

Grounded in Community:

Nottingham Citizen Scientists' Insights for Health and Wellbeing

Nottingham Community and Voluntary Service

Coventry University

Nottingham City Council



Acknowledgement and Disclaimer

Nottingham City Council Public Health is delighted to have worked in partnership with Coventry University and Nottingham Community and Voluntary Sector to have supported the first cohort of local Citizen Social Scientists. They have developed their research skills and undertaken a small-scale research project exploring topics of importance to local communities and aligned to the **Joint Local Health and Wellbeing Strategy for Nottingham 2025-2028**. The programme has generated a rich and diverse range of community-led insights, reflecting the experiences, perspectives and priorities of Nottingham residents. We are pleased to support the publication of these reports and to make the findings available to partners, stakeholders and communities across the city.

We would like to thank all Citizen Social Scientists for their enthusiasm, dedication and commitment throughout the programme. Their willingness to learn, engage with communities and explore issues that matter to local people has made a valuable contribution to our understanding of health and wellbeing across Nottingham.

While Nottingham City Council Public Health supported the delivery of the programme, the findings, interpretations, views and recommendations presented within these reports reflect the perspectives of the Citizen Social Scientists who undertook the research and should not be taken as representing the views of Nottingham City Council or Nottingham City Council Public Health.

Nottingham City Council Public Health remains committed to ensuring that the learning and insights generated through this programme are shared widely and made accessible to those with an interest in health and wellbeing. We hope that the evidence, experiences and perspectives presented within these reports will contribute to ongoing conversations, learning and reflection among communities, partners and decision-makers, and further demonstrate the value of involving residents in research and knowledge generation.

Scan to view the Joint Local Health and Wellbeing Strategy for Nottingham

Nottingham City Council

Foreword

By Dr Sinead Ouillon, Dr Dan Range, and Dr Zsofia Hacsek

Over the course of this project, working alongside the Citizen Social Scientists in Nottingham has been a deeply rewarding experience. Getting to know each researcher, understanding their unique perspectives, and supporting them as they investigated issues at the heart of their communities has demonstrated the transformative power of community-led research.

This project has highlighted why lived experience is essential in social research. By building authentic trust and leveraging deep-rooted community connections, our Citizen Social Scientists accessed networks and conversations that traditional academic or institutional research often struggles to reach. The depth, honesty, and richness of the evidence gathered speak directly to the power of this approach.

We have been profoundly impressed by the professionalism, rigour, and dedication demonstrated throughout this process. The level of critical reflection, research execution, and analytical skill shown by these citizen scientists equalled and, in many instances, exceeded what we frequently observe in conventional research settings.

Ultimately, this collaborative effort with Nottingham City Council, NCVS and our citizen social scientists has yielded crucial local insights. The findings presented in this report offer direct value for Nottingham City Council, while serving as a compelling framework for policy makers, service designers, and commissioners nationally who seek to embed genuine co-production into decision-making.

We extend our sincere thanks to every Citizen Social Scientist for trusting us to mentor and guide them through this journey, and to the community members who shared their lives so openly.

Looking forward, the success of this initiative proves that the future of effective public policy lies not in researching *on* communities, but in researching *with* them. When we equip citizens with the tools to explore their own reality, we do not merely gather data, we unlock the wisdom necessary to build healthier, fairer, and more resilient cities.



Dr Sinead Ouillon



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NCVS Foreword

At Nottingham Community and Voluntary Service (NCVS), we are incredibly proud to have played a central role in supporting this pioneering Citizen Social Science programme alongside our partners at Nottingham City Council Public Health and Coventry University. It has been both a privilege and a pleasure to work alongside such a talented, committed and passionate group of Citizen Social Scientists whose voices and experiences are at the heart of this report.

What makes this programme so special is that the research has not been conducted by researchers from outside communities, but by people from those communities themselves. The Citizen Social Scientists brought lived experience, trusted relationships and deep local knowledge that enabled them to reach people, uncover stories and generate insights that more traditional research approaches often struggle to access. The result is a collection of rich, authentic and meaningful research projects that are firmly rooted in the realities of everyday life across Nottingham.

We have been particularly inspired by the journeys of the Citizen Social Scientists themselves. Some participated as volunteers, generously giving their time to improve their communities and contribute to positive change. Others embraced the opportunity to work as independent contractors, developing new professional skills, building confidence and learning how to operate as self-employed researchers. Throughout the programme, we have witnessed individuals grow not only as researchers but as leaders, advocates and community changemakers. The dedication shown has been extraordinary, and we are excited to see how many continue to use these skills in future employment, voluntary roles and community action.

The quality of the work presented in this report is a testament to the commitment of every Citizen Social Scientist involved. From exploring health inequalities and recovery journeys to understanding family relationships, migration, employment and community cohesion, the research demonstrates the power of local people asking important questions about the issues that matter most to them. These findings provide valuable insights for commissioners, policymakers, service providers and communities seeking to improve health and wellbeing outcomes across Nottingham.

Behind the scenes, the NCVS team has worked tirelessly alongside project partners to help make this programme possible. Community-based research requires significant coordination, relationship building and practical support. Much of this work is unseen, but it has been essential in creating the conditions for community researchers to succeed and to ensure every project could progress safely, ethically and effectively.

This programme demonstrates what can happen when communities are trusted, supported and equipped with the tools to investigate the issues affecting their own lives. The Citizen Social Scientists have shown that community knowledge is not simply valuable; it is essential. Their research offers perspectives that can strengthen decision-making, improve services and help create more responsive and inclusive approaches to health and wellbeing.

Finally, we would like to thank every Citizen Social Scientist who has invested their time, energy and passion into this work. You have demonstrated the extraordinary value of community-led research and have produced a body of work that Nottingham should be immensely proud of. We hope this is only the beginning of a growing movement that places citizens, lived experience and community knowledge at the centre of understanding and addressing the challenges our city faces.

Nottingham Community and Voluntary Service

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Beyond Liver Disease: Public Awareness of Lesser-Known Alcohol-Related Harms

Trisha Mustari Sarkar

Local Priority Area:

- Alcohol

1. Introduction: What I Wanted to Find Out

My Research Questions:

1. What is the baseline level of public knowledge of lesser-known alcohol-related health harms, e.g. immune function, wound healing, bone health, fertility, and biological ageing, among adults in Nottingham?
2. Does brief exposure to evidence-based health information produce an immediate shift in knowledge and perceived personal relevance of these harms?

Why This Matters: In England, there were 8,274 alcohol-specific deaths in 2023 and 1,018,986 alcohol-related hospital admissions under the broad definition in 2023/24 (Office for Health Improvement and Disparities, 2024; 2025). Despite this, most public health messaging focuses narrowly on liver disease and addiction, leaving a wide range of other well-evidenced physical harms largely unknown to the general population. These include effects on the immune system, wound healing, bone strength, fertility, and biological ageing. These effects are not confined to people with alcohol dependence, although the strength of the evidence varies by health outcome and pattern of consumption.

This project explored whether adults in Nottingham were aware of these lesser-known harms, and whether providing clear and accurate health information could shift that awareness. The study did not aim to change behaviour — it focused on the first and most fundamental step: making sure people have access to information they may never have been given.

Literature Sources Used: The study draws on published clinical and epidemiological evidence, including population surveys on alcohol awareness (Buykx et al., 2016; Bates et al., 2018), biomedical research on each harm category (Godos et al., 2022; Radek et al., 2005; Barr et al., 2016; Fan et al., 2017; Bøstrand et al., 2022), and health behaviour theory. The study was informed by the *Health Belief Model* (Rosenstock, 1966) and the *Precaution Adoption Process Model* (Weinstein, 1988), which highlight the importance of awareness, perceived susceptibility, perceived severity, and related beliefs in health decision-making.

2. Method: Who, What, and How

The Participants (n = 32):

- **Total responses received:** 39. Seven were excluded as they did not meet the Nottingham residency criterion.
- **Final analytical sample:** 32 adults currently living in Nottingham.
- **Gender:** Women 68.8% (n = 22), Men 31.3% (n = 10).
- **Age groups:** 18–24 (9.4%), 25–34 (25.0%), 35–44 (18.8%), 45–54 (28.1%), 55–64 (9.4%), 65 or older (9.4%).
- **Drinking frequency:** Never (40.6%), Monthly or less (28.1%), 2–4 times a month (18.8%), 2–3 times a week (6.3%), 4 or more times a week (6.3%).

Research Approach: Mixed-methods approach, combining a structured online survey with open-ended qualitative questions. A pre–post design was used, meaning participants answered the same knowledge questions both before and after reading a brief evidence-based health information passage within the same survey session.

Data Gathering Methods:

- **Online survey** using Microsoft Forms, distributed over approximately one month.
- **Survey included:** demographic questions; five True/False/Not Sure knowledge items administered before and after the information; three Likert-scale perception items before the information; three related but differently worded Likert-scale items after the information; and three open-ended qualitative reflection questions.
- Where quotations have been taken from open-text responses, minor spelling and punctuation errors were corrected for readability without altering meaning. Ellipses indicate where text has been omitted.
- **Distribution channels:** email, WhatsApp, LinkedIn, and other social media platforms through personal and professional networks.

3. Ethics: Researching Responsibly

Consent and Safety: Participation was entirely voluntary. A standalone consent form was presented at the start of the survey, clearly explaining the study's purpose, the voluntary nature of participation, the right to withdraw at any time before submission, and how data would be used. Completing and submitting the survey indicated informed consent. The project was conducted in accordance with the ethical guidance of **Coventry University**.

Privacy: No personally identifiable information was collected at any point. All responses were anonymous and reported in aggregate. Data were stored securely in accordance with UK GDPR requirements. A debrief was provided at the end of the survey, including signposting to NHS alcohol support services and the Nottingham Recovery Network for any participant who wished to seek further information or support.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed: Quantitative data was analysed using R (version 4.3.1). Descriptive statistics (frequencies and percentages) were calculated for all demographic and survey items. Pre-to-post knowledge changes were assessed using McNemar's exact test, appropriate for paired binary responses. For McNemar's tests, responses were coded as correct versus not correct, with False and Not Sure responses combined in the latter category. Exact p-values are unadjusted for multiple comparisons and should be interpreted as exploratory. Likert-scale perception items were summarised descriptively, as the pre- and post-information items assessed related but non-identical constructs. Qualitative open-text responses were analysed using Thematic Analysis (Braun and Clarke, 2006), with themes identified inductively through repeated reading of responses and grouping of recurring patterns across the dataset.

Quantitative Findings:

Finding 1: Baseline Knowledge: What People Already Knew

Before receiving any information, participants were asked whether each of the five harms was true, false, or uncertain. Overall, awareness was higher than expected:

- **Immune response:** 87.5% (n = 28) answered correctly. 9.4% were unsure.

- **Wound healing:** 78.1% (n = 25) answered correctly. 18.8% were unsure, the second highest uncertainty.
- **Bone strength:** 75.0% (n = 24) answered correctly. 21.9% were unsure, the highest uncertainty of all five harms.
- **Fertility:** 84.4% (n = 27) answered correctly. 9.4% were unsure.
- **Biological ageing:** 87.5% (n = 28) answered correctly. 9.4% were unsure.

Bone strength had the lowest correct-response rate and the most uncertainty. Wound healing had the second highest uncertainty. These two harms represented the clearest gaps in confident public knowledge within this sample.

Finding 2: Knowledge Shift After the Information

After reading the health information passage, correct-response rates increased across all five harms:

Harm	Before information	After information
Immune response	87.5%	100.0% ✓
Wound healing	78.1%	96.9% ✓*
Bone strength	75.0%	96.9% ✓*
Fertility	84.4%	96.9% ✓
Biological ageing	87.5%	100.0% ✓

**Exact McNemar tests indicated evidence of improvement for wound healing (p = .031) and bone strength (p = .016). As these p-values were unadjusted for multiple comparisons, they should be interpreted as exploratory. ✓ = near-universal agreement post-information.*

Wound healing and bone strength showed statistically significant improvements. For the remaining three harms, post-information correct responses reached 96.9–100%, confirming the information consolidated existing awareness. No participant moved from a correct pre-information response to an incorrect or uncertain post-information response on any of the five knowledge items.

Finding 3: Perceived Awareness and Personal Relevance

Participants completed three Likert-scale perception items before and after the information. Because the pre- and post-information items were not identical, these findings are reported descriptively rather than as formal pre–post comparisons.

Before the information:

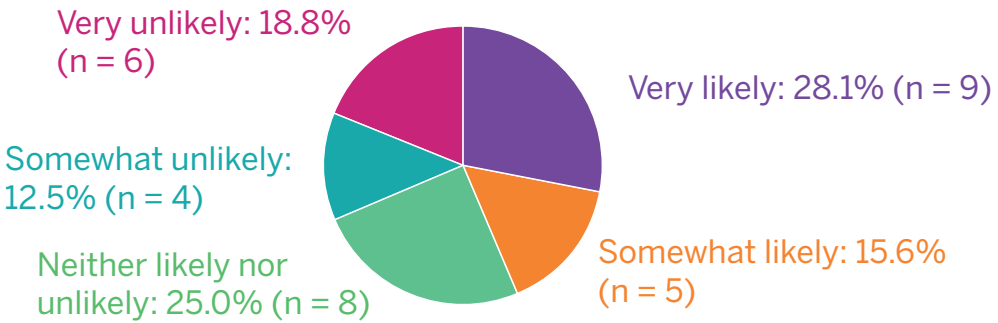
- **Well-informed about alcohol health effects:** 87.5% agreed or strongly agreed. 9.4% were neutral. 3.1% disagreed.
- **These harms feel personally relevant:** 34.4% agreed or strongly agreed. 34.4% were neutral. 31.2% disagreed or strongly disagreed.
- **Only heavy/dependent drinkers experience harm:** 28.1% agreed or strongly agreed. 15.6% were neutral. 56.2% disagreed or strongly disagreed.

After the information:

- **Information increased my awareness:** 71.9% agreed or strongly agreed. 15.6% were neutral. 12.5% disagreed or strongly disagreed.
- **Information made harms feel personally relevant:** 40.6% agreed or strongly agreed. 18.8% were neutral. 40.6% disagreed or strongly disagreed.
- **Would pay more attention to this type of guidance:** 68.8% agreed or strongly agreed. 18.8% were neutral. 12.5% disagreed or strongly disagreed.

