Nigerian cultures?
    - Are there any language barriers (e.g., differing expectations around the use of native languages at home, as well as accents in pronunciations within education settings and among peers)?
- **Actions/Interventions:**
    - Support the client in balancing their cultural identities.
    - Help the family manage generational conflicts around language and cultural expectations.

10. Gender Identity

Prompts:

- **Traditional vs. modern gender roles:**
    - Are traditional gender roles (e.g., emotional stoicism for men, family-first responsibilities for women) affecting the client's mental health?
    - Does the client feel empowered by challenging these roles?
- **Actions/Interventions:**
    - Support the client in exploring their gender identity within the context of their cultural background.
    - Encourage discussions on gender roles and mental health within the family, if appropriate.

11. Culturally Relevant Support Systems:

Prompts:

- Involve trusted community and family members (e.g., extended family, religious leaders) to reduce mental health stigma and improve trust.
- Collaborate with these support systems in care planning.

- **Action/Intervention**
    - Involve trusted family members, religious leaders, or other community figures to reduce stigma and foster trust.
    - Ensure care planning incorporates input from these trusted figures, respecting their cultural influence on the client's worldview.

12. Collectivist Values:

Prompts:

- Recognise the dual role of family as a source of both support and pressure in mental health discussions.
- Provide strategies for the client to navigate family dynamics while maintaining individual mental health goals.

- **Action/Intervention**
    - Recognise both the supportive and potentially pressurizing role of family in the client's mental health.
    - Help clients navigate the challenges of family expectations while maintaining individual goals and self-care.

13. Cultural Expressions of Distress:

Prompts:

- Pay attention to non-verbal cues or culturally specific ways the client may express distress (e.g., silence, stoicism, or withdrawal).
- Avoid misdiagnosing symptoms and use culturally appropriate interventions.

- **Action/Intervention**

○ Be attuned to cultural expressions of distress, such as withdrawal or stoicism, and avoid misdiagnosing these behaviours. ○ Use interventions that align with the client's cultural expressions, ensuring care is sensitive to their unique way of expressing distress.
Client's Signature: _____ **Date**: _____
Practitioner's Signature: _____ **Date**: _____

Key Point 4: Incorporating Social Justice in Therapy through Cultural Humility

Mental health challenges among Ghanaian and Nigerian youth often arise from systemic inequalities, such as racism in education and institutional discrimination (Crenshaw et al., 1995; Delgado, 2023). Agnes and Efia's frustrations with their schools and Nkiru's experience with broader community care highlight systemic barriers. Social justice can be operationalised at two levels - Practitioners' Role in Systemic Advocacy and Empowering Clients for Self-Advocacy.

Practitioners' Role in Systemic Advocacy

Practitioners can apply Sue et al.'s. (1992) principles to advocate for systemic change by engaging in institutional reform, such as promoting anti-racism policies and cultural awareness workshops. For example, a practitioner addressing Agnes' case could push for policies within schools to combat racism actively. Furthermore, practitioners need to recognise their cultural biases and understand clients' worldviews. They can validate cultural factors like respect for authority while adapting their interventions to include culturally sensitive strategies, such as faith-based or community-centred support (Wissing et al., 2020) . In addition, practitioners can empower clients like Agnes by teaching self-advocacy skills, enabling them to address discrimination in schools and workplaces. For example, helping clients role-play scenarios during therapy could foster confidence in asserting their rights.

Empowering Clients for Self-Advocacy

Drawing on Bell Hooks' (1994) *Teaching to Transgress* , practitioners can use six key strategies to empower clients: (1) **Education as a Practice of Freedom:** Encouraging youth to critically examine their experiences fosters agency. For instance, Agnes could explore how systemic racism, not personal failings, contributed to her mental health struggles. This reframing would help shift her focus from self-blame to recognizing societal fault. (2) **Critical Thinking and Self-Reflection:** Activities like journaling allow young people to process their cultural histories and personal experiences. For example, Osas could reflect on family pressures and develop strategies to balance cultural expectations with her own needs. (3) **Voice and Participation:** Validating and amplifying marginalised voices may ensure youth feel heard (Keypoint 2). Role-playing exercises can prepare individuals like Agnes and Osas to assert their needs effectively in challenging environments. (4) **Community and Collective Healing:** Creating group therapy sessions or support networks might provide a safe space for shared experiences and could reduce stigma and foster resilience through collective healing for these youth. (5) **Intersectionality and Inclusion:** Addressing the interconnectedness of intersecting identities such as race, gender, and immigration status would allow youth to navigate their identities confidently. For example, helping a Nigerian girl understand how her identity shapes her mental health experience would foster self-awareness and resilience. (6) **Engagement with Cultural Knowledge:** Incorporating cultural heritage into therapy reconnects clients with their roots. For example, Daba said we are very prideful people. In addition, practices like storytelling or using proverbs can highlight the value of community and cultural resilience. For instance, discussing proverbs such as "Wisdom is not in the head of one person" reinforces the strength found in cultural traditions.

Transformative Impact

Empowering youth through these strategies equips them to navigate systemic challenges and take control of their mental health. For example, Agnes' ability to critically reflect on her experiences and assert herself could help her break the cycle of silence and vulnerability that racism reinforced. Similarly, collective healing approaches foster solidarity, allowing youth to draw strength from shared experiences and cultural communities. By embedding elements of social justice and cultural humility in therapy, practitioners can address

individual mental health challenges and equip clients to challenge and resist broader systemic oppressions.

Key Point 5: Adapting Goals and Outcomes with Cultural Humility

Adapting therapeutic goals and outcomes through a culturally humble lens would require flexibility and collaboration. Traditional, Eurocentric frameworks for mental health outcomes may not adequately address the needs of Ghanaian and Nigerian youth in Inner London, whose experiences are shaped by nuanced intersecting cultural, racial, and socioeconomic factors (Stoll et al., 2022). According to Tervalon and Murray-García (1998), cultural humility entails an openness to learning from clients and adjusting therapeutic processes accordingly. In practice, this means co-creating goals that reflect the clients' cultural realities and mental health needs. For instance, goals need to recognise the importance of bicultural identity and address the pressures these youth may face in balancing family expectations with personal well-being (Iwamasa & Hays, 2019). This collaborative goal-setting process could foster client autonomy, ensuring that the therapeutic journey is empowering rather than prescriptive.

Furthermore, measuring therapeutic outcomes also needs to be culturally relevant. Traditional markers of progress, such as symptom reduction, may not fully capture the holistic progress of youth from collectivist cultures, where family and community are integral to the healing process (Triandis & Triandis, 2001). Outcome measurements would have to reflect both personal growth and improved family or community dynamics. This aligns with Crenshaw's (1989) intersectionality framework, which implies that therapy outcomes need to address multiple axes of identity, such as race, ethnicity, and socioeconomic status. It means that success may manifest not only in reduced symptoms of anxiety and depression but also in strengthened cultural identity or improved coping strategies in response to racial discrimination (Rathod et al., 2010). Thus, cultural humility requires practitioners to be flexible in defining what "success" means in therapy and in therapeutic spaces, acknowledging that healing is not a linear or uniform process.

Key Point 6: Ongoing Reflexivity and Education with Cultural Humility

Cultural humility is an ongoing process of self-reflection, learning, and adaptation, particularly for practitioners working with marginalised populations. Therefore, with this

approach, practitioners would be mandated to continuously engage in reflexivity, examining their own biases, privileges, and assumptions that could influence their clinical practice. Tervalon and Murray-García (1998) argue that cultural humility demands an acknowledgement of the practitioner's limitations in thoroughly understanding the client's lived experiences. This is particularly important when working with Black youth in London, where intersecting issues of race, immigration, and socio-economic disparity can exacerbate mental health challenges. Showunmi and Tomlin (2022) argue that the psychological stress from navigating these challenges can exacerbate mental health issues. By regularly reflecting on their cultural biases and positionality, practitioners can reduce the risk of reinforcing systemic inequalities in the therapeutic setting (Sue et al., 1992).

In addition to self-reflection, ongoing education is crucial for maintaining cultural humility. Engaging in continuous professional development that focuses on anti-racism, intersectionality, and cultural appropriateness is essential. Research has shown that culturally adapted interventions are more effective in addressing mental health disparities among ethnic minorities (Rathod et al., 2010). For instance, attending workshops or reading relevant literature on the mental health experiences of African diaspora youth can help practitioners remain sensitive to the evolving needs of their clients. Moreover, client feedback would need to be actively solicited to ensure that the therapeutic process remains aligned with the client's cultural and personal experiences (Hook et al., 2013). Feedback loops create an environment where clients feel empowered to voice concerns or suggest changes, promoting a collaborative and responsive therapeutic relationship.

By combining ongoing reflexivity, continuous education, and an openness to client feedback, practitioners can ensure that they are culturally competent and humble. This approach aligns with the principles of intersectionality and social justice, allowing practitioners to work to honour the complex identities of Ghanaian and Nigerian youth while also challenging systemic inequities within the mental health system (Crenshaw, 1989; Delgado, 2023). Therefore, cultural humility in therapy is not a one-time achievement but a dynamic, lifelong commitment to better understanding and serving clients from diverse cultural backgrounds.