Finding 4: Likelihood to Reflect on Alcohol Consumption

After reading the information, participants were asked how likely they were to reflect on their own alcohol consumption:



Qualitative Findings:

Three open-ended questions invited participants to reflect on the information they had read. Responses from the 32 eligible participants were analysed using Thematic Analysis, and three themes were identified across the dataset. Minor spelling and punctuation errors in quotations have been corrected for readability without altering meaning.

Theme 1: Bone Health Was Widely Unexpected

Across the open-text responses, bone health was the most consistently surprising harm. The dominant pattern was that participants had not previously distinguished between alcohol increasing fracture risk through falls during intoxication and alcohol directly weakening bone tissue over time. This distinction — that the harm is biological, not just behavioural — was new to most participants who commented on it.

> **"The effect alcohol can have on bone health/ fractures — I didn't realise it could have this impact, which is worrying particularly for older people who are more at risk of issues with bone health and falls."**
> Participant, aged 25–34

Theme 2: Fertility and Ageing Felt Personally Relevant

A number of participants connected the fertility and biological ageing information directly to their own lives and circumstances. Personal resonance, rather than general awareness, was the notable pattern here, with participants reflecting on what the information meant for them specifically, not for people in general.

> **"I am planning to have a baby, and I didn't know that alcohol affects fertility. Though I very rarely drink, I will keep this information in mind now onwards."**
> Participant, aged 25–34

Theme 3: Participants Commented on Gaps in Alcohol Health Communication

Several participants offered unprompted comments on alcohol health communication. One participant specifically observed that existing public health messaging tends to focus on units and drink-driving while giving less attention to the broader physical effects of alcohol and suggested this may reflect commercial interests. One participant also speculated that commercial interests may contribute to the limited scope of public health messaging.

> **"I think public health information around alcohol is poor in the UK. We are given guidance about units, and not to drink/drive, but you never seem to see campaigns about the other harmful effects of alcohol on health and well-being. I can only imagine this is due to the vast profits and taxes that the companies and the government make from alcohol sales."**
> Participant, aged 45–54

5. Linking Findings to the Research Question

On the first research question about baseline awareness, findings show that awareness of these five harms was higher than expected within this sample, ranging from 75.0% to 87.5% before any information was given. Bone health had the lowest baseline awareness and the most uncertainty, and wound healing had the second highest uncertainty. These two harms represent the clearest current gaps in public knowledge within this community sample.

On the second research question, whether brief information shifts knowledge, brief information was associated with immediate improvements across all five harm categories. Unadjusted McNemar exact tests indicated statistically significant improvements for wound healing ($p = .031$) and bone strength ($p = .016$), though these p-values are unadjusted for multiple comparisons and should be interpreted as exploratory. No participant moved from a correct pre-information response to an incorrect or uncertain post-information response on any item. In relation to perceptions, 71.9% reported that the information increased their awareness, while 40.6% agreed or strongly agreed that it made the harms feel personally relevant. Because the pre- and post-information perception questions were not identical, these perception findings should be interpreted descriptively rather than as evidence of a statistically tested change.

Surprises and Deeper Insights:

The most striking finding was the specific nature of the bone health result. Participants had not previously distinguished between alcohol increasing fracture risk through falls during intoxication and alcohol directly weakening bone tissue over time. This distinction was new, credible, and personally resonant.

Eight participants (25.0%) selected 'None of these' when asked which piece of information surprised them most. Some explicitly stated they were already familiar with the information, suggesting relatively high prior knowledge among part of the sample. A larger and more representative sample would be needed to determine whether the same pattern would be observed across Nottingham more broadly.

6. Reflection, Limitations and Next Steps

Project Limitations:

- The sample was relatively small ($n = 32$) and recruited through personal and professional networks, which may mean participants were more health-aware than the broader Nottingham adult population.
- A higher-than-expected proportion of participants were women (68.8%) and non-drinkers (40.6%), which may have contributed to the higher baseline knowledge scores observed.
- The survey measured immediate responses only. It is not possible to determine whether knowledge or perception shifts observed here persisted beyond the survey session, or whether any participant changed their drinking behaviour as a result.
- There was no control group. Some of the post-information improvement may reflect participants' growing familiarity with the questions rather than the information passage alone.
- The pre- and post-information Likert perception items were not identical. As the items assessed related but non-identical constructs, inferential comparison was not appropriate, and responses were reported descriptively only. Future studies should include identical items at both time points to enable valid pre–post perceptual comparison.
- Five McNemar exact tests were conducted without adjustment for multiple comparisons. Results should be interpreted as exploratory; if a conservative Holm correction were applied, neither significant result would survive at the $p < .05$ threshold.

Researcher Reflection:

- **What Went Well:** The pre–post design was straightforward to administer and generated clear, directly comparable results for the knowledge items. The open-text responses added important context that the quantitative data alone could not have provided.

- **Challenges:** Recruiting participants and confirming Nottingham residency was time intensive. Keeping the survey short enough to encourage completion, while still capturing sufficient detail, required careful balance.
- **What I learned:** The gap between what community members know and what public health campaigns have communicated can be significant. Providing clear and accurate information in accessible language can shift knowledge in a measurable way, even through a brief intervention.

Next Steps:

- Repeat the study with a larger, more representative Nottingham sample including harder-to-reach groups and communities with lower health literacy to test whether the information has greater impact where baseline awareness is lower.
- Work with local partners to explore whether findings can inform the content of local alcohol awareness communications, with a particular focus on bone health and wound healing.
- Investigate the most effective formats and channels for delivering this type of information to different community groups.

7. Key References

Office for Health Improvement and Disparities (2024). Alcohol profile: short statistical commentary, December 2024. London: Office for Health Improvement and Disparities.

Office for Health Improvement and Disparities (2025). Alcohol profile: short statistical commentary, February 2025. London: Office for Health Improvement and Disparities.

Barr, T. et al. (2016) '*Opposing effects of alcohol on the immune system*', Progress in Neuro-Psychopharmacology and Biological Psychiatry, 65, pp. 242–251.

Bates, S. et al. (2018) '*Awareness of alcohol as a risk factor for cancer is associated with public support for alcohol policies*', BMC Public Health, 18(1), p. 688.

Bøstrand, S.M.K. et al. (2022) '*Associations between alcohol use and accelerated biological ageing*', Addiction Biology, 27(1), e13100.

Braun, V. and Clarke, V. (2006) '*Using thematic analysis in psychology*', Qualitative Research in Psychology, 3(2), pp. 77–101.

Buykx, P. et al. (2016) '*Public awareness of the link between alcohol and cancer in England in 2015*', BMC Public Health, 16(1), p. 1194.

Fan, D. et al. (2017) '*Female alcohol consumption and fecundability: a systematic review and dose-response meta-analysis*', Scientific Reports, 7(1), p. 13815.

Godos, J. et al. (2022) '*Alcohol consumption, bone mineral density, and risk of osteoporotic fractures: a dose-response meta-analysis*', International Journal of Environmental Research and Public Health, 19(3), p. 1515.

Office for Health Improvement and Disparities (2024) Alcohol profile: short statistical commentary, December 2024. London: OHID.

Office for Health Improvement and Disparities (2025) Alcohol profile: short statistical commentary, February 2025. London: OHID.

Radek, K.A. et al. (2005) '*Acute ethanol exposure impairs angiogenesis and the proliferative phase of wound healing*', American Journal of Physiology — Heart and Circulatory Physiology, 289(3), pp. H1084–H1090.

Rosenstock, I.M. (1966) '*Why people use health services*', Milbank Memorial Fund Quarterly, 44(3, Part 2), pp. 94–124.

Weinstein, N.D. (1988) '*The precaution adoption process*', Health Psychology, 7(4), pp. 355–386.

Role of Parenting Stress, Confidence and Family Traits in Early Childhood Development

Ahona Chowdhury

Local Priority Area

- Best Start

Project Overview

This citizen social science study explored parents' experiences during the first five years of a child's life, focusing on parenting stress, confidence, parent–child relationships and perceptions of traits or developmental patterns shared within families. Sixteen parents based in Nottingham completed a mixed-methods online survey containing closed and open-ended questions. The findings suggested that participants generally viewed early development as shaped by multiple influences, with positive relationships and communication remaining important alongside practical and emotional parenting pressures. Family similarities were also commonly recognised, with most participants attributing these to a combination of genetic and environmental influences. Overall, the study provides insight into how parents understand the different factors shaping early childhood development.

1. Introduction

My Research Question: How do parents perceive the role of parenting stress, confidence and family traits in early childhood development?

Why This Matters: The first five years are a defining period of a child's life, marked by rapid physical, cognitive, emotional, and social development, shaped by both genetic influences and early life experiences. Yet these foundations are established under vastly different circumstances. Parental stress, parenting confidence, and the quality of parent–child interactions form an important part of a child's early environment. Alongside these experiences, parents may notice traits or behaviours that appear to "run in the family", reflecting their understanding of how both inherited and shared family influences contribute to development.

This research was developed around Nottingham's Best Start priority area. By bringing the public voice into the research, the study aimed to understand how parents perceive the contribution of parenting experiences, relationships, and family influences to early childhood development.

Literature and Sources Used:

- **Long-Term Impact**: Development during early childhood extends beyond immediate growth, as the capabilities formed during this period can influence later health, education, social mobility and wider outcomes throughout later life (Pan et al., 2025)
- **Parent–Child Dynamics:** The parent–child relationship represents an important part of the early family environment. The relationship is bidirectional, parents influence children while children simultaneously influence parents (Frosch et al., 2021). This is particularly relevant in Nottingham, where the Best Start Strategy identifies inequalities in children's early experiences, with social and family circumstances affecting their development (Nottingham City Council, 2025).
- **Parenting Confidence and Stress:** Greater confidence in parenting abilities has been linked to how effectively parents apply their skills in supporting their child's development. This has also been associated with improved family quality of life and lower levels of parenting stress (Martínez-Rico et al., 2025). Conversely, parenting

stress can be an important source of psychological strain. Higher levels of stress have been associated with poorer parent–child relationships and increased emotional and behavioural difficulties in children (Pan et al., 2025; Yu et al., 2025).

- **Gene–Environment Interplay:** Importantly, genetic and environmental influences do not act independently; a child's inherited characteristics can interact with their family environment and may even influence how parents respond to them. Traits that appear to "run in the family" may therefore reflect genetic influences, shared environments, or an interplay between the two (Horwitz and Neiderhiser, 2011).

2. Method: Who, What, and How

The Participants: A convenience sample of 16 participants, all aged 18 or over and residing in Nottingham, were recruited through existing contacts. Participants were personally contacted, informed about the study and provided with a link to the online survey.

Research Approach: A mixed-methods online survey design was employed to gather participants' views and experiences of factors surrounding parenting stress, parenting confidence and family influences on early childhood development. The survey combined quantitative and qualitative data through both closed and open-ended questions, enabling both measurable responses and personal insights to be collected.

Data Gathering Methods: An online survey created using Google Forms, consisting of approximately 17 questions. (n=16)

Preparation and Piloting: Due to the limited timeframe of the study, there was insufficient opportunity to conduct a pilot study prior to distributing the survey.

3. Ethics: Researching Responsibly

Consent and Safety: A consent form was embedded at the start of the online survey, outlining the study's scope and purpose. Participants were required to tick the appropriate boxes to confirm informed consent before gaining access to the questions.

Privacy and Anonymity: To maintain anonymity, no identifying information was collected. Participants instead created a unique code, allowing their response to be located and withdrawn if requested without disclosing their identity. The collected data was securely uploaded to the designated NCVS folder under the researcher's name and stored in accordance project's data-handling requirements.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed

Quantitative Data: Calculated via basic frequency counts and percentages (e.g. scoring ratings out of 10 or selecting specific factors/influences).

Qualitative Data: Evaluated through thematic analysis, identifying recurring patterns, phrases, and ideas in participant open-text responses.

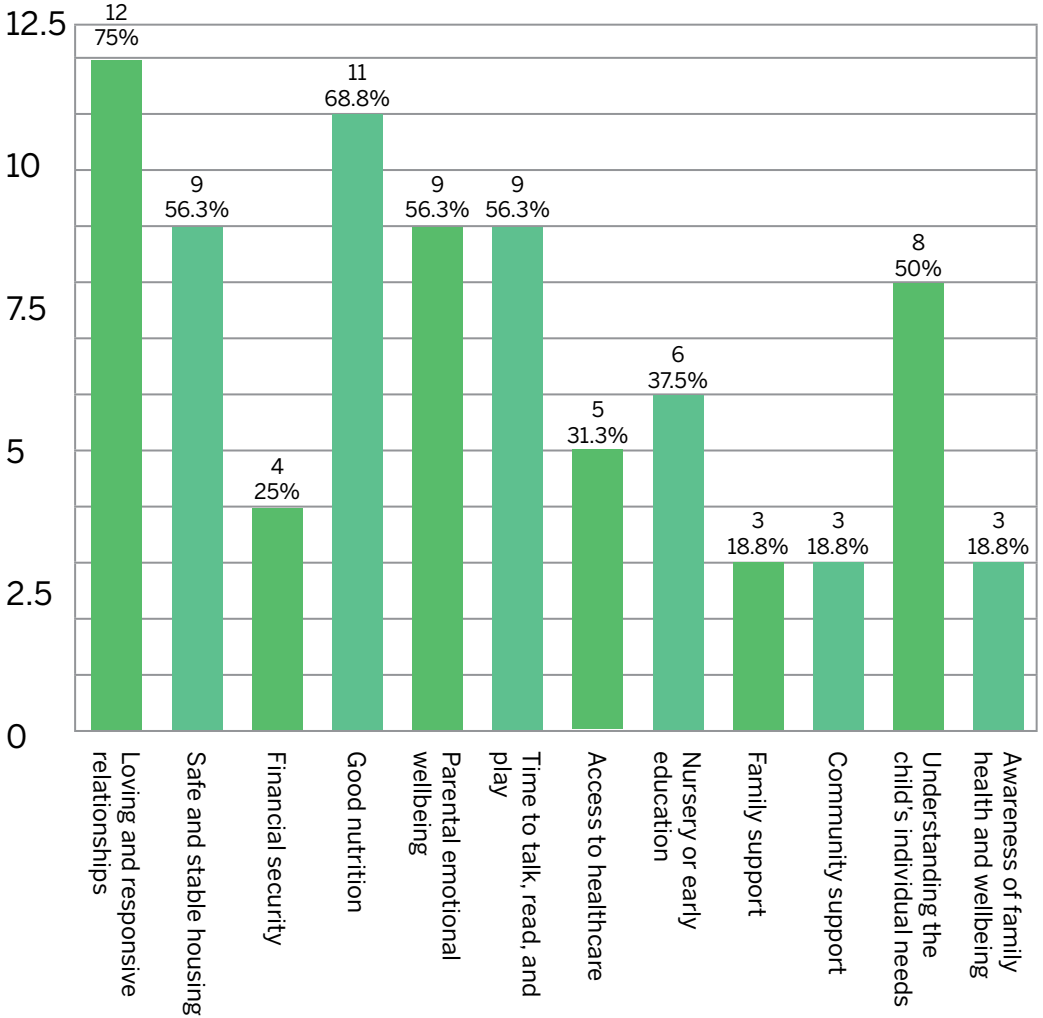
Key Findings and Themes

1. General Views on Early Development

All 16 participants rated the first five years to be highly important in shaping a child's future, giving a score of either 9 or 10 out of 10, with 12 participants (75%) selecting the highest score. Participants also largely viewed child development as being shaped by multiple influences rather than one factor alone, with 10 of 16 selecting a combination of factors. The remaining participants identified the parent–child relationship, home environment, or physical and mental health as the greatest individual influence on early childhood development.