Challenges in Integrating Intersectionality and Cultural Humility in Therapeutic Space

Operationalizing intersectionality in therapy through cultural humility poses challenges due to the complexity of intersecting identities. Defined by Crenshaw (1989), intersectionality highlights overlapping identities like race, gender, and socioeconomic status, creating unique experiences of marginalisation. Practitioners may struggle to account for these layers without oversimplifying them. For instance, Ghanaian and Nigerian youth in Inner London face distinct challenges shaped by their race, immigration status, and cultural identity, making comprehensive assessments difficult (Hook et al., 2013). Biases and power dynamics in therapeutic relationships further complicate cultural humility's implementation. While cultural humility emphasises self-reflection and client expertise (Tervalon & Murray-García, 1998), unconscious biases may persist, perpetuating power imbalances. Practitioners may inadvertently make assumptions about Black youth from immigrant backgrounds, undermining trust and collaboration (Sue & Sue, 2015). Systemic limitations, including inadequate cultural capability and resources, could also hinder the integration of intersectionality. Tools like the ADDRESSING 3Cs model could remain underutilised due to insufficient training and time. For example, NHS Talking Therapy services often fail to collect detailed data on ethnic and national origins, impeding tailored interventions for Ghanaian, Nigerian and diverse youth (London Assembly, 2015). Moreover, Western therapy's individualistic focus can clash with collectivist African values, creating a disconnection between practitioners and clients (Triandis & Triandis, 2001). Cultural expressions of distress present another challenge. Practitioners unfamiliar with non-verbal or culturally specific manifestations of anxiety or depression, such as stoicism or withdrawal, risk misdiagnosis or ineffective care (Rathod et al., 2010). Lastly, cultural humility demands ongoing self-reflection and learning, which are difficult to sustain in under-resourced settings with high caseloads (Mathieson et al., 2018) and limited training opportunities (Yanagihara et al., 2021).

In conclusion, while cultural humility offers a promising approach to intersectional therapy, its operationalisation requires addressing systemic barriers, enhancing cultural humbleness, and fostering institutional support for lifelong learning. Without these changes, gaps in

culturally appropriate care for marginalised groups, such as Ghanaian and Nigerian youth, will persist.

7.5. Accessibility and Systemic Barriers

Another prominent finding relates to accessibility and systemic barriers faced by Ghanaian and Nigerian youth in inner London. One of the most significant issues highlighted in the research is the sense of being *"forgotten"* by Efia or *"dismissed"* by Agnes by the mental health system and Adjua, who spoke of the frustration of waiting 12 weeks for therapy. These reveal deep-seated problems within the system. For someone in distress, the feeling of being forgotten and dismissed and a prolonged waiting period is not just an inconvenience—it represents a continuation of their suffering without support. This situation brings to mind the concept of "institutional neglect," as described by Kiely and Warnoc (2023, p. 317) “where institutions fail to recognise or respond to eligible demands for care. Institutional neglect therefore takes place not when needs are the subject of contestation, but when institutions fail to provide for care needs which they have historically recognised as valid." I find this particularly troubling because it suggests that the very structures meant to provide care are, in some cases, perpetuating harm.

The systemic barriers also extend to mental health services' outreach and awareness efforts, as seen in Sub-GET 2.2. The practitioners recognised the need for more proactive community engagement, yet the resources and time allocated for this are clearly inadequate. Uwase’s point about only having one hour a week for community engagement initiatives highlights this underinvestment. I am reminded of the concept of structural violence, though attributed to Johan Galtung (1969), I find Paul Farmer's (2004) version apt in this context. Farmer illustrates how the system's organisation perpetuates inequality and limits access to care due to superficial intervention. The idea that we need to *"take our interventions to them"* by Uwase, an NHS IAPT practitioner, resonates deeply with me, as it calls for a fundamental shift in how mental health services engage with diverse communities. This proactive approach is essential, as it aligns with community-based participatory research and practice (Cacari-Stone et al., 2014; Minkler, 2010; Page-Reeves, 2019), which prioritises

meeting communities where they are and actively involving them in the design and delivery of services.

Additionally, the findings around stigma and lack of awareness within these communities, as explored in Sub-GET 2.1, reveal another layer of systemic barriers. The pervasive stigma around mental health, Williams (2015) and Breland-Noble et al. (2015) found stigma as a contributing factor hindering African American children from accessing mental health services. The London Assembly (2015, p. 11) highlights that "people do not even want to associate themselves with statutory organisations, " partly due to stigma. In 2015, the NHS England and DOH (2015, p. 4) made a commitment, which states, "We must make it much easier for a child or young person to seek help and support in non-stigmatised settings.". This specific commitment to tackling the stigma associated with mental health in black communities is captured in the NHS Long-Term Plan (NHS, 2019). This policy needs an evaluation along these discourses to assess its impact.

In summary, the discussion of accessibility and systemic barriers brings to light the complex challenges Ghanaian, Nigerian and diverse youth face in London. The system, as it stands, is marked by institutional neglect, structural violence, stigma and underinvestment in community engagement—all of which severely limit access to effective mental healthcare. These findings indicate a clear need for systemic reforms prioritising proactive outreach and dismantling barriers preventing equitable access to mental health services. As I reflect on these issues, it becomes clear to me that creating a more inclusive and effective mental healthcare system is not just an option but a necessity.

7.6. Evidenced-based Therapy

Evidence-based practice (EBP) was prominently featured in my findings. It holds substantial theoretical importance in healthcare (Sackett et al., 1996), particularly mental health services (Aisenberg, 2008; Drake, 2003). I first discussed EBP's theoretical importance and its intent, its limitations in my findings from the lens of my participants, and adapting the IAPT Positive Practice Guild for minoritised communities, which is the front-line EBP to caring for anxiety and depression, all in the context of my research findings.

7.6.1. EBP's Theoretical Importance

All the NHS practitioners explained how they adhere to IAPT EBP because, like Uwase said, "*that's what I've been taught to do"*. One of its primary contributions is its capacity to bring rationality and standardisation to clinical practice. By basing healthcare decisions on scientific evidence, EBP minimises subjective judgments and ensures that treatments are consistent and reliable (Melnyk & Fineout-Overholt, 2022). This approach is particularly valuable in mental health interventions like Cognitive Behavioral Therapy (CBT), where standardization of methods helps clinicians apply structured, evidence-based 'treatments' that have been proven effective even for culturally adapted CBT (Dalmia et al., 2023; Rathod et al., 2010; Wallace et al., 2020). This consistency might present significant challenges given the definition of 'care' I posited as a holistic, person-centred approach that addresses physical, emotional, psychological, and social well-being, supporting dignity and independence through tailored interventions that integrate individuals' environments and relationships (see Section 1.3,4) for diverse populations, such as the Ghanaian and Nigerian youth in Inner London. A perceived reliable 'care' based on validated interventions may be defective, such as adapted CBT (Sackett et al., 1996).

In the course of this study, an important fact I resonate with is that EBP attempts to bridge the gap between theory and practice, ensuring that research informs clinical interventions (Sackett et al., 1996). This theoretical link between empirical knowledge and real-world application ensures that mental health services remain dynamic and responsive to new scientific discoveries. This dynamism would be the starting point for mental health services like IAPT to evolve continuously, incorporating the latest advances into treatment protocols (Curtin et al., 2023; NCCMH, 2023). This is particularly relevant to my Ghanaian and Nigerian young people, who may have unique cultural and social experiences influencing their mental health. It provides a mechanism for adapting evidence-based treatments to better meet the needs of diverse populations, ensuring that these groups benefit from the latest developments in mental healthcare. However, for my research population, this notion has been suboptimal.

Patient-centred care is another critical theoretical aspect of EBP, emphasising that care needs to be based on scientific evidence and tailored to meet patients' needs, preferences, and cultural backgrounds, as discussed by practitioners in the Impact workshop and Rogers (1951). However, one of the limitations of EBP is that its evidence base is often developed from research on majority populations (Melnyk & Fineout-Overholt, 2022), which may not adequately reflect the experiences of minoritised groups such as Ghanaian and Nigerian youth. This could create a theoretical tension between the goal of standardization and the need for culturally responsive care, which all NHS IAPT practitioner participants in the semi-structured interview highlighted. Addressing this gap would require intentional integration of cultural humility into EBP, ensuring that treatments are adapted to align with the specific cultural contexts of the populations being served (Curtin et al., 2023). Without these adaptations, the theoretical ideal of patient-centred care may not fully materialise in practice for minoritised groups.

Finally, though not exhaustive, EBP theoretically promotes improved outcomes by fostering accountability in healthcare. Clinicians are encouraged to base their treatment decisions on interventions that have been validated through research, ensuring that patients receive care with a high likelihood of success (Straus et al., 2018). This accountability is particularly relevant in mental health services, where disparities in care persist for minoritised populations. As a result of the accountability, we have been able to evaluate IAPT to some extent. Reports on ethnic inequalities in IAPT services indicate that while EBP forms the foundation of these services, outcomes for Black African and Black Caribbean populations are often worse compared to their White counterparts (Curtin et al., 2023). IAPT is the front-line EBP for the treatment of anxiety and depression, see Section 2.4.4.1. Curtin et al.'s (2023) study was funded by the National Institute for Health and Care Research (NIHR) School for Public Health Research (SPHR) to explore the enhanced health and wellbeing pathway within the IAPT service. It showed a lack of tailored support for specific communities. Another study commissioned by the NHS Race and Health Observatory to understand ethnic inequalities in access, experiences, and outcomes within IAPT services also shows that while there is progress, people from minoritised ethnic groups still experience worse outcomes, longer waiting times, and lower treatment access than White

British individuals (NCCMH, 2023). These findings are consistent with that of this research. However, my point here is that the accountability feature of EBP is inextricably beneficial in this regard. It shows a need for a critical examination of how the IAPT EBP is implemented in practice, particularly for minoritised groups, to ensure that the theoretical benefits of EBP—such as improved outcomes and equitable care—are realised for all populations.