Key Factors for 'Best Start': Building on these views of early development, participants were asked to select up to three factors they considered most important for giving a child the best start in life (see Figure 1). Loving and responsive relationships were most frequently selected (12 of 16), followed by good nutrition (11 of 16). Safe and stable housing, parental emotional wellbeing and time to talk, read, and play were also commonly selected (9 of 16 each).

Figure 1. Factors participants considered most important for giving a child the best start in life. (n = 16).



2. Theme 1: Parenting Confidence and Parent-Child Relationship

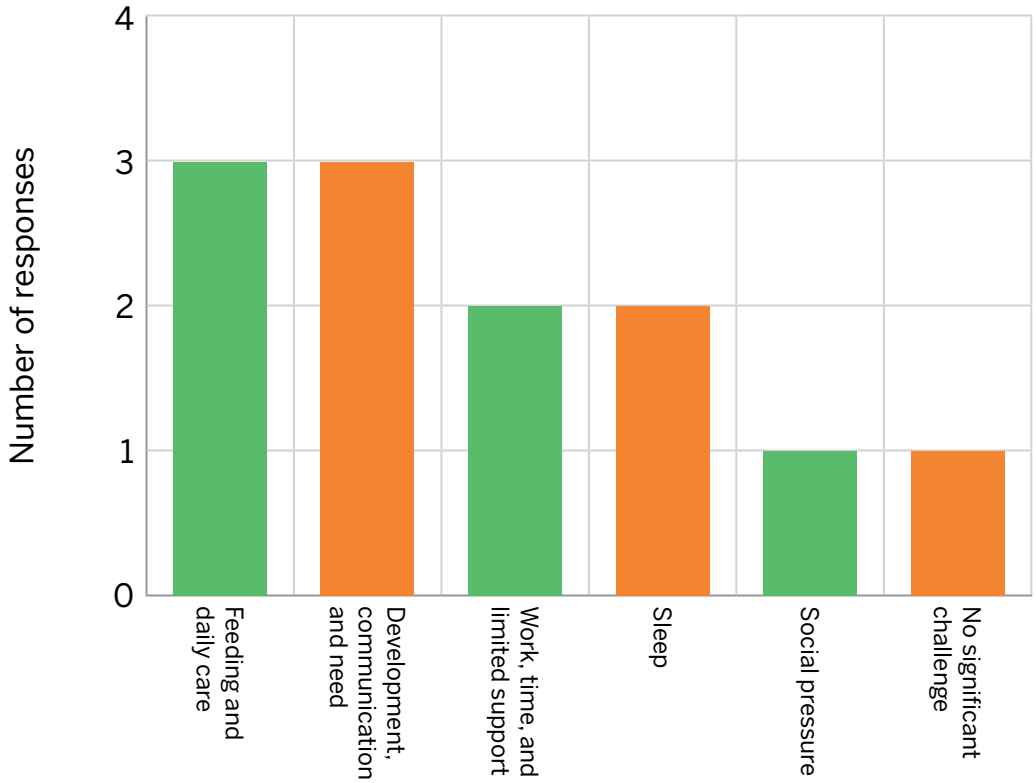
Confidence: Parenting confidence was consistently high, with all 16 participants rating their confidence as either 4 or 5 out of 5. When considering what shaped their confidence, several common themes emerged including parenting experience, learning and adapting to challenges and the parent–child relationship. Quality time, providing guidance and seeing their child progress were also recurring themes, alongside support from family and friends and participants' own experiences of being parented.

Parent-child interaction: The importance of parent-child interaction was also reflected in participants' everyday activates. When describing moments in which they felt most connected to their child, talking emerged as the strongest recurring theme, alongside playing, learning and shared creative or outdoor activities.

3. Theme 2: Parenting Stress and Challenges

Experiences of parenting stress varied considerably, with childcare difficulties emerging most frequently reported by 7 in 16 participants. Employment or study commitments, concerns about the child's development and behavioural challenges were also commonly reported (6 in 16 each). These experiences were reflected in participants' descriptions of their most challenging moments, which centred around feeding and daily care, developmental or communication needs, balancing work and parenting, limited support and sleep difficulties (Figure 2).

Figure 2: Recurring themes in participants' descriptions of early parenting challenges (n = 14)



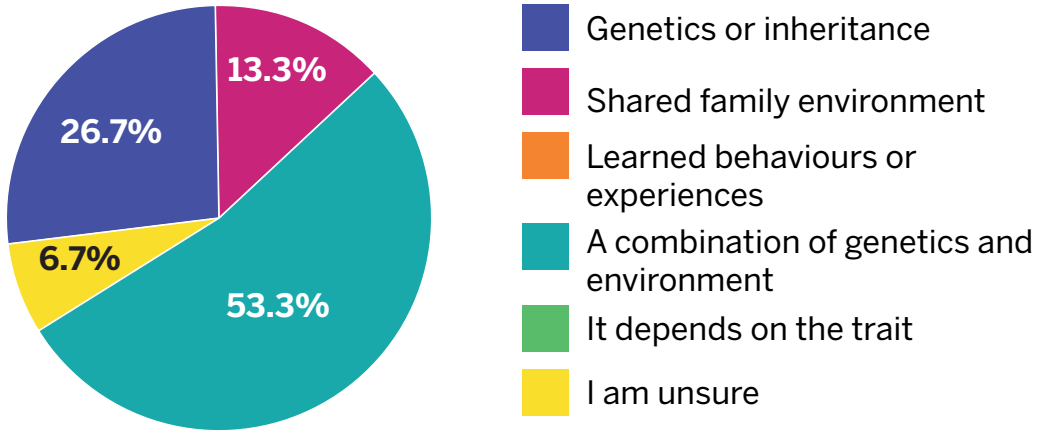
4. Theme 3: Family Traits and Inherited Characteristics

Beyond the immediate challenges of parenting, participants also recognised that certain traits and developmental patterns appeared to "run in the family". Social behaviour (12 of 16), personality or temperament (11 of 16) and emotional sensitivity or anxiety (10 of 16) were most commonly identified as traits perceived to have a familial or inherited influence. Recognising these similarities often helped parents better understand their child, respond with greater patience and adapt their parenting approach. When considering what might explain these similarities, most participants selected a combination of genetics and environment (8 of 15), suggesting that they did not generally view family traits as being explained by inheritance alone. A smaller proportion attributed them to genetics or inheritance (4 of 15), while only a few selected shared environment or were unsure (Figure 3).

Figure 3. Participants' views on what may explain similarities in traits and development within families (n = 15).

Q: When you notice a trait or developmental pattern that 'runs in the family', what do you think is most likely to explain the similarity?

15 responses



5. Linking Findings to the Research Question

The findings revealed three closely connected themes: parenting pressures, factors supporting confident and connected parenting, and parents' understanding of child development and family influences. Participants also viewed development as multifactorial rather than driven by a single influence.

Confidence vs. Stress: High parenting confidence often coexisted with practical and emotional pressures, including childcare, work, sleep and concerns about behaviour or development, showing that confidence does not remove the stresses of parenting. This relationship is also recognised by Martínez-Rico et al. (2025).

Parent–Child Connection: Across the data, the parent–child relationship emerged as an important enabling factor, with loving and responsive relationships, communication, shared activities and understanding the child repeatedly linked to confidence and connection.

Family Traits: Familial similarities were generally attributed to both genetics and environment, consistent with the gene–environment interplay (a mixture of **nature and nurture**) described by Horwitz and Neiderhiser (2011), rather than single inherited factors.

Surprises

Despite high levels of reported practical and emotional pressure (e.g. childcare issues, sleep deprivation), 100% of participants rated their parenting confidence high ("4" or "5" out of "5), showing that feeling stressed does not necessarily undermine a parent's self-belief.

6. Reflection, Limitations and Next Steps

Project Limitations

The study was limited by its small convenience sample of 16 participants, recruited through existing contacts and based in Nottingham. This may have introduced selection and response bias, reducing the representativeness of the findings. The limited timeframe also restricted further recruitment of participants and prevented formal piloting, so potential gaps within the survey could not be identified.

Researcher Reflection

Reflecting on the study, the survey design was effective in capturing both overall response patterns and the reasoning behind them. The mixed-question format was particularly effective, allowing clear patterns to be identified whilst revealing themes that may otherwise have been missed.

Next Steps and Future Research

Future research could therefore involve a larger and more diverse sample, pilot the survey before distribution and compare experiences across different parental groups. Future research could explore genetic and environmental influences in greater depth, while larger studies could further examine parenting stress, confidence and parent–child interaction across more diverse groups of parents.

References

Frosch, C.A., Schoppe-Sullivan, S.J. and O'Banion, D.D. (2021). Parenting and child development: A relational health perspective. *American Journal of Lifestyle Medicine,* [online] 15(1), pp.45–59. doi:10.1177/1559827619849028.

Horwitz, B.N. and Neiderhiser, J.M. (2011). Gene-environment interplay, family relationships, and child adjustment. *Journal of Marriage and Family*, [online] 73(4), pp.804–816. doi:10.1111/j.1741-3737.2011.00846.x.

Martinez-Rico, G., Gracia-Grau, P., Canadas-Perez, M. and Gonzalez-Garcia, R.J. (2025). Checking your browser - reCAPTCHA. [online] Nih.gov. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12068602/ [Accessed 6 August 2026].

Nottingham City Council (2025). Best start: Joint local health and wellbeing strategy programme delivery plan 2025 – 2028. Available at: https://healthandcarenotts.co.uk/care-in-my-area/nottinghamcity-pbp/priorities-programmes/ [Accessed 6 August 2026].

Pan, B., Gong, Y., Wang, Y., Miao, J., Zhao, C. and Li, Y. (2025). *The impact of maternal parenting stress on early childhood development: The mediating role of maternal depression and the moderating effect of family resilience.* BMC Psychology, 13(1). doi:10.1186/s40359-025-02575-6.

Yu, S., Liao, M., Liu, X. and Li, Y. (2025). The relationship between parenting stress and preschool children's social–emotional competence: The chain mediating role of parental reflective functioning and parent–child relationship. *Frontiers in Psychology*, 16. doi:10.3389/fpsyg.2025.1679084



Understanding Barriers to Healthy Eating and Healthy Lifestyle Behaviours Among Families with Children Aged 0–4 Years in Nottingham

Kolade Adedeji

Local Priority Area

- Eating and Moving for Good Health

1. Introduction: What I Wanted to Find Out

My Research Question: What are parents' and carers' views, experiences, barriers, and support needs regarding healthy eating and healthy lifestyle behaviours for children aged 0–4 years in Nottingham?

Why This Matters: The study sought to understand parents' knowledge of healthy eating, where they obtain information, the barriers they experience, and the types of support they believe would help families make healthier choices. The findings aim to inform practical recommendations that could support local public health initiatives and improve access to healthy eating information for families with young children.

Literature/Sources Used: Public health nutrition resources, including the Eatwell Guide and standard food packaging frameworks such as the traffic-light labelling system.

2. Method: Who, What, and How

The Participants: Six parents and carers from different socioeconomic and ethnic backgrounds across Nottingham.

Research Approach: Qualitative approach.

Data Gathering Methods: Six individual semi-structured interviews.

Preparation and Piloting: The project was initially designed to use a focus group. However, recruitment showed that childcare responsibilities, work commitments, and family schedules made co-ordinating a focus group difficult. Following discussion with the project supervisor, the method was adapted to individual semi-structured interviews. This allowed flexibility in scheduling/location and enabled participants to speak more openly without peer pressure, resulting in richer qualitative data.

3. Ethics: Researching Responsibly

Consent and Safety: Participants were offered flexible interview arrangements (convenient times and locations) to ensure accessibility and comfort. One-to-one interview settings were used so participants could speak honestly without feeling influenced by others.

Privacy: Data was gathered via qualitative interviews and subjected to verbatim transcription and thematic analysis. All participant details are anonymised in reported findings.

4. Data Analysis and Findings: What I Discovered

Verbatim transcription followed by thematic analysis to identify patterns and shared experiences.

Key Findings and Themes:

Theme 1 (Barriers): Cost, Affordability and Label Interpretation

Cost was identified as an important factor influencing food purchases, exacerbated by rising food prices. Healthier food options were sometimes perceived as more expensive.

Limited confidence in interpreting food packaging labels (traffic-light system) and uncertainty regarding correct portion sizes served as significant knowledge barriers.

> **"It depends on what we can afford."**

> **"I don't really know what the red, amber and green labels mean."**

Theme 2 (Enablers): Practical Education and Trusted Community Support

Parents welcomed practical advice, affordable meal planning, and clear guidance.

Delivering information via trusted community services or healthcare professionals (such as health visitors) increases parents' confidence and engagement.

Theme 3 (Awareness/Interest): Knowledge vs. Information Access

Parents understand the general concept of healthy eating for growth and development, but lack clear access to reliable sources. Most relied on search engines/social media. Awareness of public tools like the Eatwell Guide was low.

> **"Healthy eating is giving children the right food in the right portions."**

> **"I have never heard of the Eatwell Guide before."**

> **"A balanced diet that helps children grow and stay healthy."**

5. Linking Findings to the Research Question

Parents recognise the importance of healthy eating but face clear barriers: lack of awareness of official guides (Eatwell Guide), difficulty understanding food labels/portions, reliance on unverified internet sources, and financial constraints due to rising food prices. They require practical, clear, and affordable guidance delivered through trusted, accessible local services.

Surprises: Knowledge of public health tools like the Eatwell Guide was surprisingly low, with several participants having never heard of it. Additionally, shifting from focus groups to semi-structured interviews yielded much richer, more candid personal responses than originally anticipated.

6. Reflection, Limitations and Next Steps

Project Limitations: Small sample size (six participants), which means financial impacts and experiences vary across different households and cannot be generalised to all families.

Researcher Reflection: Changing the method from a focus group to semi-structured interviews strengthened data quality. It taught the value of listening to community voices and adapting flexibly to real-world participant constraints.

Next Steps / Recommendations:

1. **Nottingham City Council, Public Health and other local partners:** Develop simple leaflets, short videos, and social media content explaining the Eatwell Guide, food labels, and child portion sizes.
2. **Campaigns:** Feature practical, affordable meal ideas taking cost-of-living impacts into account.
3. **Healthcare professionals:** Health visitors and children's services should routinely promote trusted nutrition resources during contacts.
4. **Community groups:** Provide practical healthy eating education and clear signposting.
5. **Policy:** Combine educational interventions with practical financial/cost-conscious support.



Supporting Young People's Mental Health and Safety in the Digital Age: Exploring the Impact of Social Media and Online Gaming, and Potential Solutions

Stephanie Ng

Local Priority Area:

- Best Start: Young People's Mental Health

1. Introduction: What I Wanted to Find Out

My Research Question:

What are participants' perceptions of the impact of social media and online gaming on young people's mental health and safety, and how can young people be better supported to thrive in the digital age?

Why This Matters:

Digital technology plays a central role in communication, education, and entertainment. Rather than viewing technology as something to simply restrict or avoid, this research recognises its ongoing importance and seeks balanced, practical approaches that combine safe digital engagement with real-world relationships, learning, and community participation.

Literature / Sources Used:

The study sits within broader research into digital habits, online risks (cyberbullying, harmful content), and protective factors (social connection, safe online communities, and positive digital engagement).

2. Method: Who, What, and How

The Participants (59):

- **Online survey (n=59):** Included parents/carers (66.1%) and professionals; teachers, youth workers, and wellbeing practitioners (33.9%).
- **Age groups covered indirectly:** Under 11 years (9), 11–13 years (12), 14–15 years (10).
- **Characteristics:** Represented neurodivergent young people (20), neurotypical (16), those with social anxiety (14), and those experiencing social isolation/withdrawal (8).
- **Focus Group (n=10):** A sub-group of survey completers from diverse professional and family backgrounds.

Research Approach:

Mixed-methods approach (combining quantitative survey data with qualitative focus group discussions).

Data Gathering Methods:

- Online survey (59 responses using multiple-choice, Likert scales, and multi-select questions).
- 1 qualitative focus group (10 participants).

Preparation and Piloting:

The survey was piloted with three friends before distribution. Minor amendments were made to question wording and layout to improve clarity and flow.

3. Ethics: Researching Responsibly

Consent and Safety:

Participation was entirely voluntary. Participants received an information sheet detailing the study's purpose and usage. Completing the survey or joining the focus group indicated informed consent.

Privacy:

No personally identifiable information was included. Survey data was anonymised and reported in aggregate. Focus group quotes used generic codes: **P** (Parent), **T** (Teacher), **Y** (Youth Worker), and **W** (Wellbeing Practitioner). Data was stored securely with limited access.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed:

Quantitative data was analysed using descriptive statistics (frequencies and percentages). Qualitative data was analysed using thematic coding to identify recurring patterns.

Key Findings and Themes:

Theme 1: Online Experiences (Risks and Benefits)

- **Barriers / Safety Risks Identified (n=59):** Harmful online content (79.7%), contact from strangers (66.1%), cyberbullying (64.4%), sharing personal information (55.9%), online grooming (49.2%), and dangerous challenges (32.2%).
- **Negative Mental Health Impacts (Occurring Often/Very Often):** Low mood (57.6%), anxiety (55.9%), poor sleep (55.9%), social withdrawal (50.8%), low self-esteem (47.5%), irritability (47.5%), and FOMO (44.1%).
- **Enablers / Positive Impacts:** Staying connected with friends (78.0%), stress relief (54.2%), sense of belonging (45.8%), achievement (44.1%), motivation (30.5%), creative confidence (28.8%), teamwork (22.0%), and improved mood (16.9%).
- **Safety Skills Gained:** Learning to find safe online communities (44.1%), accessing emergency help (25.4%), recognising contact from strangers (22.0%), reporting cyberbullying (16.9%), and identifying unsafe online content (16.9%).

Theme 2: Why Young People Spend Time Online (Drivers)

Top Drivers: Boredom (79.7%), staying connected with friends (78.0%), habit/dopamine-driven behaviour (74.6%), escaping stress (72.9%), sense of belonging (71.2%), accepting communities (66.1%), low face-to-face confidence (64.4%), and offline friendship difficulties (59.3%). Focus group insights noted online spaces offer a relief from offline "social burnout" or masking (especially for neurodivergent youth).

Theme 3: Managing Screen Use and Unmet Needs

Unmet Needs: 49.1% agreed/strongly agreed that excessive screen use reflects unmet real-world needs for competence, mastery, achievement, and belonging.

Parental Confidence: Confidence in balancing screen time varied significantly, many parents reported low/no confidence (scores 1–2), highlighting the need for greater parent education and support in helping young people develop healthy digital habits.

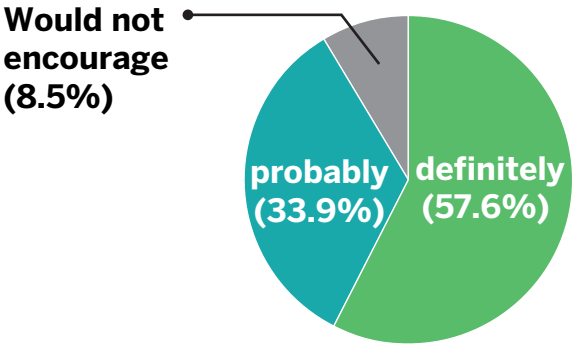
Theme 4: Support and Solutions

Most Requested Measures (n=59):

1. Hobbies and activities (86.4%)
2. Flexible youth clubs (81.4%)
3. Emotional regulation programmes (78.0%)
4. Safe social spaces (76.3%) and Parent education (76.3%)
5. Confidence-building (72.9%) and Mentoring (69.5%)

Safe Online Engagement: Over 70% agreed that safe online spaces provide a vital outlet, especially for isolated (74.6%), neurodivergent (72.9%), and socially anxious (72.9%) young people.

Proposed Platform Support: 91.5% of respondents stated they would definitely (57.6%) or probably (33.9%) encourage a young person to use a safe, moderated digital platform that bridges online engagement to real-world participation.



5. Linking Findings to the Research Question

Participants view social media and online gaming as double-edged tools: while they present clear risks (harmful content, anxiety, sleep loss), they also fulfil key needs for connection and belonging. Participants suggested that the issue is not technology itself, but how it is designed and used to meet young people's emotional and social needs. Supporting young people to thrive requires preventative, non-restrictive, and balanced approaches, combining safe digital environments with enriched, accessible offline community opportunities and parental support.

Surprises / Deeper Insights:

Excessive screen use is rarely just a tech problem; it is heavily tied to underlying social fatigue, lack of local activities, and unmet emotional needs. Furthermore, digital spaces are viewed as critical safety valves for neurodivergent and socially anxious youth.

6. Reflection, Limitations and Next Steps

Project Limitations:

- Relatively small overall sample size (59 survey respondents, 10 focus group members).
- Recruitment relied heavily on personal/professional networks, limiting generalisability to the broader population.

Researcher Reflection:

- **What Went Well:** Using a mixed-methods approach provided both broad numerical data and deep, lived-experience insights.
- **Challenges:** Participant recruitment was time-intensive. Managing and coding large volumes of qualitative focus group text required careful organisation.
- **Skill development:** Enhanced skills in research design, piloting, qualitative coding, and quantitative interpretation.

Next Steps:

- Scale up research with larger, more diverse community samples.
- Focus future projects on testing "blended" (online-to-offline) youth platforms and developing parent digital education workshops.

People, Poverty, Food Initiative

Henry Adefolaju

Local Priority Area:

- Eating and Moving for Good Health

1. Introduction: What I Wanted to Find Out

Research Question:

How do poverty and food insecurity affect people's ability to eat healthily and stay physically active, and what practical, community-based support can help improve health and wellbeing?

Why This Matters:

This research is directly connected to the work of **Open Arms Organisation CIC** in Nottingham. Through services like food parcel programmes, community meals, Elders Circle, and wellbeing activities, Open Arms regularly supports individuals experiencing food insecurity, low income, and social isolation.

Having physical access to food does not always mean people have the financial resources, confidence, or opportunities to make healthy choices or stay active. This project explores the lived experiences of community members to directly inform future Open Arms programming around nutrition, movement, and wellbeing.

Literature and Sources Used:

Guidance and evidence on nutrition, physical activity, and food insecurity from the **Office for Health Improvement and Disparities (OHID)** and the **Food Standards Agency (FSA)**.

Lived experiences, historical data, and ongoing feedback from Open Arms Organisation CIC's existing community projects.

2. Method: Who, What, and How

Participants: Service users and volunteers supported by Open Arms in Nottingham, including older adults, families, and individuals from diverse cultural backgrounds experiencing food insecurity or low income.

Research Approach: Mixed-methods (combining quantitative surveys/questionnaires with qualitative discussions).

Data Gathering Methods: Delivered over a four-day research period (approx. three hours per day) with 4–10 participants per day. Methods included questionnaires alongside informal discussions and direct conversations.

Preparation and Piloting: Yes. Questions were piloted and reviewed with a colleague at Open Arms CIC prior to fieldwork, leading to minor adjustments in wording and structure to improve clarity and accessibility.

3. Ethics: Researching Responsibly

Framework: Applied ethical guidance and templates provided by Coventry University.

Consent and Safety: Informed consent was obtained prior to participation. Participants were informed about the study's purpose, that participation was entirely voluntary, and that they could decline to answer any question.

Privacy and Sensitivity: Respect for privacy, dignity, and confidentiality was maintained throughout. Findings were aggregated into broader themes rather than identifying individual responses, keeping in mind the sensitive nature of financial hardship and food insecurity.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed

Survey responses were counted and compared to identify numerical patterns. Qualitative notes from informal discussions and conversations were systematically reviewed to group recurring ideas into thematic categories.

Key Themes and Illustrative Quotes

Theme 1: Barriers (Food Affordability, Insecurity, and Employment Restrictions)

> **"Many low-income households are forced to purchase cheaper processed foods because healthy foods... are often expensive."**

> **"Rising food costs, inflation, low wages, benefit reductions [are major pressures]."**

Theme 2: Health, Wellbeing, and Everyday Poverty

> **"Food insecurity can lead to 'stress, anxiety, and depression' as well as physical health issues."**

> **"Poverty involves 'social exclusion, limited opportunities, poor living conditions, and lack of access to support services'."**

Theme 3: Physical Activity Barriers

> **"Lack of safe spaces for exercise, long working hours, stress, social isolation, and financial difficulties [challenge staying active]."**

Theme 4: Enablers (Community Support, Shared Meals, and Dignity)

> **"Shared meals and activities encourage social interaction, cultural understanding, and healthier lifestyle choices."**

> **"Support vulnerable individuals and families by promoting healthy eating, physical activity, and wellbeing."**

Theme 5: Cultural and Personal Preferences

> **"Importance of culturally appropriate food regardless of income or background."**

5. Linking Findings to the Research Question

People experiencing poverty and food insecurity genuinely want to eat healthily and remain active, but systemic and financial barriers (rising food costs, restricted income, right-to-work barriers) severely limit their choices. Improving health requires more than individual effort, it calls for practical, affordable, accessible, and culturally appropriate community support.

Understanding poverty and food insecurity is essential for addressing health inequalities and improving community wellbeing. These

issues affect not only individuals but society as a whole. Community organisations, governments, charities, and local services all have an important role in reducing poverty, improving access to healthy food, and creating opportunities for healthier and more equal lives.

Surprises: Participants already possessed a strong awareness and understanding of the importance of healthy eating and exercise; the gap was strictly caused by financial and social barriers, not a lack of knowledge.

6. Reflection, Limitations and Next Steps

Project Limitations:

- Small participant sample size focused primarily on individuals already connected to Open Arms.
- Short data collection window (four days).
- Limited organisational resources and time to conduct a wider city-wide study.

Researcher Reflection:

What Went Well: Conducting fieldwork within the familiar Open Arms community centre created a safe, welcoming environment that fostered open and honest dialogue.

Challenges and adaptations: To support participants facing financial or personal constraints, the project provided refreshments, travel assistance, and flexible accommodations for parents bringing children.

Next Steps:

Open Arms CIC will use these findings to design practical cooking sessions, budget-friendly nutrition advice, and accessible physical activities.

Future research should deeper examine the structural links between employment/right-to-work restrictions and food security across broader demographics in Nottingham.



Exploring Perceptions and Awareness of Nutrition in Recovery

Joanna Brown

Local Priority Area:

- Eating and Moving for Good Health (e.g. Nutrition in Recovery)

1. Introduction: What I Wanted to Find Out

My Research Question: How do individuals in substance recovery, as well as support staff, perceive and experience the role, awareness, and delivery of nutrition education during the recovery process?

Why This Matters: During active addiction, physical health, regular eating habits, and proper dietary intake are frequently neglected. Proper nutrition plays a foundational role in restoring physical health, supporting neurological healing, stabilising mood, and preventing relapse. Understanding how service users and staff experience nutrition guidance allows recovery services to better address holistic well-being.

Literature and Background: Grounded in holistic recovery frameworks and public health approaches to addiction care, this study examines nutrition as a pillar of long-term recovery alongside sleep and hydration.

2. Method: Who, What, and How

The Participants: A total of five participants based in Nottingham took part in the study. These included service users in various stages of addiction recovery (covering crack cocaine and alcohol abuse) and recovery service staff/facilitators.

Research Approach: Qualitative approach designed to capture deep personal insights, lived experiences, and nuanced perceptions.

Data Gathering Methods: Five semi-structured one-hour interviews following a standardised interview schedule covering initial recovery experiences, nutritional awareness, and future interest in educational resources.

Preparation and Piloting: The interview schedule was pre-structured and tested against core recovery themes to ensure open-ended, non-judgmental questioning regarding diet and well-being.

3. Ethics: Researching Responsibly

Consent and Safety: Informed consent was obtained from all participants prior to commencing the audio recordings. The voluntary nature of participation and the scope of the project were explained clearly.