In conclusion, EBP holds significant theoretical importance in healthcare by providing a structured, evidence-based framework for clinical decision-making. Its strengths lie in its capacity to standardise care, reduce uncertainty, and bridge the gap between research and practice. However, the theoretical ideals of EBP would need to be sufficiently adapted to account for the cultural and social determinants that influence the experiences of minoritised populations, which I discussed in Section 7.4.2. For Ghanaian and Nigerian youth in Inner London, integrating cultural humility into EBP is essential to fully realising the theoretical promise of patient-centred, evidence-based care.

7.6.2. Adapting the EBP IAPT Positive Practice Guild for Minoritised Communities

To adapt the *Positive Practice Guide* evidence-based practice (EBP), based on the limitations I identified in my analysis, several critical changes need to be considered to ensure it is effective for culturally diverse populations, such as the young Ghanaian and Nigerian individuals in this study.

One of the primary limitations of EBP is its tendency to overlook cultural contexts in favour of standardised care, as argued by Aisenberg (2008). The limited representation of ethnic minorities in clinical trials, coupled with the lack of attention to cultural nuances, often makes EBP interventions less effective for diverse populations. This is illustrated in Nkiru's experience, where she described her initial therapy as "very white-focused" and disconnected from her cultural reality. The *Positive Practice Guide* could be adapted by emphasising cultural competence and humility as essential, not secondary, components of care. Instead of treating cultural awareness as an afterthought, it would have to be sufficiently and genuinely embedded within every aspect of therapeutic practice (See Section 7.3.1). Nkiru's eventual success with a Black and ethnic minority therapist who was

culturally familiar and Kofis', who was culturally sensitive, highlights that cultural understanding is central to effective care, even when perceived.

Intersectionality also needs to be a more prominent part of the EBP framework. In the case of Efia, her fear of disappointing her family, combined with family and societal pressures, reveals overlapping social identities. The *Positive Practice Guide* could integrate intersectionality more deeply by equipping practitioners with tools to recognise and address the compounded effects of race, gender, migration status, religion and other identities on mental health. Efia's experience reveals that traditional therapy frameworks, which often treat identity categories in isolation, fail to capture the full scope of these challenges. Therefore, therapists need to be trained in cultural humility practice to understand how intersecting identities influence mental health (discussed in ADDRESSING 3Cs Framework Section 7.4.2.3.3).

Moreover, I believe that the definition of "evidence" in EBP needs to be broadened to acknowledge the importance of the therapeutic relationship more deeply. As I analysed Kofi's experience, it became clear that his therapy's empathetic and flexible nature was as important as the specific techniques used. In my view, the *Positive Practice Guide* needs to emphasise the relational aspects of therapy, advocating for a balance between evidence-based techniques and the human connection between therapist and client (Hoffman et al., 2015). Relying solely on rigid, research-driven interventions can be limiting, particularly when cultural understanding is lacking. Kofi's experience demonstrates that even when therapists do not fully grasp a client's cultural background, flexibility and empathy can bridge the gap and enhance the effectiveness of care.

In line with Tanenbaum's (1994) critique of the narrow focus on research evidence relating to a balancing approach in EBP that values clinical judgment alongside empirical evidence. The Guide could be adapted to encourage and trust practitioners to use their professional expertise to tailor treatments/care to each client's unique needs. This will reflect the APA's integration of clinical expertise with patient preferences and cultural backgrounds (Hoffman et al., 2015), which acknowledges that research evidence alone is insufficient for optimal care.

Additionally, the guide needs to be seen to address the social and cultural determinants of mental health proactively, not as an afterthought. Practitioners need to be adequately trained to not only focus on symptom reduction but also to consider the different ways in which societal factors contribute to a client's mental health issues. By doing so, EBP would potentially become more holistic and responsive to the lived realities of individuals like Kofi and Efia.

In conclusion, while the *Positive Practice Guide* provides important strategies for applying EBP to minoritised communities, it will need to evolve to address the cultural, intersectional, and relational dimensions that traditional EBP models often do not sufficiently consider. By adapting the *Guide* to incorporate cultural humility, intersectionality, and the importance of the therapeutic relationship, EBP can be made more effective for diverse populations. This adaptation will ensure that EBP is theoretically sound and practically relevant for individuals from varied cultural backgrounds, leading to a more inclusive and responsive mental healthcare model.

7.7. Faith and Spiritual Influences

In my analysis, I find the influence of religious beliefs on the mental health experiences of Ghanaian and Nigerian young people in inner London deeply complex. The significance of these beliefs, as repeatedly emphasised in the narratives, reveals that faith often serves as a source of comfort but also acts as a barrier to accessing formal mental healthcare. The findings are congruous to the findings from studies like those by Dein (2010, 2018) and Rosmarin et al. (2009). This duality shows how religious beliefs are deeply entrenched within my participant's world and how they shape their perceptions of mental illness and its care.

Most participants relied heavily on prayer and faith as their primary coping mechanisms. To demonstrate how intense this is – Ghanaian young participants: Adjua, "*praying, speaking to God is helpful";* Akua, "We pray to God"; Kofi, "*Prayer and faith in God were my refuges".* Nigerian young participants: Daba, *"Praying about things is a kind of therapy for me";* Nkiru, *"I pray to God about it"; and* Osas,*"I pray. I read my Bible".* This highlights the centrality of spiritual practices in their lives, especially when facing mental health challenges, which aligns with the study by Bignall et al. (2019). Bignall et al. observed that in African and

Caribbean communities, mental illness is often understood as a spiritual or moral issue, leading individuals to seek help from religious leaders rather than mental health professionals.

As I analysed the data, the role of religion and spirituality as both a source of strength and a contributor to stigma became increasingly clear. Participants like Osas, Daba, and Chike found comfort in their religious communities but also faced pressures that reinforced the stigma surrounding mental health. This observation is consistent with Breland-Noble et al. (2015), who discussed how religious communities might prioritise spiritual solutions, sometimes at the expense of seeking professional mental healthcare. Chike, a Nigerian father, said, *"All that we know as Africans is about prayer (...) we haven't balanced our life well.".* Reflecting on these insights, I see the critical need for more integrated service models that genuinely respect and incorporate religious and spiritual beliefs into mental healthcare. As well as the need for mental health professionals to engage more deeply with religious leaders and communities to bridge this gap.

This is particularly relevant in communities like those in Sub-GET 2.1, where participants noted a lack of awareness and acknowledgement of mental health issues, with cultural and religious interventions often substituting for professional care. Shelly, a community-based practitioner, highlighted the church's deep trust and influence within the community, stating that it *"has more power in what they share with parents than any other professional."* This is particularly true. For instance, the South London and Maudsley NHS Foundation Trust instituted an initiative to train faith leaders in mental health awareness (London Assembly, 2015), a promising example of an effective integration. Similarly, the 2019 Improving Access to Psychological Therapies (IAPT) program, which incorporates provisions for religion and spirituality to enhance treatment accessibility for ethnic minorities, represents an important step (Beck et al., 2019), though its impact has yet to be fully assessed. The National Collaborating Centre for Mental Health (NCCMH, 2023) also highlighted how cultural and religious insensitivity among providers can negatively impact treatment, further emphasizing the need for a more inclusive approach.

As Shelly, a community-based practitioner, emphasised, the church holds significant trust and influence within the Black community, often commanding more attention from congregants than mental health practitioners. Given the important roles of religion and spirituality in Black mental health and care, the following two sections will explore initiatives that the systems have adopted to involve faith institutions and their leaders and the models used for their training.

7.7.1. Initiatives to Include Faith and Faith Leaders in Mental Health

Given the influential role faith and faith leaders play in many communities, especially underserved ones (Chatters et al., 2015; Dein, 2018; Lekwauwa et al., 2023; Rosmarin et al., 2009), various initiatives have been launched to engage faith communities in mental health support, equipping faith leaders with the knowledge and tools to aid individuals experiencing mental health challenges. The examples discussed here are not exhaustive but highlight significant efforts to integrate faith with mental healthcare.

One such initiative is the *Mental Health First Aid (MHFA) Training for Faith Leaders*, provided by Mental Health First Aid England. This program is tailored to help faith leaders recognise early signs of mental health issues and offer appropriate support. By promoting early identification and providing basic mental health education, the MHFA program helps reduce stigma and facilitates connections to professional mental health services when necessary (MHFA England, 2024). Thrive LDN, in collaboration with faith-based organizations, has delivered MHFA training across London, further enhancing the capacity of faith leaders to respond to mental health issues in ways that are culturally sensitive and aligned with the spiritual needs of their communities (Thrive LDN, 2021). These efforts are aimed to help bridge the gap between formal mental health services and community-based support, making mental healthcare more accessible and reducing stigma.

Another prominent initiative is the *Heads Together Campaign*, spearheaded by the Royal Foundation of the Duke and Duchess of Cambridge. This campaign goes beyond raising mental health awareness by actively involving faith leaders in mental health conversations. By collaborating with faith communities and offering resources that blend spiritual support with mental healthcare, Heads Together contributes to destigmatizing mental health within

religious contexts (Heads Together, 2022). Similarly, FaithAction has engaged religious communities through mental health education projects, offering faith leaders training on mental health conditions. Their work emphasises the need for support while addressing mental health stigma in faith settings(FaithAction, 202).