Privacy: Anonymity and confidentiality were strictly preserved. Real names have been anonymised using code names (**P1**, **P2**, **P3**, **P4**, **P5**) in data reporting, and audio recordings were scheduled for secure deletion post-collation.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed:

Interview transcripts were analysed thematic-style by highlighting recurring themes, key quotes, shared insights, and significant differences between service users' and staff members' perspectives.

Key Findings and Themes:

Theme 1: Barriers

Financial Constraints and Food Costs: Healthy food options are often perceived as expensive or out of reach compared to cheaper, processed options.

Lack of Facilities and Life Skills: Many service users reside in temporary accommodation or HMOs where cooking equipment (hobs, ovens) may be absent or limited to a basic microwave. Furthermore, complex cooking routines create intimidation.

Lack of Formal Prioritisation: Nutrition is rarely embedded systematically into early recovery care plans unless driven by medical emergencies or key worker personal initiatives.

Stigma and Shame: Feelings of shame surrounding past neglect, current poor eating habits, or body image concerns can prevent engagement.

> **"You're in a room with a microwave and a kettle, trying to rebuild your life... how are you supposed to cook a fresh meal when you don't even have a hob, let alone the extra cash for fresh veg?"**

Theme 2: Enablers

Key Worker Relationships: Individual key workers who proactively bring up diet and physiological care act as essential access points for nutrition awareness.

Simple, Practical Solutions: Focus on one-pot meals, low-cost options, quick prep (e.g. microwave cooking techniques, couscous), and free community/allotment produce.

Peer and Group Support: Informal food sharing (e.g. food banks/ donations within recovery hubs) and non-judgmental group settings foster healthy engagement.

> **"It was my key worker who first asked me, 'What are you actually feeding your body today?' That simple question completely changed how I looked at my day-to-day routine."**

Theme 3: Awareness and Interest

Direct Recognition of Mood and Energy Impact: Participants explicitly connected nutritional intake to mental clarity, mood stability, reduced cravings, and sustained physical recovery.

High Demand for Practical Workshops: Strong interest exists among both service users and staff for concise, practical, non-judgmental health and nutrition workshops.

Misunderstanding of Jargon: Terminology like "optimum nutrition" is generally unfamiliar to participants, but once defined, the underlying concept is viewed as vital.

> **"When I'm eating proper food, my head is clearer, my mood stops swinging all over the place, and those heavy cravings just don't hit me as hard."**

5. Linking Findings to the Research Question

Nutrition is widely recognised by service users and staff as a vital component of recovery that directly affects mood, cravings, physical repair, and energy levels. However, structured nutritional advice remains largely absent or informal within standard recovery pathways. Service users desire practical, low-cost, non-jargon educational support integrated into their ongoing care.

Surprises:

How significantly sugar cravings replace substance use due to empty calories and blood-sugar spikes.

The strong interest in microwave cooking and simple "one-pot" meal skills adapted specifically for individuals living in temporary or facility-limited housing.

6. Reflection, Limitations and Next Steps

Project Limitations: Small sample size (five participants) from a single localised service centre in Nottingham, meaning findings may not represent all regional recovery environments.

Researcher Reflection: The semi-structured conversational format allowed participants to speak openly and candidly without feeling judged. Managing time and guiding technical terms (like optimum nutrition) required clear, accessible explanations.

Next Steps:

- Recommend incorporating short, mandatory health and nutrition modules for recovery staff.
- Develop practical, hands-on "budget one-pot cooking" and "healthy microwave cooking" workshops for service users.
- Introduce accessible informational leaflets highlighting blood sugar management and simple low-cost nutrition strategies.



How to Reduce the Guilt and Shame of Relapse when in Addiction Recovery

Brendan

Local Priority Area:

- Alcohol
- Severe Multiple Disadvantage

1. Introduction: What I Wanted to Find Out

My Research Question: How can we reduce the guilt and shame associated with relapse to improve re-engagement with addiction recovery services?

Why This Matters: Lived experience and peer observations at the Nottingham Recovery Network (NRN) showed that the intense magnitude of guilt and shame following a relapse often leads service users to completely stop engaging with support, despite having made significant progress. Reducing these emotional barriers is critical to increasing re-engagement rates.

Literature and External Sources Used:

- **National and Local Data:** Reviewed official substance misuse statistics from the Office for Health Improvement and Disparities (OHID) and Gateshead JSNA reports.
- **Models and Academic Literature:** Utilised the Stages of Change model (where relapse is recognised as a standard stage) alongside academic studies on negative self-conscious emotions, shame spirals, and pathways out of addiction.

2. Method: Who, What, and How

The Participants: A total of 29 participants took part:

- **11 In-Person Participants:** Recruited directly via Nottingham Recovery Network (NRN) Hub/Academy, consisting mostly of staff/service workers (10) and service users (five) with direct recovery connections.
- **18 Online Participants:** Reached via recovery Subreddits on Reddit.com (e.g. r/Sober, r/recovery, r/alcoholism), with 88% having personal lived experience.

Research Approach: A hybrid, mixed-methods approach combining qualitative thematic exploration and quantitative survey metrics.

Data Gathering Methods: An online Google Workspace questionnaire consisting of multiple-choice, scale-based, and open-ended text questions.

- **In-person sessions:** Conducted one-to-one sessions to allow for deep-probing questions, keeping participants highly focused on core themes.
- **Online sessions:** Distributed digitally across relevant online communities.

Preparation and Piloting: The questionnaire was refined and validated following feedback from course trainers and collaboration with project consultant Dr Sinead Ouillon to ensure question focus, variety, and thematic clarity.

3. Ethics: Researching Responsibly

Consent and Safety:

- Participants read a detailed information sheet outlining project goals, data handling, and support contacts before agreeing to mandatory digital consent checkboxes.
- Participation was entirely voluntary, and respondents were informed they could pause or withdraw at any time.
- In-person interviews used a mirrored screen so participants could verify the accuracy of transcribed responses in real time.

Privacy:

- Data was collected and stored securely in cloud-based spreadsheets protected by passcodes, device identity verification, and 2-factor authentication (2FA).
- In-person interviews occurred in private, vetted rooms at NRN's Hub. All outputs were fully anonymised.

4. Data Analysis and Findings: What I Discovered

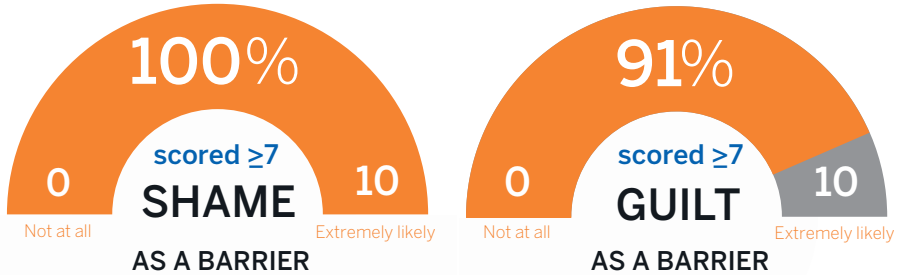
How Data Was Analysed: Qualitative responses and quantitative metrics were processed separately (in-person vs. online) and then combined. AI models were used to perform thematic coding on transcriptions and calculate survey tallies.



Image © John Rodriguez on Unsplash

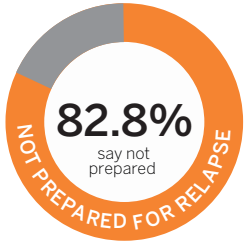
Key Findings and Metrics:

- **Guilt and Shame as Barriers:** 91% of combined respondents scored guilt ≥7/10 as a barrier to re-engaging, and 100% scored shame ≥7/10.



- **Lack of Discussion:** 67.9% believe relapse is not discussed enough in recovery services.
- **Lack of Preparation:** 82.8% feel people in recovery are not adequately prepared for relapse.
- **Critical Correlation:** A 100% correlation was found between believing relapse isn't discussed enough (67.9%) and feeling unprepared for it (82.8%).





Key Qualitative Themes

Theme 1: Guilt (External Focus – Impact on Others)

Primary Drivers: Fear of letting others down / betraying trust (67.9%), broken promises to self/moral failure (53.6%), loss of built-up progress/wasted effort (39.3%), and the pressure of "clean time" hierarchies.

Theme 2: Shame (Internal Focus – Self-Worth)

Primary Drivers: Feeling like a total failure or a "bad person" (60.7%), fear of judgment from staff/peers (46.4%), humiliation (46.4%), and experiencing an identity crisis ("being a different, shameful person when using").

Theme 3: Cognitive Reframing and Solutions (Enablers)

Language Shift: Moving from "deficit-based" language (e.g. *Relapse Prevention*, which frames relapse as a catastrophic failure) to "strengths-based" language (e.g. *Understanding Relapse or Relapse Management*, which treats it as learning data).

Ideal Re-Engagement Process: Overwhelmingly driven by non-judgmental compassion (60.7%), person-centred care (35.7%), normalising relapse without encouraging it (35.7%), and accessible peer support (28.6%).

5. Linking Findings to the Research Question

The Answer: To reduce guilt and shame and increase service re-engagement, recovery services must:

1. **Normalise conversations around relapse** proactively before it happens, rather than reactively.
2. **Shift language** from threat/deficit-based terms (*prevention*) to benign/learning terms (*understanding/management*).
3. **Eliminate the "clean time" hierarchy culture** that makes individuals feel like all progress is lost if a lapse occurs.
4. **Guarantee non-judgmental emotional safety** and active, compassionate outreach.

Surprises:

- There was a stark difference in priorities between datasets: In-person participants prioritised **non-judgmental compassion (+25.1% higher)**, whereas online participants prioritised **peer support (+27.9% higher)** and practical service adjustments (e.g. medication reviews, flexible staff).
- There was complete consensus (100% correlation) that avoiding discussions on relapse directly causes service users to feel unprepared when it occurs.

6. Reflection, Limitations and Next Steps

Project Limitations:

- Small sample size (29 participants) limited wider statistical generalisability.
- Geographic discrepancy: Local NRN users benefited from high-quality local services, whereas online respondents had varied global service experiences.
- Lack of direct UK-wide official data tracking exact "relapse" rates vs. general "drop-out" rates.

Researcher Reflection:

What Went Well: Excellent participant engagement driven by strong existing relationships with peers and staff at NRN.

Challenges: The time required for qualitative fieldwork and analysis was significantly higher than anticipated.

Next Steps and Future Recommendations:

Questionnaire Redesign: Simplify abstract scenario questions (e.g. "design the perfect process") into direct, low-effort questions about specific service changes.

Service Development: Safely design proactive "relapse planning" groups that avoid triggering users while stripping away the taboo nature of the topic in public recovery spaces.



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Exploring Out-of-Hours Support Needs for Individuals in Recovery

Eileen

Local Priority Area:

- Alcohol
- Severe Multiple Disadvantage

1. Introduction: What I Wanted to Find Out

My Research Question:

What are the out-of-hours (evenings and weekends) support needs, emotional experiences, and activity preferences of individuals recovering from substance use?

Why This Matters:

Recovery services and support centres predominantly operate during standard daytime working hours. However, recovery is a 24-hour process, and evenings and weekends can present heightened vulnerability, loneliness, and triggers for relapse. Understanding how service users experience these out-of-hours periods is essential to designing effective, community-led support networks that prevent isolation and sustain long-term recovery.

Literature and Context:

This research builds upon community-led Social Science approaches to Severe Multiple Disadvantage (SMD). It focuses on addressing gaps in traditional service provision by examining peer-led networks, mutual aid groups (e.g. AA/NA/CA, SMART Recovery), and safe social spaces as protective factors during non-operational hours.

2. Method: Who, What, and How

The Participants:

The research involved seven participants recruited through a local recovery centre/hub:

Age demographics: Ranged across age groups from 31 to 60.

Service use: All participants had prior experience using local recovery support services.

Research Approach:

A qualitative approach was used to capture rich, lived-experience narratives regarding evenings, weekends, coping mechanisms, and support availability.

Data Gathering Methods:

Data was collected using standardised semi-structured Participant Interview Record Sheets containing six core questions covering post-centre activities, emotional states during out-of-hours, current support networks, willingness to attend evening/weekend activities, and suggestions for future provision.

Preparation and Piloting:

The interview record sheet was designed to ensure accessible language for participants. Questions were structured sequentially to transition from routine daily habits to emotional reflections and specific service suggestions.

3. Ethics: Researching Responsibly

Consent and Safety:

Participants were provided with clear information regarding the purpose of the study. Participation was voluntary, and participants were informed of their right to skip questions or stop the process at any time.

Privacy:

Strict anonymity and confidentiality measures were maintained:

- Identifiable personal details were omitted.
- Unique participant identifier codes (e.g. Participant 1, Participant 7, EP 2, EP 3) were used across all interview sheets to protect individual identities.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed:

Completed interview record sheets were systematically analysed using thematic analysis. Responses were transcribed, coded, and grouped into primary patterns reflecting common barriers, existing coping strategies, and future desires for service provision.

Key Findings and Themes:

Theme 1: Barriers (Isolation, Boredom, and Out-of-Hours Vulnerability)

Evening Loneliness and Mood Drops: Multiple participants noted significant mood drops, tiredness, boredom, and feelings of being **"lost"** or **"lonely"** once services closed for the day or during weekends.

Triggers and Cravings: Unstructured evening time creates vulnerability to intrusive thoughts and cravings. Participant 7 highlighted that unsupported evenings are **"difficult, vulnerable times... when I want to return to taking drugs"**, and Participant 4 noted that **"when you have urges [they] are hard to fight"**.

Reluctance or Difficulty Opening Up: Participants reported finding it hard to communicate their struggles to family/friends who don't understand, or to formal crisis teams during non-crisis hours.

> **"Usually I go home and feel unsupported. The evenings without support are my difficult, vulnerable times – this is usually when I want to return to taking drugs and sometimes do."**
> *(Participant 7)*

Theme 2: Enablers (Spousal Support, Mutual Aid, and Personal Routines)

Strong Social/Family Support: Spousal support, supportive partners, and family networks serve as major protective factors (e.g. EP 2 relying heavily on his wife; EP 3 citing family/friends).

Fellowship and Mutual Aid: Attending AA, NA, CA, or SMART recovery meetings provides crucial continuity outside centre hours.

Personal Coping Strategies: Engaging in domestic routines, freelance work, gardening/allotments, listening to music, walking the dog, or volunteering helped manage unstructured time.