The Church of England has also made strides in addressing mental health within its religious framework, developing resources specifically for clergy and lay leaders. These resources provide practical and theological guidance for church leaders, equipping them to offer pastoral care for individuals facing mental health challenges. Recognising the growing demand for mental health understanding within religious leadership, this initiative reflects the Church's commitment to supporting mental well-being among its communities (The Church of England, 2024).

Within the Muslim community, the *Muslim Youth Helpline (MYH)* has promoted mental health literacy, particularly among Imams and community leaders. Their faith-sensitive workshops ensure Muslim leaders can address mental health issues while remaining aligned with Islamic teachings (Muslim Youth Helpline, 2023). The *Mind and Soul Foundation,* a Christian organization, aims to bridge the gap between faith and mental health by offering theological and psychological training to Christian leaders (Mind and Soul, 2023). In addition, Black Mental Health UK has collaborated with religious leaders to deliver mental health education tailored to the experiences of Black individuals (Black Minds Matter UK, 2023).. Recognizing spiritual central role in Black communities, these initiative equips faith and leaders with the knowledge to address the intersections of race, faith, and mental health. The goal is to reduce stigma and promote culturally appropriate care within Black congregations.

These initiatives reflect a growing recognition of the critical role that faith leaders play in mental healthcare. By equipping religious leaders with appropriate training and resources, these programs promote more inclusive, culturally sensitive, and effective mental health interventions, particularly for my research population communities where religious figures are often the first point of contact for emotional support.

7.7.2. The Biopsychosocial-Spiritual (BPSS) Model

The Biopsychosocial-Spiritual (BPSS) Model has increasingly been integrated into the training of faith leaders, recognizing their critical role in mental healthcare, particularly in communities where spirituality is deeply intertwined with everyday life (Foreman, 2017; Mendenhall et al., 2022; Saad et al., 2017). This model provides a holistic approach by incorporating biological, psychological, social, and spiritual dimensions. This is especially valuable in communities where traditional mental health services may be underutilised due to stigma or a preference for spiritual interventions, as evident in my findings and other research (Dein, 2010, 2018; Rosmarin et al., 2009). Koenig (2008) argues that integrating spiritual care into mental health frameworks allows faith leaders to bridge the gap between medical and spiritual understandings of health, positioning them as vital players in mental health awareness and intervention.

The BPSS model is an extension of the Biopsychosocial (BPS) model, which was initially developed by George L. Engel in 1977. Engel introduced the BPS model to challenge the traditional biomedical model, advocating for a more holistic understanding of health by integrating biological, psychological, and social dimensions (Engel, 1977). The spiritual component was later added by scholars and practitioners who recognised the importance of spirituality in understanding an individual's well-being, especially in more holistic and culturally diverse contexts (Sulmasy, 2002; Wright & Maureen, 2000), and it has a significant place in Medical Family Therapy (Delbridge et al., 2014; Hodgson et al., 2014)

The BPSS model's cultural adaptability is a significant advantage, as it contextualises mental healthcare within a community's specific cultural and spiritual beliefs. In contexts where spirituality is integral to identity, such as among Ghanaian and Nigerian communities in the diaspora, the model's incorporation of spiritual elements can help normalise mental health discussions. Faith leaders in these communities are trusted figures who influence their congregants' attitudes towards health, and BPSS training would enable them to introduce mental health concepts in ways that resonate with cultural and spiritual values. This can be especially important for youth from these and diverse backgrounds, who may experience unique stressors such as migration, family pressure, and discrimination but are hesitant to

seek mental healthcare due to fears of legal, stigma or spiritual consequences. Legal, we saw how Kemi could not seek help due to her undocumented immigrant status. Faith leaders trained in the BPSS model can help mitigate these fears by reframing mental health within the community's spiritual and cultural frameworks.

However, while the model's spiritual dimension is an asset, it also presents challenges. Faith leaders may place an overemphasis on the spiritual aspect of the model, leading to a tendency to spiritualise mental health issues rather than address them through appropriate medical or psychological interventions. For instance, studies have shown that some faith leaders view mental illness primarily as a spiritual or moral failing, which can lead to delays in seeking professional mental healthcare (Campbell, 2021). This over-reliance on spiritual explanations risks undermining the BPSS model's holistic intent, particularly in cases where biological or psychological care is necessary. Training programs need to emphasise the equal importance of all dimensions, biological, psychological, social, and spiritual, so faith leaders do not unintentionally reinforce harmful misconceptions that would prevent individuals from accessing timely and appropriate care when needed (Heseltine-Carp & Hoskins, 2020).

Another challenge is that Faith leaders from different denominations or religious practices may interpret the spiritual dimension of the BPSS model in ways that conflict with mental health frameworks, leading to inconsistent implementation. For example, certain religious beliefs may prioritise spiritual interventions such as prayer or fasting over medical treatment, which can limit the effectiveness of mental healthcare (Swihart et al., 2023). Moreover, not all faith leaders may be equipped to navigate the biological or psychological aspects of the model, particularly those with limited education or training in these areas. Rego and Nunes (2019) suggest that while faith leaders may excel in offering spiritual support, many struggle to incorporate biological or psychological components into their care. The reluctance to acknowledge other dimensions beyond the spiritual often stems from a strong belief system that prioritises spirituality as the primary lens through which life and challenges are understood. This perspective is frequently reinforced by religious scriptures that emphasise the spiritual dimension while downplaying or ignoring other aspects, such as biopsychosocial factors. As a result, individuals who seek to give equal importance to these other dimensions may face stigma, as their approach is perceived as

conflicting with dominant spiritual beliefs. This might reduce the model's overall efficacy. This inconsistency raises concerns about whether faith leaders can fully integrate the BPSS model into their practices and whether additional supports, such as partnerships with mental health professionals, could augment the lapses.

Another critical limitation of the BPSS model's use in training faith leaders is the potential for reinforcing existing power hierarchies within religious communities. Faith leaders often hold significant authority, and their interpretations of mental health issues may carry considerable weight. Without proper training or oversight, faith leaders might reinforce harmful practices, such as the prioritization of spiritual solutions over medical interventions, which could exacerbate mental health problems rather than alleviate them due to the power imbalance (Dein, 2010, 2018). In addition, the reliance on faith leaders as primary mental health providers can create barriers to care, particularly if they are unable or unwilling to refer individuals to mental health professionals. The success of the BPSS model in faith leader training hinges on the development of strong referral systems and collaborative relationships between faith communities and mental health services (Delbridge et al., 2014; Runnels et al., 2018).

In conclusion, while the Biopsychosocial-Spiritual Model provides a valuable framework for training faith leaders in mental health awareness, its application is not without challenges. The model's holistic nature and inclusion of spirituality align well with the roles that faith leaders play in their communities, offering a culturally relevant approach to mental healthcare. However, the overemphasis on spirituality, inconsistency in its application across different faith traditions, and the potential reinforcement of power hierarchies present significant barriers. Addressing these challenges requires a careful balance between spiritual, biological, and psychological dimensions, as well as the development of collaborative networks between faith leaders and mental health professionals.

7.8. Intergenerational Dynamics and Mental Health

I found that the tension between family expectations and the younger generation's understanding of mental health is deeply reflective of acculturation and intergenerational conflict (Berry, 1997; Hwang & Wood, 2009; Kwak & Berry, 2001). Acculturation, the process

of adapting to a new culture, often generates intergenerational conflict, particularly within immigrant families where younger generations like Daba acculturate to the host culture more rapidly than their elders, who may prioritise traditional values. Sub-GET 2.3 explicitly highlight Ghanaian and Nigerian young people in London and how this acculturation process can exacerbate mental health challenges, such as anxiety and depression, due to the cultural expectations and pressures faced within their families. Social Identity Theory (Tajfel & Turner, 2004) helps elucidate these tensions: as individuals derive self-concept from group affiliations, the dissonance between identifying with the host culture and maintaining family heritage can strain their sense of belonging and well-being.

For these young individuals, their ethnic identity often becomes salient in environments where they face systemic discrimination or cultural misunderstandings, which can exacerbate feelings of alienation and stress. Experiences of discrimination, whether overt or subtle, are major contributors to anxiety and depression in minority groups as discussed within the construct of critical race theory (Sections 7.2 & 7.3.1). This is compounded by the pressures to conform to both the expectations of their heritage culture and the dominant culture in the UK, leading to what Berry (1997) describes as acculturative stress. For example, the young participants' parents expected them, Agnes, to *“stay strong”,* Kofi to *“man up”,* and even Kudi, a Nigerian mother, expected her daughter to *“man up”* despite their struggles. This expectation aligns closely with the concept of filial piety, which, although primarily discussed in the context of East Asian cultures (Legge, 2001), is equally relevant in African diasporic communities (Etieyibo, 2022). Filial piety involves a deep-seated obligation to respect and uphold family values, often requiring the suppression of individual needs or desires to maintain family honour. In these young participants’ cases, the pressure to *"stay strong;"* or to *“man up”* embodies this cultural expectation, where showing vulnerability or seeking external help for mental health issues could be perceived as a failure to meet familial and cultural standards. This mirrors the findings of Han and Cheung's (2024) systematic review, which argued that filial piety can contribute to significant emotional burdens on young people, especially when they are expected to prioritise family expectations over personal well-being.