> **"I have my wife who is a wonderful individual and very supportive. Beyond that I sometimes join online SMART meetings. In-short, yes."**
> *(Participant 2)*

Theme 3: Awareness and Interest (Desire for Inclusive Safe Spaces and Activities)

High Demand for Evening/Weekend Provision: Every participant expressed a desire or willingness to participate in evening or weekend activities, provided times and locations are convenient.

Recovery-Inclusive Safe Spaces: Participants explicitly requested "recovery inclusive safe spaces to go" during off-hours.

Nuanced Balance ("Recovery Fatigue"): Some participants cautioned that while out-of-hours options are vital, care must be taken to avoid "recovery fatigue" so individuals can build lives outside of recovery services.

> **"Yes. I would like to see more recovery inclusive safe spaces to go."**
> *(Participant 1)*

5. Linking Findings to the Research Question

Individuals in recovery face significant emotional vulnerability, isolation, and heightened risk of relapse during evening and weekend hours when primary service hubs are closed. While spousal support and mutual aid groups (AA/NA/SMART) help buffer these risks, there is a clear demand for community-based, recovery-inclusive safe spaces and structured evening/weekend activities to maintain connection and prevent isolation.

Surprises:

The Dual Need for Connection vs. Independence: While out-of-hours support was overwhelmingly requested, participants highlighted the importance of avoiding "recovery fatigue". Higher-functioning or partnered participants stressed the need for activities that allow them to live a normal life "outside" of recovery alongside formal support options.

Gap Between Crisis and Everyday Needs: Participants noted that current out-of-hours awareness is often limited strictly to emergency options like AandE or Crisis Teams, leaving a gap for non-crisis social support.

6. Reflection, Limitations and Next Steps

Project Limitations:

Sample Size: Small sample size (N=7) drawn from a single recovery context, limiting wider statistical generalisability.

Self-Report Data: Relied on short-form written interview responses, which restricted deep probing into specific clinical histories or backgrounds.

Researcher Reflection:

What Went Well: The structured interview sheets provided a comfortable, non-intrusive medium for participants to express vulnerable feelings regarding loneliness and cravings.

Challenges: Transcribing handwritten records with varying levels of detail required careful cross-comparison to capture the exact sentiment of each participant accurately.

Next Steps and Recommendations:

- **Pilot Evening Social Hubs:** Trial opening community safe spaces 1–2 evenings per week or on weekends offering low-pressure social activities.
- **Diversify Provision:** Ensure out-of-hours offerings include both recovery-focused groups (e.g. SMART/fellowships) and social/hobby-based groups to cater to different stages of recovery.
- **Future Research:** Conduct a broader survey across multiple Nottingham community hubs to assess the cost-effectiveness and feasibility of extended weekend operating hours.

How Fear of Rejection and Low Self-Belief Affect People's Engagement with Support Services

Philip

Local Priority Area:

- Severe Multiple Disadvantage (Selected based on themes of addiction, isolation, and mental health barriers)

1. Introduction: What I Wanted to Find Out

My Research Question: How do emotional and psychological barriers, specifically fear of rejection and low self-belief, influence a person's willingness to engage with support services?

Why This Matters: Accessing support services can help individuals improve their wellbeing and create positive change, but emotional barriers often make it difficult for people to reach out. By understanding these barriers, support services can learn to create safer, more welcoming, and inclusive environments where individuals feel confident to seek help earlier.

Literature/Sources used: Research in psychology, mental health, and social support, which suggests people often avoid asking for help because they fear being judged, misunderstood, or rejected.

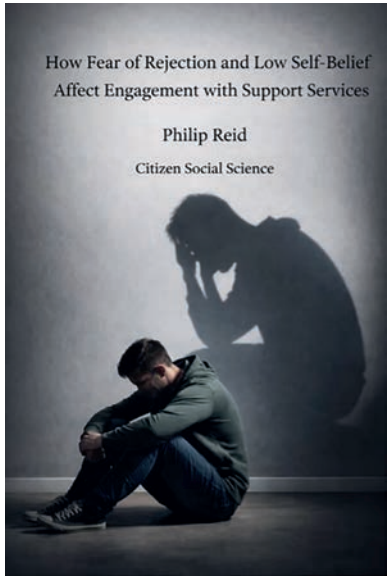
2. Method: Who, What, and How

The Participants: Four participants with lived experience of accessing support services.

Research Approach: Small-scale qualitative approach within Citizen Social Science.

Data Gathering Methods: I conducted four semi-structured interviews.

Preparation and Piloting: I prepared thoroughly before each interview by planning to use open-ended questions and taking time to build trust and rapport. I focused on creating a safe, respectful, and confidential environment where I could listen without judgement.



3. Ethics: Researching Responsibly

Consent and Safety: I ensured participants felt safe by allowing them to speak at their own pace and answering questions in a safe, respectful environment. Because some participants were nervous about discussing personal experiences, I was patient and continuously reassured them of their safety.

Privacy: I provided reassurance that all shared information would remain strictly confidential.

4. Data Analysis and Findings: What I Discovered

I identified recurring themes across the four interviews to understand the emotional barriers preventing help-seeking and the enablers that encouraged engagement.

Key Findings and Themes:

The findings from the four interviews revealed several recurring themes that demonstrate how fear of rejection and low self-belief

influence engagement with support services. Although each participant had different life experiences, there was remarkable consistency in the emotional barriers they described.

Theme 1 (Barriers): Fear of Rejection, Judgement, and Stigma

Participants feared how professionals, family members, and society would perceive them due to addiction, mental health difficulties, or immigration status. Some feared asking for help might result in their children being removed from their care.

> **"Because I've experienced a lot of rejection in the past... I'm very sensitive to rejection."**

> **"think I was crazy."** *(When fearing speaking to a doctor)*

> **"It's about stigma. It's about what other people think about you."**

> **"When I was in addiction... I was isolated, confused, scared and full of shame."**

Theme 2 (Barriers): Low Self-Belief and Isolation

Poor self-esteem caused participants to question their self-worth, view needing help as a personal failure, and isolate themselves, often delaying support until they reached a point of desperation.

> **"Low self-esteem has always made me question, 'Am I worth it?"**

> **"If you need help from others you have failed in some way."**

> **"I just hide away and end up isolating myself."**

> **Fear "overruled everything."**

Theme 3 (Enablers): Trust, Reassurance, and Safe Environments

Positive, welcoming, and non-judgemental first experiences helped reduce anxiety. Hearing things like "you're not the only one" from a keyworker was highly effective at reducing isolation.

> **"If that first contact is welcoming, non-judgemental and supportive, it greatly increases the chance that someone will stay."**

> **"Services need to create an environment where people feel safe and secure."**

5. Linking Findings to the Research Question

Emotional barriers, such as shame, fear of rejection, and low self-worth are just as significant as practical barriers when accessing support services. The emotional risks of reaching out often feel too overwhelming unless services actively create compassionate, consistent, and psychologically safe environments.

Surprises: Despite participants having very different life experiences, there was remarkable consistency in the emotional barriers they described. It was also notable how often internal beliefs caused individuals to delay seeking help until their circumstances became completely overwhelming.

6. Reflection, Limitations and Next Steps

Project Limitations: The project was small in scale (four interviews). Arranging interviews that suited both the participants and myself was a major logistical challenge.

Researcher Reflection: The interviews went well because participants were willing to speak openly about their experiences. Building rapport and listening without judgement helped create a comfortable atmosphere where people felt able to share personal stories. The semi-structured interview format allowed participants to express themselves freely while ensuring the research questions were covered. The information gathered provided rich insights that supported the aims of the research.

One of the main difficulties was arranging interviews that suited both the participants and myself. Some participants were understandably nervous about discussing personal experiences, and I had to be patient and reassure them that their information would remain confidential. I also found it challenging at times to remain focused on asking questions while listening carefully and making notes. As this was my first experience of carrying out research interviews, I was learning new skills throughout the process.

The first thing I learnt is the importance of listening without judgement. Giving people the time and space to tell their stories helps build trust and often leads to richer, more meaningful information.

The second thing I learnt is the value of careful planning and preparation. Good organisation, clear interview questions and ethical practice helped the research run smoothly and produced reliable findings.

These lessons are important to me because I hope to continue working in peer support and recovery services. The skills I have developed through this project will help me build trusting relationships, communicate effectively and support others in a respectful and compassionate way.

Next Steps:

For future research: Recruit a larger, more diverse group of participants and allow more time for interviews and follow-up questions to gain even deeper insights. This would provide a broader range of experiences and strengthen the findings.

For local services: Prioritise positive first impressions, maintain consistency in staffing so users see familiar faces, and provide clear reassurance to individuals who fear the consequences of seeking help (especially parents fearing child removal).



Families and Supporters of Those in Recovery from Addiction

Yvonne Powles

Local Priority Area

- Alcohol
- Severe Multiple Disadvantage (Substance Use / Lived Experience)

1. Introduction: What I Wanted to Find Out

My Research Question:

Do families need services to support them in the care of their loved ones in addiction/alcoholism?

Why this matters:

Family members, particularly mothers, are largely overlooked in the recovery process. In the name of caring, families often unknowingly enable their loved ones, keep them comfortable, or struggle to set healthy boundaries due to a lack of guidance and skills. This research aims to inform and encourage ongoing, structured support for families and carers to better equip them with effective strategies for both their own self-care and their loved one's recovery.

I am the mother of a son in recovery/active addiction. As someone who accesses a support group, I recognised that while the road to recovery must ultimately come from the individual, family support is often the catalyst for long-lasting recovery.

Literature and Sources Used:

The project drew insights from podcasts, literature, and academic studies on family recovery and addiction, including:

Sam Davis (Interventionist, *The Unbroken Podcast*): Highlighted how family education shifts the recovery dynamic.

Discovery Point Retreat ("*Family Recovery*" Podcast): Emphasised helping families understand recovery without judgment.

Buckeye Recovery Network and Karen Wilcock (Addiction Specialist, *Treehouse Recovery* Podcast): Discussed family engagement, therapy, and education as crucial components of rehab.

Dr Gabor Maté (Writer, Doctor, Addiction Specialist): Insights into health, stress, and addiction.

Bare Knuckle Recovery (Recovery Support Podcast): Addressed how mothers are often the last to let go and the overall impact on the family system.

Amber Hollingsworth (Addiction Counsellor, *Put the Shovel Down* Podcast).

David Michael Straw (father of an addict and writer) and **Beverley Conyers** (sister of an addict and writer).

Prof. Lee Robins (Professor of Social Science in Psychiatry): Study on heroin use among returning Vietnam veterans, citing strong family disapproval and relationship bonds as key factors in stopping substance use.

2. Method: Who, What, and How

The Participants:

- Participants on the Stronger Roots Recovery Walk (30th July 2026).

- Members of a local family and carers of loved ones in addiction group in Nottingham.
- Members of the splinter and signposted group from the family and carers group.
- A peer/friend who has a family member who is an alcoholic.

Research Approach:

Mixed-methods approach using both qualitative interview insights and quantitative survey data to draw worded conclusions alongside graphs/charts.

Data Gathering Methods:

Initial Survey and Journal Pilot: Distributed 20 numbered envelopes (10 surveys, 10 mini wellbeing journals) to randomise sampling and maintain participant anonymity.

In-Depth Fieldwork: Conducted five follow-up engagements using face-to-face interviews, online sessions, or structured questionnaires returned via email.

Preparation and Piloting: Initial survey envelopes were handed out, but the questionnaire was not formally piloted with a test participant due to initial self-doubt regarding question formulation.

Adjustments: Direct discussions and reassuring feedback from course tutors/organisers confirmed the project direction, boosting confidence to proceed.

3. Ethics: Researching Responsibly

Consent and Safety:

Cover notes were enclosed with both the survey envelopes and questionnaires, explicitly informing participants of their right to opt in or opt out at any time.

Participants were informed that a duty of safeguarding overrides confidentiality where safety concerns arise.

Privacy and Data Protection:

No names or identifying details were recorded; participants were assigned alphanumeric codes (e.g. **#1**, **#a**).

Paperwork was kept securely with the researcher at all times to be destroyed upon completion, and all emailed responses were deleted after processing in line with GDPR guidelines.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed:

Quantitative survey tallies were compiled into pie charts and bar charts (including custom hand-crafted, recycled-art charts).

Qualitative responses and interview transcripts were analysed by identifying recurring themes around boundary setting, support needs, and family dynamics.

Key Findings and Themes:

Theme 1: Barriers (Unsolicited Advice, Boundary Breakdown, and Research Challenges)

Participant Challenges: Unsolicited advice from people lacking lived experience (e.g. "kick them out", "let them hit rock bottom") is common but unhelpful. Carers struggle with setting and maintaining boundaries, often giving money out of fear or care, which inadvertently supports the addiction. Gaps in support from mental health organisations, particularly crisis teams, were highlighted.

Researcher Barriers: Personal confidence in formulating questions and time constraints due to work commitments slowed initial setup.

Theme 2: Enablers (Peer Support, Education, and Team Encouragement)

Attending support groups gives family members the language, tools, confidence and strategies needed to navigate addiction and practice self-care, dispelling guilt and shame.



Mothers are particularly likely to engage in support groups and sustain connections long-term.

Key course support networks (including course mentors Davia, Sarah, Amy, Glen, and Zsofia) provided timely guidance whenever concerns arose.

Theme 3: Awareness and Community Interest

Widespread interest across the local recovery community validated the core concept: families actively seeking education are far better equipped to support a loved one effectively.

5. Linking Findings to the Research Question

Do families need services to support them? While families can survive without formal services, those who seek and respond to professional support and mutual aid groups are **significantly more likely** to achieve positive outcomes for both themselves and their loved ones.

When carers receive education, they stop enabling behaviours, maintain healthy connections, and create an environment that supports long-term recovery.

Surprises and Perspective Shifts:

The research question evolved continuously, opening up more avenues for exploration than originally anticipated.

Perspective on Incarceration: An unexpected finding was that most families responded positively to the idea of a prison sentence over active substance use—viewing prison as a safe, structured space where their loved one could achieve temporary sobriety, receive food, and access education, rehabilitation, or chapel services.

6. Reflection, Limitations and Next Steps

Project Limitations:

Time constraints due to work commitments and delayed response times from participants with busy family lives limited the scale of the fieldwork.

Small formal survey returns (three completed booklets) meant quantitative findings were supplemented primarily through qualitative interviews and direct face-to-face engagements.

Researcher Reflection:

The experience was deeply rewarding and engaging. Emailing questionnaires proved to be an effective strategy that gave participants time to respond comfortably.