Chichi's experience, where she felt pressured to remain in university despite overwhelming stress, also resonates with Berry's (1997) model of acculturation. Chichi's narrative, *"The pressure of my family members telling me that I couldn't leave uni and I had to finish uni even while I was stressed added to it,"* highlights this tension. Her experience is indicative of acculturative stress, where the pressure to conform to traditional values, such as achieving academic success, conflicts with her own mental health needs at the time. This is consistent with Hwang and Wood (2009), who found that acculturative stress often exacerbates psychological distress among immigrant youth as they struggle to reconcile their personal experiences with the expectations imposed by both their heritage and the host culture.

The generational gap in understanding mental health, as illustrated by Efia's fear of *"disappointing everyone who worked so hard to bring me here,"* reflects intergenerational ambivalence, a concept explored by Luescher and Pillemer (1998). Intergenerational ambivalence refers to the coexistence of conflicting emotions within family relationships, particularly when younger generations experience a divergence in values or priorities from their parents. Efia's narrative exemplifies this ambivalence. She feels a deep sense of duty to honour her parents' sacrifices, yet this duty also creates a significant emotional burden that complicates her mental health and the ability to address her mental health needs. This is further supported by Kwak and Berry (2001), who noted that the generational transmission of values can lead to internal conflict in immigrant families, particularly when younger family members feel pressured to uphold traditional values that may be at odds with their own experiences or the societal norms of the host country.

In summary, the tension between traditional values and the evolving understanding of mental health among younger generations highlights the complexity of navigating these dynamics in a multicultural context.

7.9. Resilience and Coping Mechanisms

This aspect is paramount due to the human drive to endure and overcome adversity. These individuals navigate their challenges through a complex interplay of cultural, religious, and personal coping strategies that are not merely reactive but deeply embedded in their

identities, shaped by their cultural heritage and social environments. The core of their coping mechanisms, however, remains largely undocumented.

One of the most compelling aspects of resilience that emerged from my analysis is the reliance on faith and prayer as primary coping mechanisms, detailed discussed in Section 7.7. I also find it intriguing to understand that though there was pressure from family expectations for these young generation youth to "man up" or "stay strong," it also played a significant role in shaping their resilience, reflecting a cultural socialisation of stoicism and endurance (Pathak et al., 2017). By this, I refer to the way societies instil values of emotional restraint, resilience, and coping without external assistance in response to adversity. This expectation is particularly evident in the experiences of participants like Kofi and Efia, who internalised these norms, leading them to suppress their emotions and avoid seeking external help. This aligns with the notion that many African cultures emphasise resilience and self-reliance, often at the expense of open emotional expression (Akotia et al., 2014). Traditional African views on development and intelligence emphasise resilience, stoicism, and endurance, often instilled through family expectations and socialisation practices. In African traditions,

> *'Socialization is not organised to train children for academic pursuits or to become individuals outside the ancestral culture. Rather, it is organised to teach social competence and shared responsibility within the family system and the ethnic community (Nsamenang & Lamb, 1994, p. 137)*

Traditional African views on development and intelligence often emphasise resilience, stoicism, and endurance as key virtues. As Daba said, what he went through shaped his *"maturity."*

Their resilience and coping thus align with Lazarus and Folkman's (1984, p. 293) Transactional Model of Stress and Coping. "Transactional Model views the person and the environment in a dynamic, mutually reciprocal, bidirectional relationship". This model describes coping as a dynamic process where individuals assess stressors and choose strategies to manage them, often categorised into problem-focused and emotion-focused strategies (Lazarus & Folkman, 1984). Problem-focused coping involves taking direct action

to address a stressful situation, such as seeking professional help or finding solutions to specific challenges, while emotion-focused coping involves regulating one's emotional response to the stressor, often through practices like mindfulness or emotional release (Carver et al., 1989). I see this reflected in the participants' stories, where both problem-focused and emotion-focused coping strategies are evident. Nkiru's proactive effort to secure culturally appropriate therapy is a clear example of problem-focused coping, where she actively sought to change her situation. On the other hand, Kofi's reliance on prayer exemplifies emotion-focused coping, where he managed his emotional response rather than the external stressor itself.

However, while these approaches offer significant emotional support, they can sometimes hinder individuals from seeking formal mental healthcare, especially when cultural stigmas around mental illness persist (See Section 7.3.4). Thus, incorporating culturally relevant coping mechanisms into mental healthcare, such as recognising the role of spirituality and community, is vital for developing effective interventions in diverse populations (Fernando, 2010).

Altogether, participants' narratives on resilience were wholly foregrounded in cultural practices and adherence to community norms. I am drawn to Michael Ungar's (2008) theory of resilience, which posits that resilience is not merely an individual trait but also a process involving the negotiation of resources in culturally meaningful ways- "culturally and contextually" (p. 218). In other words, resilience is deeply embedded in cultural and social contexts, where individuals utilise the resources available to them in ways that are congruent with their cultural identities.

Bronfenbrenner's Social Ecological Model (Bronfenbrenner, 1979), also offers a framework for understanding how the multiple layers of these young people's environments shape their coping mechanisms and how more needs to be done for them at each layer. At the microsystem level, for example, Agnes' parents' encouragement to "stay strong" serves as a form of familial support, as already analysed, and highlights the significant impact of close relational ties on fostering resilience. Considering the mesosystem, seeking prayer with Christian friends, which some participants described, illustrates how social networks within

religious communities provide coping strategies that serve as a crucial buffer against stress. Looking at the exosystem, I recognise the critical role of institutional support mechanisms. Kofi's positive experience with professional therapy exemplifies how broader institutional structures, such as mental health services, contribute to individual resilience. While more distant than family or community, this support is essential in providing the specialised care needed to address more complex or lingering psychological challenges.

Finally, their experiences are shaped by the intersection of factors such as race, gender, and culture, all of which significantly influence their access to mental health services and the effectiveness of the coping mechanisms they employ. As I reflect on the resilience and coping strategies observed in this study, I realise that these mechanisms are complex and intricately woven into the participants' cultural identities and social contexts.

7.10. Strengths and Limitations

Strengths

A key strength of my study is its use of IPA, which enabled a perceived deep exploration of the lived experiences of Ghanaian and Nigerian young people regarding the care for anxiety and depression in Inner London. This qualitative methodology focuses on participants' subjective interpretations, offering nuanced insights that might be missed by quantitative approaches (Smith et al., 2009). By centring participants' lived experiences, I uncovered rich, detailed understandings of their mental health journeys.

Moreover, my research integrates intersectionality theory and Critical Race Theory (CRT), providing a robust framework for understanding how race, culture, and socioeconomic status intersect to shape mental health outcomes. This approach allowed me to address the unique challenges faced by the study population and offered a culturally sensitive lens through which to view their experiences with mental healthcare (Crenshaw, 1991; Delgado & Stefancic, 2017). This cultural and contextual relevance ensures that the findings are deeply connected to the realities of the participants' lives.

In designing my research, I emphasised a participant-centred approach, which prioritises the voices of those most affected by the issues under study. This approach is especially valuable

in mental health research, where understanding personal experiences is crucial to grasping the complexities of mental health conditions (Eatough & Smith, 2017). By foregrounding the perspectives of the participants, I ensured that their stories and insights directly shaped the findings.

Additionally, my study makes an original contribution to a relatively understudied area—namely, the mental healthcare experiences of Ghanaian and Nigerian youth in London. This focus addresses a gap in the literature, offering insights that can inform future research, policy, and practice, particularly in enhancing culturally sensitive mental health services (Adebowale, 2020). By shedding light on these experiences, the study provides a foundation for improving mental healthcare for these diverse youth and communities.

Limitations

A notable limitation of my study is the small and homogeneous sample size, a characteristic typical of IPA. While this approach enabled a detailed exploration of individual experiences, it restricts the generalizability of the findings to the broader population of Ghanaian and Nigerian youth in London (Smith et al., 2009). The richness of insight derived from the participants' narratives is balanced by the need for caution in extrapolating these findings beyond the specific contexts explored in this study.

Another challenge lies in the potential for researcher bias in interpretation. Given the interpretative nature of IPA, there is an inherent risk of my own perspectives influencing the analysis. Although I employed strategies such as reflexivity, bracketing, and transparency throughout the analytical process, the subjective nature of this methodology means that my interpretations are inevitably shaped by my background and worldview (Brocki & Wearden, 2006; Giorgi, 2011; Pringle et al., 2011). This introduces a layer of complexity to the findings, as they reflect both the participants' experiences and my own lens of understanding, explicated in the concept of double hermeneutics (Eatough & Smith, 2017).

The intersectional lens brought valuable insights into the multifaceted nature of the participants' experiences. However, it also introduced challenges in terms of complexity when operationalising these concepts in empirical research (i.e. Section 7.4). The interplay of multiple social identities and their impact on mental health is inherently intricate, and

despite my efforts to capture this, there may have been instances where the analysis oversimplified or overlooked certain dimensions (Cole, 2009; McCall, 2005).

Additionally, while I incorporated Critical Race Theory (CRT) into the theoretical framework, the study's emphasis leaned more towards individual and cultural factors affecting mental health. This limited focus on broader systemic factors means that elements such as policy frameworks and healthcare system dynamics, which significantly influence mental health outcomes, were not as deeply explored (Gillborn, 2006). A more comprehensive examination of these institutional aspects could provide further insight into the systemic challenges faced by Ghanaian and Nigerian youth in London.

Together, these strengths and limitations highlight the unique contributions of my research while highlighting areas where future studies could expand. By addressing the challenges outlined here, subsequent research could provide an even more nuanced understanding of the mental health experiences among Ghanaian and Nigerian youth in London.

7.11. Chapter Conclusion

I have discussed the theoretical implications of the emerging themes from the analysis, revealing the complex interplay of cultural, social, and systemic factors that shape the mental health experiences of Ghanaian and Nigerian young people in Inner London. The discussion identified the value of cultural humility as a framework that goes beyond cultural competence, advocating for a continuous, reflexive process where practitioners engage with their clients' unique cultural contexts. This approach is crucial for bridging the disconnect between traditional EBP methods and the lived realities of marginalised communities. The study also emphasised the role of intergenerational dynamics, the influence of faith, and the systemic barriers that often hinder access to appropriate care. Addressing these barriers requires a collaborative effort among mental health professionals, community leaders, and policy-makers to create a more inclusive and responsive mental healthcare system.

Chapter 8: Conclusion

8.1. Recommendations for Policy and Mental HealthCare Practice

Some recommendations will be brief, as they are already examined in Chapter 7 on the theoretical implications of the findings; in such cases, I will refer to the relevant section. Wampold & Imel (2015) emphasise the importance of using research findings to guide clinical practice in mental healthcare, particularly therapeutic approaches. Similarly, Fine et al. (2003) argue that researchers have an ethical obligation to use their findings to advocate for social change and to work in partnership with marginalised communities to address the issues identified in their research. However, I am cautious about presenting broad implications from an expert's standpoint. During my interviews, I asked participants directly what they thought would be beneficial in terms of policies and interventions in the care for anxiety and depression. Therefore, my recommendation stems directly from their views, preferences and suggestions, including those from the Impact Workshop.

Based on the findings from my research on the mental healthcare experiences of young Ghanaian and Nigerian individuals in inner London, I propose several recommendations aimed at improving mental healthcare practices for culturally diverse populations.

8.1.1. Integrating Cultural Humility into Mental HealthCare Practices

I identified a critical issue: the current mental healthcare framework often lacks cultural relevance and sensitivity, leading to suboptimal therapeutic outcomes. To address this gap, I advocate for integrating cultural humility into mental health practice (discussed extensively in Section 7.4). Unlike cultural competence, which suggests a static accumulation of knowledge, cultural humility emphasises continuous self-reflection and learning by practitioners (Hook et al., 2013; Tervalon & Murray-García, 1998). It encourages an ongoing, dialogical engagement with clients, recognising the practitioner's limitations and biases and making it more dynamic and adaptable. The shift towards cultural humility is gaining traction, as evidenced by the Royal College of Psychiatrists' efforts to expand its Cultural Competence and Diversity toolkit to include this approach (Royal College of Psychiatrists, 2021). Certain elements I discussed in Section 7.4 will be invaluable to this integration.

8.1.2. Expanding and Adapting Evidence-Based Practices (EBP) to Include Cultural Contexts

The limitations of traditional evidence-based practices (EBP) are strikingly evident in the participants' narratives, particularly when these practices fail to align with their cultural experiences. Nkiru's initial encounter with what she described as "white-focused" therapy exemplifies the inadequacy of a uniform approach in mental healthcare. To rectify this, I propose expanding EBP to encompass culturally adapted interventions (discussed in Section 7.6). The efficacy of culturally adapted Cognitive Behavioral Therapy (CBT) for diverse populations is well-documented (Dalmia et al., 2023; Rathod et al., 2010; Wallace et al., 2020). The Improving Access to Psychological Therapies (IAPT) program, now known as NHS Talking Therapies, has been progressively adapting its CBT interventions to enhance cultural relevance (NHS England, 2024). However, incorporating elements of cultural humility will strengthen its efficacy (discussed in Sections 7.4 & 7.6.3). The adaptation would need to be profound and courageous, deeply embedding the cultural, religious, and social contexts, including personal experience of both the client and practitioner, thereby bridging the gap between standardised practices and the specific needs of culturally diverse clients.

8.1.3. Enhancing Accessibility and Outreach Efforts

I found that accessibility was a significant barrier, with participants like Efia and Adjua expressing frustration over long wait times and feeling neglected by the mental health system. To address these issues, I advocate for mental health services to adopt proactive outreach strategies, bringing interventions directly to communities, as suggested by both the NHS and community-based practitioners in this study (see Sub-GET 2.2 & Section 7.5).

This approach aligns with community-based participatory research, which emphasises collaboration with communities to design interventions that meet their specific needs. The Black Thrive Lambeth initiative, highlighted by Bindun, is a strong example of this strategy, improving mental health access for Black residents through outreach programs with local faith groups and organisations. My findings can help refine such initiatives by providing evidence of how systemic barriers impact access to care. By concentrating on reducing wait

times, improving follow-up procedures, and ensuring proactive and responsive outreach, I support the need for increased resources and strategic planning in these programs.

8.1.4. Addressing Stigma Through Community Education and Engagement

Stigma emerged as a significant barrier in this research, causing participants to avoid professional help and rely on religious or informal coping mechanisms. To address this, I recommend implementing culturally tailored education programs within communities to challenge misconceptions and reduce stigma. These programs need to leverage respected community figures, including religious leaders, to promote mental health awareness. The Time to Change campaign, which ran from 2009/10 until its end in 2021, was a partnership between Mind and Rethink aimed at reducing culturally specific stigma, particularly among African and Caribbean populations (Mind, 2021b; NSMC, 2009). While the campaign showed promise in its early stages (King's College London, 2013), later evaluations indicated its impact was negligible (Henderson et al., 2020). The findings of this study also suggest that any gains made by the campaign did not significantly penetrate the communities I studied.

I believe the Time to Change campaign was a laudable initiative that needs continuing but requires revamping. This research provides valuable insights into how this can be adapted within Ghanaian and Nigerian communities, offering context for designing more effective, culturally sensitive anti-stigma campaigns (see Section 7.4). By respecting religious beliefs while promoting the benefits of professional mental healthcare, these initiatives can bridge the gap between traditional coping strategies and modern therapeutic practices (Section 7.7).

Edith suggested integrating mental health education into school curricula, which may help normalise mental health conversations from a young age and gradually shift community perceptions. Education can be a powerful tool for enhancing the well-being of young migrants, especially those from these communities. The Organisation for Economic Cooperation and Development (OECD, 2018) reviews how the resilience of students with an immigrant background is supported through educational techniques such as targeted language training, early skill assessments, and creating a welcoming school environment. Additionally, promoting parent engagement and offering extracurricular activities help

integrate students socially and emotionally, fostering a more resilient and adaptable transition.

Access to such quality education would play a crucial role in shaping migrants' experiences and can provide several mental health benefits. Firstly, it can foster a sense of belonging and integration into the broader society, which is essential for mental health. Migrant youth feeling disconnected from their host society due to cultural or language barriers can exacerbate feelings of anxiety, depression, and isolation. Schools that offer culturally responsive teaching and support systems for mental health can help bridge these gaps, allowing young migrants to navigate both their academic and emotional challenges. Promoting an environment where cultural diversity is embraced and respected can be therapeutic, and mental health support can be integrated into the educational framework (see Section 7.8). It can potentially lead to migrant youth feeling more supported and understood, reducing their mental health risks (Mind, 2021).

Additionally, schools often serve as the first point of contact where signs of mental distress may be noticed. As such, school-based mental health programs can offer targeted interventions through trained staff before issues become severe (Education Committee, 2023). This proactive approach could ensure that migrant youth, who may already face numerous systemic and personal challenges, have access to support services early on. Moreover, education would provide migrant youth with tools for empowerment, enhancing their ability to advocate for themselves and navigate mental health services more effectively, as discussed in Section 7.4.2.4.2, where I discussed how practitioners can empower clients for self-advocacy. Having access to resources and information can empower them to seek help when needed, breaking down the stigma often associated with mental health in many migrant communities.

By integrating mental health education into the curriculum and providing culturally sensitive support, education can act as a protective factor against the mental health challenges faced by migrant youth, fostering resilience, promoting well-being, and contributing to their overall successful integration into society.

8.1.5. Incorporating Lived Experiences into Therapeutic Practices

Shelly, a community-based practitioner, shared their success with community-based practice, where all practitioners shared African Caribbean heritage, emphasising the value of lived experiences in therapeutic settings. I recommend that mental health services recruit and train practitioners from diverse backgrounds who can bring their lived experiences into their practice. This approach not only enhances cultural relevance but also fosters trust and rapport between the practitioner and the client. Additionally, practitioners need to be encouraged to share aspects of their identity and experiences, as appropriate, to create a more relatable and supportive therapeutic environment. (see Section 7.4 & Sub-GET 2.2)

8.1.6. Promoting Flexibility and Tailored Interventions

The rigid structure of the current mental healthcare model was another point of contention, with participants like Robert acknowledging the limitations of a standardised approach. I propose that mental health services adopt a more flexible model of care that allows for the tailoring of interventions to meet the individual needs of clients. This flexibility needs to extend to the duration and content of therapy sessions, ensuring that cultural, religious, and personal factors are adequately addressed. Practitioners can offer more personalised and effective care by moving away from a strictly protocol-driven approach. These were discussed in detail in Section 7.4.2.3: Tailoring Interventions Based on Intersecting Identities with Humility and Section 7.6.3: Adapting the EBP IAPT Positive Practice Guild for Minoritised Communities.