The project built personal confidence, proving that initial self-doubt can be overcome through peer and mentor support.

Next Steps and Future Work:

I would definitely do the surveys and questionnaires much earlier in the programme. And I would worry less and try to be a bit more confident in my processes instead of second-guessing every step.

I would also produce more quantitative data as reading the data and producing the graphs and charts was very interesting. I planned to use Excel graphs and charts and make them colorful however my love of recycled art/crafts leant itself so well to this part so I would use more art/craft in this part to present colorful charts/graphs. Perhaps some people prefer to look at a graph or chart as a way of reading data.

I would love now to conduct another survey on support for children at risk of addiction or those with addicted family members. I am hoping to set up a group at my school where we can engage pupils with the help of support coaches at The Wellbeing Hub.



Mental Health and Coping Behaviours: The Role of Smoking/Vaping among South Asian Men

Anurupa Mitra Chowdhury

Local Priority Area

- Smoking and Tobacco Control, and Work and Health

Project Overview

This citizen social science research project explores "Mental Health and Coping Behaviours: The Role of Smoking/Vaping among South Asian Men." The study aimed to explore the relationship between mental health and smoking/vaping behaviours, considering participants' history of mental health conditions and their recent experiences of stress, anxiety, low mood and difficulty coping with everyday pressures. It further explored whether stress and everyday life pressures may trigger smoking/vaping or contribute to their use as coping behaviours.

A short mixed-method survey was completed by 10 South Asian men who are working or involved in business and are current smokers or have stopped smoking within the last few years. The survey combined closed and open-ended questions to explore participants' mental health history and recent mental wellbeing, sources of stress, coping strategies, experiences of smoking and vaping, use of vaping alongside or instead of cigarettes and the influence of South Asian cultural, family and community attitudes towards mental health and smoking/vaping.

The research project seeks to provide insight into whether and why smoking/vaping may function as a coping behaviour; how mental health and everyday life pressures may influence these behaviours; and what alternative coping strategies participants use.

Research Question

How do mental health, stress and everyday life pressures influence the use of smoking and vaping as coping behaviours among South Asian men?

Why this matters

Demographics and Representation: Nottingham is an ethnically diverse city, with 43% of residents belonging to ethnic minority groups and 14.9% identifying within the broad Asian ethnic group (2021 Census). Despite their vital contribution to local life, ethnic minority groups remain under-represented in health research, running the risk that public health services fail to reflect their specific needs.

Smoking and Mental Health Disparities: Smoking remains a major preventable cause of ill-health and premature death, with around 64,000 smoking-related deaths each year in England (NHS England, n.d.). Locally, 18.2% of Nottingham adults were current smokers in 2023 (Nottingham City Council, 2025), with higher rates among men and strong links to factors including ethnicity, deprivation and mental health (Nottingham City Council, 2019). While statistics highlight these disparities, they do not reveal why people smoke or vape or whether these behaviours form part of how people cope with daily stress.

Research Objective: To address this evidence gap, this citizen social science project explores the lived experiences of South Asian men who work or own businesses in Nottingham. It investigates how stress and everyday pressures along with societal, cultural and family influences affect their mental wellbeing, coping strategies and smoking or vaping habits. By bringing visibility to an under-represented group, this research aims to inform culturally tailored mental health support and smoking cessation initiatives.

Literature and Sources

This project synthesises published academic literature and local population data to examine smoking, vaping and mental health within the South Asian community:

Mental Health and Smoking/Vaping: A large population study of 27,437 adults in Great Britain found that smoking and vaping were more common among people reporting mental health conditions or psychological distress, with greater smoking dependence also observed among smokers experiencing mental health difficulties (Taylor et al., 2023). However, its cross-sectional design demonstrates correlation rather than causation.

Cultural Context: Research conducted across mental health institutions in South Asia highlights specific regional and cultural dynamics linking tobacco use to severe mental illness, reinforcing the need to examine these behaviours within South Asian populations (Rajan et al., 2023).

Local Health Inequalities: Nottingham's Joint Strategic Needs Assessment (JSNA), particularly *Smoking and Tobacco Control* (2019) and *Work and Health* (2025) sections, highlights local disparities in smoking, health and employment, underscoring how wider socioeconomic factors shape overall wellbeing.

Demographic Relevance: 2021 Census data confirms Nottingham's ethnic diversity, providing a strong rationale for focusing on local South Asian residents (Office for National Statistics, 2023).

Research Gap: Together, these sources highlight an intersection between psychological distress, coping mechanisms and socioeconomic circumstances. Crucially, they reveal a key gap in local evidence: understanding why and under what circumstances South Asian men may use smoking or vaping in relation to mental health, stress and everyday pressures.

Method

The Participants: The research involved 10 South Asian men, all of whom were residents of Nottingham. Participants were individuals I had come to know through community interactions or through work-related settings. All participants were working or involved in business and were either regular smokers or had stopped smoking within the last few years, reflecting the specific population relevant to the research question.

Participants were approached directly and invited to contribute to the research by completing a short online survey. The survey did not collect participants' names or full contact details, and responses were recorded using participant-generated codes. This approach helped protect participants' privacy and provided a space where they could express their experiences and views openly and without hesitation.

Research Approach: A mixed-methods approach was used, combining both quantitative and qualitative data. The survey included closed-ended questions, which provided measurable data on mental health experiences, stress, smoking and vaping behaviours, and open-ended questions, which allowed participants to describe their experiences, coping behaviours and influences in their own words.

This approach was particularly valuable for citizen social science because it allowed the research to identify patterns across participants while also capturing the lived experiences and perspectives behind those patterns.

Data Gathering Methods: Responses were collected from 10 participants through an online survey.

Preparation and Piloting: I sought guidance from my mentor before developing my survey questions and piloted the survey with a co-researcher to assess its clarity and suitability. No changes were required following the pilot.

Ethics

Consent and Safety: Participants were provided with study information outlining the purpose of the research, voluntary participation, privacy, and their right to withdraw. Informed consent was obtained before participants could proceed with the survey.

Privacy: Participant names and contact details were not collected or recorded within the survey, and survey responses were recorded using participant-generated codes. In the report, participants were referred to using neutral identifiers such as P1, P2 and P3 to protect their identity. The collected data were securely uploaded to the designated NCVS folder under the researcher's name and stored in accordance with the project's data-handling requirements.

Data Analysis and Findings

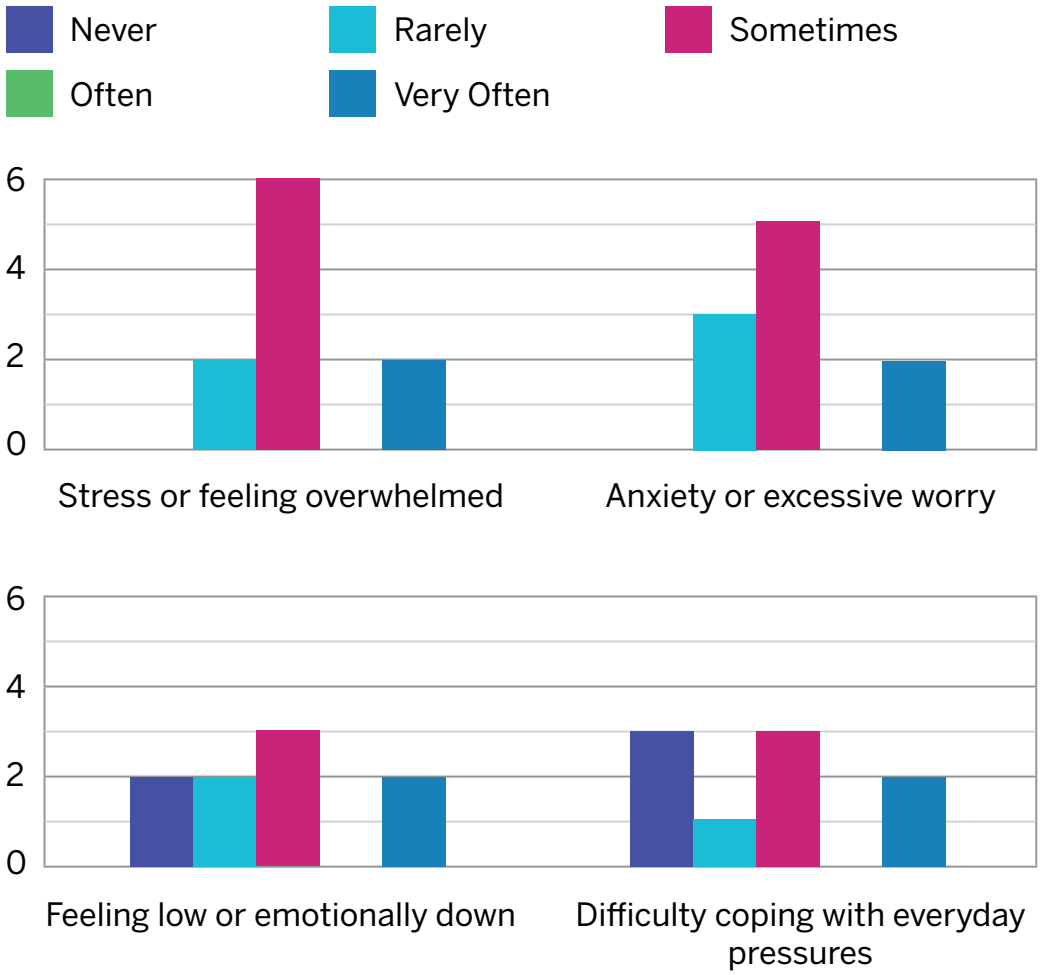
A mixed-methods approach was used to analyse the responses. Closed-question responses were counted to identify patterns across the 10 participants, while open-ended responses were reviewed for recurring ideas, experiences and differences, which were grouped into key themes. As the study involved only 10 participants, findings are primarily reported as counts (e.g. six of 10) rather than relying on percentages.

Key Findings and Themes

Theme 1 – Mental Health, Stress and Everyday Pressures

Although nine of the 10 participants reported no history of a diagnosed mental health condition or professional support, experiences that may affect mental wellbeing were evident. All 10 participants reported experiencing stress or feeling overwhelmed to some degree during the previous month: six of 10 participants experienced stress or feeling overwhelmed at least 'sometimes' while two of 10 reported experiencing it 'very often'. Anxiety or excessive worry was also reported by all participants to varying degrees, including two who experienced it 'very often'. Figure 1 illustrates the distribution of these recent experiences.

Figure 1. Recent experiences affecting mental wellbeing



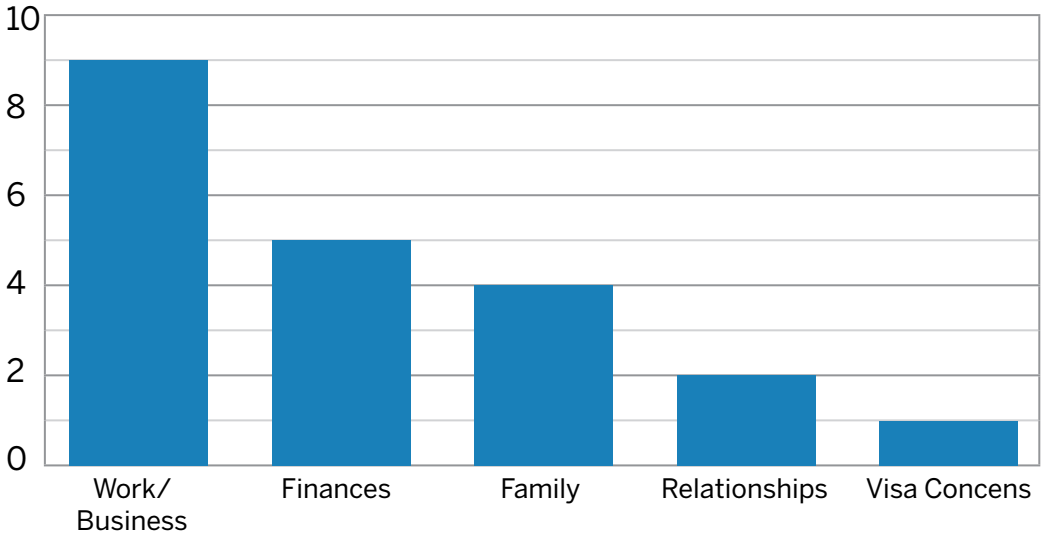
Everyday pressures provided important context for these experiences. Participants were asked an open-ended question about the main sources of stress or pressure in their everyday lives, allowing them to describe these freely rather than selecting from predetermined categories. Despite this freedom, clear similarities emerged across the responses. Work or business was mentioned by nine of 10 participants, making it the most commonly recurring source of stress (Figure 2), followed by financial and family-related pressures. Relationship and visa-related concerns were also reported.

For example, one participant described their pressures as:

> **"Work, Finance, Family, Relationship."** — *P7*

> **"High work pressure and challenges."** — *P9*

Figure 2. Main sources of everyday stress or pressure identified from open-ended responses (n = 10).



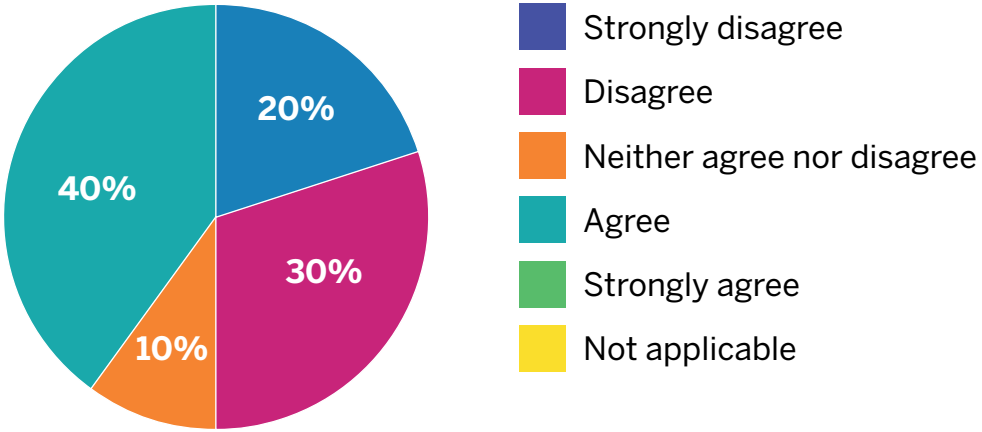
These findings suggest that stress and anxiety can be experienced even in the absence of a reported history of a formally recognised mental health condition, while also highlighting the importance of work, financial and family circumstances in participants' everyday experiences.