8.1.7. Promoting Intergenerational Dialogue

As I reflect on the generational gaps in understanding mental health, I acknowledge the importance of fostering communication between generations. Facilitating family therapy sessions that include discussions about mental health could address these cultural and generational differences. McGoldrick et al. (2020) discuss the importance of understanding and addressing generational patterns within families, especially through therapeutic interventions. They emphasise how generational differences and cultural contexts influence family dynamics and mental health. Edith's suggestion to integrate mental health education

into schools resonates with me as a crucial step to equip younger generations with the tools to navigate these conversations at home. This aligns with Zins et al.'s. (2007) article highlights the need to integrate social and emotional learning (SEL) in schools and its importance for mental health education. It underlines how early education on mental health can prepare students to manage these conversations effectively at home. (discussed in Sub-GET 2.3, Section 7.4 & 7.8)

8.1.8. Leveraging Technology and Social Media

I see significant potential in using social media to promote mental health services, particularly to reach younger populations who are more likely to engage with digital content. Social media campaigns that feature culturally relevant messages and narratives could contribute significantly to normalising discussions about mental health and encourage individuals to seek help. Agnes reported how Mind App was beneficial. A few online tools have emerged that would need more culturally humble adaptation (See Section 7.4). For example, NHS's "Every Mind Matters" app provides support for managing anxiety and mental health and offers tailored advice, tips, and resources to help manage anxiety, stress, and other mental health challenges (NHS, 2021). Additionally, the NHS also endorses apps like the "WorryTree app" (2021), which is designed to help users manage worries and anxiety using Cognitive Behavioral Therapy (CBT) techniques, and "Beat Panic app" (2024), which specifically helps manage panic attacks. These are supposedly culturally adapted. However, elements in Section 7.4 will enhance its cultural suitability.

Sim and Wong (2023) evaluate youth engagement in the CHAT social media mental health campaign. The study found that the CHAT social media campaign effectively increased audience engagement related to mental health awareness among young people. This was primarily achieved through frequent posts and advertisements, which raised the campaign's visibility. However, the study also highlighted challenges such as potential message fatigue, which could diminish the effectiveness of mental health messaging over time.

8.2. Recap of Key Study Outcomes

The research revealed several key outcomes, highlighting the unique challenges faced by these communities when navigating mental health services. Firstly, it identified a significant gap in culturally sensitive care, where participants felt misunderstood or overlooked by mainstream mental health services. This disconnect often stemmed from a lack of awareness or consideration of their cultural backgrounds, which influenced their perceptions of mental health and the types of support they sought. The study also emphasised the role of cultural stigma and systemic distrust in shaping help-seeking behaviours among young people from these communities. Participants frequently encountered cultural expectations and family dynamics that discouraged open discussions about mental health, contributing to delayed access to care. Furthermore, the research highlighted the importance of integrating culturally humble practices, such as involving community leaders and adapting therapeutic approaches to reflect the cultural realities of these young people. The findings emphasised the need for policy changes to address these disparities and provide a more inclusive and supportive mental healthcare system environment.

8.3. Contributions to the Field

This research makes several important contributions to the field of mental healthcare for Black African youth, specifically focusing on the Ghanaian and Nigerian populations in Inner London. It adds to the growing body of literature that advocates for culturally adapted care models, providing empirical evidence of the limitations of standard mental health practices when applied to diverse populations. This study emphasises the value of centring participant narratives and fostering community engagement in research by employing a multimethod approach that integrates IPA and participatory workshops.

Additionally, the study challenges traditional Evidence-Based Practices (EBP) by demonstrating the need to balance empirical evidence with cultural considerations, particularly in therapeutic contexts. This work aligns with calls for a more holistic approach to mental healthcare that recognises the intersectional identities of individuals, incorporating race, culture, and socioeconomic status into the understanding of their

experiences. By highlighting these nuances, the research offers practical insights for mental health practitioners and policy-makers, suggesting that training in cultural humility and adaptation of therapeutic practices could improve engagement and outcomes for Ghanaian and Nigerian youth in the UK.

8.4. Future Research Directions

Building on the insights gained from this study, several areas warrant further research to deepen understanding and enhance mental health support for Ghanaian and Nigerian youth in Inner London. Future studies could explore the longitudinal impact of culturally adapted mental health interventions on service engagement and outcomes among these populations. Such research could provide evidence for the effectiveness of specific adaptations, offering guidance for broader implementation in mental health services.

Another area for exploration is the role of community-based mental health initiatives, such as peer support programs and partnerships with faith-based organisations, in reducing stigma and improving access to care. Investigating how these initiatives can be scaled and integrated into formal healthcare systems would be valuable for developing more comprehensive support networks for young people.

Finally, research could examine the experiences of other Black African subgroups and their interaction with mental health services to provide a comparative analysis. This approach would help to identify common barriers and unique challenges, contributing to a more nuanced understanding of the broader Black African community's mental health needs. Additionally, examining the impact of digital and online platforms in mental healthcare, especially in engaging Black youth, could reveal new avenues for support in a post-pandemic context where digital health has become increasingly prominent.

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10. Appendices

Appendix A: Executive Summary of the Impact Workshop

Double-click to open

Promoting Cultural Humility in Mental Healthcare for Black Youth in London: Impact Workshop

Abstract

Historical and ongoing gaps in mental healthcare for Black individuals in the UK, particularly within Child and Adolescent Mental Health Services (CAMHS), have been well-documented. Despite international and national efforts to address these disparities, including the UN Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities and the UK Equality Act, inequalities persist. A 2018 review by the Care Quality Commission (CQC) highlighted that CAMHS continues to fail Black youth, with significant gaps in care. Furthermore, there are established links between poor mental health, youth, and gang violence. This is an ongoing doctoral research study investigating the mental healthcare experiences of young Ghanaian and Nigerian people in Inner London, using interpretative phenomenological analysis. An Impact Workshop was organised to disseminate my research findings, promote cultural humility, and improve mental healthcare outcomes.

Appendix B:Interview question guild

Semi-structured Interview questions for 16 – 24 years old, Parents/carers, and Practitioners
Introduction

Thank you for agreeing to participate in this interview. We are interviewing you to understand better Black Africans, specifically Nigerians and Ghanaian young people, lived experience of common mental disorders and the care or treatment you received in London. This is about your experience, so there are no right or wrong answers to any of our questions. As you are already aware, participation in this study is voluntary. Your decision to participate or not participate will not affect you at all. The interview should take approximately 30 minutes to 1 hour, depending on how much information you want to share. With your permission, I would like to audio record the interview because I don't want to miss any of your comments. All responses will be kept confidential. We will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview anytime and for any reason. Are there any questions about what I have just explained?

Interview questions or topic guides for participants

Theme 1: The diagnosis (CMD)

I would ask them what problem they have and keep it open. They will be asked to describe it and then ask if they have been diagnosed with anything. I am interested in their ideas, not how they fit their ideas into this list

1. Depression:
    a. subthreshold disorders
2. Anxiety:
    b. generalised anxiety disorder (GAD)
    c. panic disorder
    d. phobias
    e. social anxiety disorder
    f. obsessive-compulsive disorder (OCD)
    g. post-traumatic stress disorder (PTSD)
3. Emotional disorders
4. Common mental disorder (CMD)

Theme 2: The problem

1. Can you tell me the brief history of your problem from when it started and when you began seeking help?
2. Can you tell me who you first sought help from and what it was like?
    Prompt: Parents, school, college, Clergy/Pastor/Imam, etc., GP, professional therapist – voluntary or mainstream CAMH
3. How long did you wait if you were referred or self-referred before you were then seen by a professional from voluntary or/and mainstream CAMH?
4. What happened during this time?
5. How did it make you feel?

Theme 3: mental healthcare (MHC)

1. What professional treatment or support, if any, did you get for your problem?
   Prompt: e.g., Were you given medication in addition to therapy?
2. How do you feel when you have therapy/treatment/care?
3. Could you describe what happens during therapy in your own words?
4. Can you describe the therapist's culture, race, religion, or demeanour (outward behaviour) that made you feel a particular way?
   Prompt: stigma, shame, racism, feel relax, feel good, motivated, etc.
5. What would you say if you had to describe what therapy means to you?
   Prompt: what words come to mind, and what images? Do you have a nickname for it?

Theme 4: Identity

1. How would you describe yourself as a person?
   prompt: what sort of person are you, most important characteristics, happy, moody, nervy?
2. Has your experience of therapy made a difference to how you see yourself?
   prompt: if so, how do you see yourself now as different to before you started therapy? How would you say you have changed?
3. What about compared to before you had the mental health problem?
4. What about the way other people see you?
   prompt: members of your family, friends, religious community, etc.?

Theme 5: Coping

1. What does the term mental illness mean to you? How do you define it?
2. How much do you think about your own mental health?
3. Did you see yourself at any time as being ill?
   prompt: always, sometimes?
4. Did it impact in your daily activities of life, your studies for example?
5. How long have you lived with the problem?
6. Do you have strategies for helping yourself? ways of coping – practical, mental?
7. Can you tell me the things you do, if any, that improved your quality of life? Did they emanate from the professional or yourself?
8. Do you think about the future much? Can you tell me more?
9. What support, if any, did you get from others, like family members, friends, or neighbours, to assist you with your problem?

Theme 6: Barrier

1. Is there anything that make/made it difficult for you to access or seek professional help?
2. Anything that helped?

Parents/carer's interview questions

Theme 1: Diagnosis

I would also begin by asking them what problem their young person have and keep it open. They will be asked to describe it and then ask if they have been diagnosed with anything. I am interested in their ideas not how they fit their ideas into these list

1. Depression:
    a. subthreshold disorders
2. Anxiety:
    b. generalised anxiety disorder (GAD)
    c. panic disorder
    d. phobias
    e. social anxiety disorder
    f. obsessive-compulsive disorder (OCD)
    g. post-traumatic stress disorder (PTSD)
3. Emotional disorders
4. Common mental disorder (CMD)
5. What is your perception of common mental disorder?
   Prompt: personal, cultural, religion?
6. What are your views and perceptions on the care or treatment received by your child?

Practitioner interview questions

Theme 1: Diagnosis

I would also begin by asking them what problem their young person have and keep it open. They will be asked to describe it and then ask if they have been diagnosed with anything. I am interested in their ideas not how they fit their ideas into these list

1. Depression:
    a. subthreshold disorders
2. Anxiety:
    b. generalised anxiety disorder (GAD)
    a. panic disorder
    b. phobias
    c. social anxiety disorder
    d. obsessive-compulsive disorder (OCD)
    e. post-traumatic stress disorder (PTSD)
3. Emotional disorders
4. Common mental disorder (CMD)

Theme 2: Personal information/Background

1. How long have you been delivering treatment or therapy?
2. Do you have any other experience?
3. What is your understanding and perceptions of NAGYP perception of CMD?
   prompt: Parents, community, religion, culture, etc.

4. How would you deal with NAGYP experiencing CMD? Is there anything particular that marks out this particular client group?

Theme 3: Professional - MHC Model used

1. What is the rationale of MHC model used in your practice?
2. What is your professional perception and understanding of the model?
3. What is your personal view of the model?
4. What is your perception of the best or suitable model or intervention for NAGYP?
5. Tell me about your own experiences as a therapist supporting NAGYP
6. Could you describe the professional training received specifically in response to meeting the needs of NAGYP or Black young people in general?

Theme 4: Practice environment

1. Does the practice have clear policy and procedure or guidelines in supporting NAGYP?
2. Are there better ways you think would deliver better outcome for NAGYP?

Theme 5: Barrier

1. Could you describe in your own words the constraints of rendering the best suitable therapy or treatment or support for NAGYP?

Bracketing interview for the researcher

1. What is your perception of common mental disorder?
   - Personal?
   - Professional?
   - Cultural?
   - Religion?

Appendix C: Ethics Approval Letters

Dear Anthony

Thank you for sending in your ethics application.

I am writing to confirm that ethical approval has been granted by the UCL Institute of Education for your doctoral research project titled:

A multimethod investigation into Nigerian and Ghanaian young people's experiences of care for common mental disorders in inner London

This ethical approval has been granted from 3rd May 2022 and the document you provided has been saved to your student file.

Please can you also upload the approved ethics form to your UCL Research Student Log https://researchlog.grad.ucl.ac.uk/.

I wish you all the best for your forthcoming research.

Regards,

Appendix D: Data Management Plan

3. Anth_Data Management Plan.do

Please double-click to open. Its about 9 pages long.

The data management plan for this project outlines the multi-method data collection, including observational data, semi-structured interviews, and focus group discussions (Impact Workshop), targeting youth, their parents, and professionals. Data will be stored on UCL's secure Data Safe Haven with regular backups. Data organization includes pseudonymization, structured naming, and consistent file formats. Long-term data preservation is planned for up to 10 years in UCL's repository

Appendix E: PPI Award Letter

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The NIHR UCLH Biomedical Research Centre awarded a PPI bursary of £1,863 to support the "Let's Talk Common Mental Disorders" project on anxiety and depression, covering expenses like venue hire, refreshments, and participant vouchers.

Appendix F: Step 3: Constructing Experiential Statement for All Participants

Due to the sensitive nature of the issues discussed and in accordance with the Data Protection Act (DPA) 2018, the data supporting this study's findings are available from the author upon reasonable request

It is about 450 pages long

The document is the main resource of the IPA analysis. It is divided into three columns. The first column is the "Experiential Statement", the second is the "Participants full Transcript", and the third is the "Exploratory Noting".

Step 3 involves consolidating and refining the exploratory notes, embodying a phase of the hermeneutic circle where 'the self' and the participant's lived experiences interact collaboratively. This process is anchored in specific segments of the transcript, where data is managed by distilling the transcript's details and exploratory notes into essential elements. Here, the exploratory notes become the central focus of analysis, although they remain connected to the transcript. The aim is to transform these 'notes' into concise 'statements' that capture key insights, expressed in phrases that are complex enough to stay rooted in the transcript while allowing for conceptual interpretation. The hermeneutic circle represents interpreting individual parts within the context of the whole and vice versa.

Appendix G: Group Experiential Themes (GETs) with experiential statements for All Participants – Cross-Case Analysis.

Result Prepare for Writing 4.3.docx

This is a 38 pages long – Double-click to open

Group Experiential Themes (GETs) with experiential statements. This main resource for the analysis

Each GET was supported by experiential statements, ensuring the analysis remained closely tied to the participant's narratives (Smith et al., 2022). This rigorous approach honoured the idiographic intent of IPA and enriched the interpretative synthesis of the group-level understanding. For prominence, I presented the three main GETs in **BOLD UPPER CASE**,

while **Lowercase Bold** titles identify sub-GET. Under each sub-GET, relevant experiential statements are grouped, tracing back to earlier analysis phases.

Appendix H: Impact and Communication Strategy

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This is an 8 pages long

The strategy is a more comprehensive plan to achieve and maintain the plans for impact set out in your research proposal. The step-by-step guide within this section should be used for reference. It takes you through each stage of the process, including setting objectives, developing key messages, identifying your audience, getting them involved, and measuring success. Opportunities for making an impact may arise at any stage during or after your research project. It is important that you have a strategy in place so that you can increase the chances of such opportunities occurring and are able to take advantage of them when they do. This is meant to be a **living document** and we recommend revisiting it at least **once a year**.

Appendix I: Published Protocol: Isiwele et al., 2022,

Isiwele - 2022 - Child and Adolescent Ment

Abstract

This is an 12 pages long – Double-click to open

The 2018 Care Quality Commission review revealed that mental health services for young people in England, especially Black and ethnic minorities, lack responsiveness. This study aims to understand the needs of Nigerian and Ghanaian youth in London with common mental disorders (CMDs) by exploring their, their families', and practitioners' perspectives. Three methodologies—scoping review, intersectionality-based policy analysis (IBPA), and interpretative phenomenological analysis (IPA)—will guide the analysis across three phases, assessing policies, services, and lived experiences. Expected by 2025, findings aim to reduce stigma, promote early interventions, and address social issues like school dropout and juvenile detention among affected youth.

Appendix J: Impact Worksop Invitation Letters.

Appendix J Impact
Worksop Invitation Le

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The upcoming workshop, “Cultivating Cultural Humility in Mental Health Services,” invites Nigerian and Ghanaian youth (16–25), their parents, practitioners, and policymakers to engage in improving mental health services. Scheduled for June 7, 2024, at UCL, the workshop will present research findings, gather participant feedback, and emphasise culturally sensitive mental healthcare. Participants will collaboratively explore challenges and co-develop practical solutions, with insights from youth, caregivers, and professionals shaping the future of mental health support for Black communities in London.

Appendix K: Microsoft Forms for registration – Impact Workshop

Appendix K
Microsoft Forms for r

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The “Promoting Cultural Humility in Black Youth Mental Healthcare” workshop at UCL on June 7, 2024, invites Nigerian and Ghanaian youth, parents, and professionals to engage in research dissemination and foster culturally sensitive mental health practices. Sessions include keynote presentations, interactive discussions, action plan development, and networking. Participants are encouraged to share accessibility or dietary needs and may consent to anonymous audio recording for reports. The workshop aims to enhance inclusive mental healthcare approaches for Black youth in London.

Appendix L: Feedback Forms for Impact Workshop Evaluation

Appendix L Feedback
Forms for Impact Wor

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The “Promoting Cultural Humility in Black Youth Mental Healthcare” workshop evaluation form gathers feedback from youth and professionals on their experiences, understanding, and learning outcomes. It asks youth about their engagement, relevance of content, and application of insights. Professionals evaluate their understanding of cultural humility, confidence in applying it, and desired resources. All participants assess the workshop's effectiveness, safety, inclusivity, and offer suggestions for future sessions. The form aims to refine future workshops on culturally sensitive mental health care for Black youth in London.

Appendix M: Impact Workshop Information Sheet

Participants Information Sheet.doc

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The “Promoting Cultural Humility in Black Youth Mental Healthcare” workshop on June 7, 2024, at UCL, aims to share research on mental health care for Ghanaian and Nigerian youth in London, fostering cultural humility among practitioners. Activities include a keynote presentation, interactive discussions, and collaborative planning. Participants’ anonymised insights will contribute to publications. Confidentiality is assured, and attendees are encouraged to engage and shape actionable strategies for inclusive mental health support.

Appendix N: The Research Consent and the Impact Workshop Consent Form.

Appendix N The Research Consent anc

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The consent form for the study on mental health care for Nigerian and Ghanaian youth in London details participants' rights, data usage, and confidentiality measures. Participants agree to interviews or focus groups, with anonymised data stored securely. They can withdraw anytime, and recordings may be used for future research. A separate form for the cultural humility workshop consent includes permission for anonymised use of personal

experiences in reports and publications, emphasising voluntary participation and data protection.