Theme 2 – Smoking/Vaping as a Coping Behaviour

Participants were directly asked to rate their agreement with the statement: "Smoking or vaping helps me feel calmer or better able to cope when I am under stress or pressure." Responses showed a clear difference in opinion: 6 of 10 participants agreed or strongly agreed, three disagreed and one neither agreed nor disagreed (see Figure 3).

Figure 3. Participants' agreement that smoking or vaping helps them feel calmer or better able to cope under stress or pressure (n = 10).

Q7 To what extent do you agree with the statement: *"Smoking or vaping helps me feel calmer or better able to cope when I am under stress or pressure."*



The open-ended responses provided further context for these differing views, revealing why some participants perceived smoking or vaping as a coping strategy, while others did not associate these behaviours with managing stress or pressure. Among participants who perceived a coping benefit, smoking/vaping was described as providing temporary relief, distraction, personal space or time to think. For example:

> **"It's a distraction for a while."** — *P3*

> **"...a moment of me time."** — *P5*

However, the qualitative responses also revealed contrasting experiences, with some participants not associating smoking or vaping with coping:

> **"I do not rely on smoking or vaping as a coping mechanism."** — *P10*

Overall, the findings suggest that smoking/vaping may function as a perceived coping strategy for some participants, particularly by providing temporary relief, distraction or a break during stressful situations. However, this was not universal, and the findings demonstrate an association rather than showing that stress causes smoking or vaping.

Theme 3 – The Role of Vaping

Vaping played a relatively limited role in this study, with six of 10 participants reporting that they had never vaped. Among the four who had, vaping was used in different ways, including reducing cigarette consumption, supporting quitting, using vaping alongside smoking or vaping independently of smoking.

Therefore, vaping within this study should not automatically be interpreted as a stress-coping behaviour or simply as a replacement for smoking; however, for some participants, it appeared to function as a substitute for or complement to cigarette smoking.

Theme 4 – Cultural, Family and Community Influences

Cultural, family and community attitudes emerged as important influences on how participants cope with mental health difficulties, as well as their attitudes towards smoking and vaping. Nine of 10 participants believed that South Asian cultural, family or community expectations affect how people deal with mental health difficulties. When this was explored further, seven participants explicitly indicated that these attitudes affect how people seek support or cope with challenges. One participant highlighted a potential consequence:

> **"It's regarded as taboo."** — *P2*

Another participant explained:

> **"Smoking is generally frowned upon... That's the reason I always hid it from my family..."** — *P4*

In contrast, another participant described smoking as normalised within their social environment:

> **"It's a community where most people smoke. So it's normal."** — *P5*

These contrasting perspectives suggest that there is no single South Asian experience. Cultural, family and community influences may discourage smoking and contribute to concealment in some settings, while smoking may be more socially normalised in others. They may also influence whether and how individuals acknowledge mental health difficulties, seek support and cope with challenges.

Theme 5 – Alternative Coping Strategies and Barriers

Smoking and vaping were not the only coping behaviours reported. Participants described a range of alternative ways of managing stress and difficult situations, including exercise and swimming, spending time with or talking to family and friends, meditation, music, reading, entertainment, socialising, taking time alone and practical problem-solving.

When participants were specifically asked what alternatives to smoking or vaping might support mental wellbeing, suggestions included physical activity, meditation, walking, relaxation, social activities and openly discussing difficulties with trusted people.

One participant suggested:

> **"Sharing issues with close friends or family"** — *P9*

Another identified:

> **"Meditation... This helps to calm one's mind."** — *P8*

However, participants also identified practical barriers to adopting alternative coping strategies, including limited time, work and family commitments, cost, access to suitable facilities and opportunities, and difficulties incorporating alternatives into established routines.

Overall, these findings demonstrate that participants used and recognised multiple ways of coping beyond smoking or vaping. However, whether these alternatives are practical or accessible may depend on an individual's time, responsibilities, financial circumstances and access to suitable opportunities or support.

Linking Findings to the Research Question

The findings suggest that smoking can function as a coping behaviour for some South Asian men in Nottingham, particularly during periods of stress and everyday pressure. Participants described smoking as providing temporary relief, distraction, personal space or a break from stressful situations, with work/business pressures emerging particularly strongly. However, this relationship was not universal, and participants also used a range of non-smoking coping strategies. Vaping played a comparatively limited and varied role.

Surprises

A notable finding was that nine of 10 participants reported no history of a diagnosed mental health condition or professional support, despite stress and anxiety being commonly reported. It was also striking that work/business pressures emerged independently across nine of 10 open-ended responses, despite participants not being given predetermined categories. Finally, cultural influences were not uniform: smoking was described as *taboo* or discouraged by some participants, but as *normalised* within the social environment of another.

Reflection, Limitations, and Next Steps

Project Limitations: The main limitation was the small sample size of 10 participants, recruited through community and work-related contacts within Nottingham. Therefore, the findings cannot be generalised to all South Asian men. The limited timeframe for recruitment and data collection also restricted the opportunity to obtain a larger and more diverse sample. As the study relied on self-reported experiences, responses may also have been influenced by participants' individual perceptions and willingness to discuss sensitive topics such as mental health and smoking. Recruitment through existing community and work-related contacts may also have limited the diversity of perspectives represented.

Researcher Reflection: The project successfully gathered both quantitative and qualitative insights, with the open-ended questions particularly valuable in allowing participants to express their experiences in their own words. A notable strength was the emergence of similar themes independently across responses, particularly around work/business pressures.

The principal challenge was recruiting participants who met the specific criteria within the available timeframe. This was addressed by drawing on existing community interactions and work contacts, while maintaining voluntary participation and protecting participants' privacy. The experience demonstrated the value of creating a confidential space for exploring potentially sensitive community issues.

Next Steps: If repeated, the study should recruit a larger and more diverse sample of South Asian men across Nottingham, representing a wider age range, occupations and South Asian backgrounds. A longer recruitment period and broader community engagement would help achieve this.

Future research should build on this exploratory study by addressing the limited local evidence on how stress and everyday pressures influence smoking and vaping as coping behaviours among South Asian men in Nottingham. Studies involving a larger and more diverse sample could examine in greater depth how pressures such as work, finances and family responsibilities relate to smoking and vaping behaviours, while also exploring the influence of cultural attitudes on coping and help-seeking. Interviews or focus groups could provide richer insight into why smoking is perceived as a coping strategy and help identify culturally appropriate, acceptable and accessible alternatives to smoking and vaping.

References

NHS England (n.d.) *Tobacco dependency programme*. Available at: www.england.nhs.uk/ourwork/prevention/tobacco-dependency-programme/ (Accessed: 8 August 2026).

Nottingham City Council (2019) Smoking and Tobacco Control. *Nottingham City Joint Strategic Needs Assessment*. Available at: nottinghaminsight.org.uk/themes/health-and-wellbeing/jsna/adults/smoking-and-tobacco-control-2019/ (Accessed: 7 August 2026).

Nottingham City Council (2023) Demography and Social Environmental Context Chapter. *Nottingham City Joint Strategic Needs Assessment*. Available at: www.nottinghaminsight.org.uk/themes/health-and-wellbeing/jsna/behavioural-factors-and-wider-determinants-of-health/demography-and-social-environmental-context-chapter-2023/ (Accessed: 7 August 2026).

Nottingham City Council (2025) Work and Health. *Nottingham City Joint Strategic Needs Assessment*. Available at: www.nottinghaminsight.org.uk/themes/health-and-wellbeing/jsna/adults/work-and-health-2025/ (Accessed: 7 August 2026).

Office for National Statistics (2023) *How life has changed in Nottingham: Census 2021*. Available at: www.ons.gov.uk/visualisations/censusareachanges/E06000018/ (Accessed: 8 August 2026).

Rajan, S. et al. (2023) "Tobacco use in people with severe mental illness: Findings from a multi-country survey of mental health institutions in South Asia", *Tobacco Induced Diseases*, 21, 166. doi: 10.18332/tid/174361.

Taylor, E., Brose, L.S., McNeill, A., Brown, J., Kock, L. and Robson, D. (2023) "*Associations between smoking and vaping prevalence, product use characteristics, and mental health diagnoses in Great Britain: a population survey*", BMC Medicine, 21, 211. doi: 10.1186/s12916-023-02890-y.



The Impact of Job-Seeking on Graduate Mental Health, Coping Strategies, and Support Systems in Nottingham

Abdulmujeeb Opeyemi Muhammad-Olodo

Local Priority Area:

- Work and Health

1. Introduction: What I Wanted to Find Out

My Research Question:

How does job-seeking affect the mental health of post-graduates in Nottingham, how do they cope with these challenges, and what are their perceptions of existing support systems and potential solutions from across the local system?

Why This Matters:

- Unemployment and poor-quality employment both severely harm mental health.
- With 17.7 million UK graduates (as of 2025) and local contributions from Nottingham Trent University and the University of Nottingham, a significant population faces job-seeking stress.
- Between 16% and 69% of UK students and recent graduates report mental health challenges.
- Finding a job in Nottingham has been widely reported as difficult, making local context critical.

Literature and Context:

The project references data on UK graduate numbers, national student mental health statistics, and evidence linking unemployment to psychological distress, depression, and anxiety.

2. Method: Who, What, and How

The Participants:

- Six graduates living/searching for jobs in Nottingham (three males, three females).
- Included Master's graduates (primarily Public Health) and one PhD graduate.
- Recruited via WhatsApp announcements, word-of-mouth, and flyers using purposive and snowball sampling.

Research Approach: Qualitative study.

Data Gathering Methods: Six semi-structured, audio-recorded interviews, transcribed verbatim and analysed using Braun and Clarke's reflexive thematic analysis.

Preparation and Piloting: Questions were created and tested with a research mentor, requiring minimal initial changes.

3. Ethics: Researching Responsibly

Consent and Safety: Ethical approval was granted by Coventry University (Institutional Review Board). Participant information sheets were shared prior to seeking consent, with opportunities to clarify questions via email/phone.

Privacy: Full anonymity was enforced throughout. Participants were assigned non-identifying codes (**P1–P6**) to protect their identities.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed:

Transcripts were analysed using Braun and Clarke's reflexive thematic analysis to identify patterns and underlying themes regarding mental health, coping, and support structures.

Key Findings and Themes:

Theme 1: Emotional Erosion in a Hostile Job-Search Environment (Barriers / Impact)

- **1.1 Cycles of Stress:** Repeated application rejection and recruiter silence lead to continuous waves of sadness, depression, and physical exhaustion.

> **"I'm sad for a moment. I'm depressed for a while... And then the results come back and the rejection again and then it's like I'm in a cycle of sadness all over and over again."** — *P1*

- **1.2 Withdrawal:** Constant failure causes graduates to apply expecting to fail or to stop applying altogether.

> **"I have totally stopped (applying) because I know it won't get anywhere."** — *P2*

- **1.3 Questioning Abilities:** Lack of feedback destroys self-confidence and leaves graduates doubting their professional skills.

> **"The most devastating part is not hearing back from the recruiters and wondering if you actually have the skills for those specific jobs... and how strong of a candidate you are."** — *P5*

- **1.4 Gloomy Market:** Seeing peers in identical struggles creates a collective sense of hopelessness.

> **"It's been a bit gloomy... when you look at what's happening, not just with yourself, but with your peers... we're all in similar situations."** — *P5*

Theme 2: Unmet Expectations Aggravated by "Tight" Labour Market (Barriers)

- **2.1 Shattered Aspirations:** High initial hopes (e.g. entering public health) are broken by reality and alumni warnings.

> **"So actually I came in to do my postgraduate master's degree in public health... and at the beginning of the course, I had so much hopes and aspirations to join the public health department of England. However, mid-study and then after we graduated, stories were coming up because we had several alumni talking to us about how difficult is it to get entry..."** — *P2*

- **2.2 Experience Paradox:** Requirements for senior or UK-specific experience prevent graduates from gaining entry-level roles.

> **"Some of them like asking for experience here in the UK, but I don't have this experience because you didn't hire me."** — *P3*

- **2.3 Alternative Routes:** Graduates pivot to other sectors (e.g. midwifery, Royal Mail sorting) as backup plans to survive.

> **"So for example, for now... I currently have my Royal Mail job where I sort mails and parcels... I'm just sort of using this opportunity as a way to sort of fund my studies and my future ambitions."** — *P4*

- **2.4 Hiding Credentials:** Participants intentionally hide Master's degrees to avoid being rejected as "overqualified" for lower-level jobs.

> **"When I mentioned that I had a master's degree, sometimes they replied that I'm overqualified."** — *P3*

Theme 3: Coping, Surviving, and "Holding It Together" (Enablers)

- **3.1 Faith and Determination:** Religious beliefs (e.g. trust in Allah's plan) and sheer persistence keep candidates moving forward.

> **"It's like you just take that leap of faith, and you just apply... if something's good coming to me, it will come... You cannot wish what Allah doesn't wish for you."** — *P4*

- **3.2 Social Support:** Practical job-sharing and emotional encouragement from partners, family, and friends act as vital lifelines.

> **"I have a few friends that send me job opportunities... they did not stop sending me jobs... And that was very helpful."** — *P1*

- **3.3 Everyday Routines and Non-Graduate Work:** Gym, rest breaks, watching TV, and working retail jobs (e.g. Asda) help buffer financial and emotional stress.

> **"In terms of looking after myself and my mental health, I would say that I go to the gym. The gym is the number one. It has really helped me profoundly."** — *P5*

Theme 4: Navigating Uneven and Invisible Support Systems (Awareness)

- **4.1 University Services:** University career/employability teams are the most visible and helpful support (mock interviews, CV reviews).

> **"It was really helpful, especially for learning how to do the job searching and the interviews, because I did the mock interview with them and that has helped me a lot."** — *P3*

- **4.2 Job Fairs:** Fairs are limited by competing demands, or perceived as performative rather than leading to real jobs.

> **"I'm very much aware (of services) because my friend sends those career and employability fairs into a group, but... I'm barely able to go because I'm caught up in my other job." — P1**

- **4.3 Support Invisibility:** Support from local organisations and partners around mental health or graduate employment is largely invisible, unknown, or absent.

> **"I keep up with Nottingham Council news through social media channels, but I haven't seen anything on... young people's mental health during job-hunting. So I'm not sure if anything's happening in that space."** — *P5*

Theme 5: Imagining Better Support and Fairer Opportunities (Solutions / Recommendations)

- **5.1 Mental-Health-Aware Support:** Explicit recognition of job-seeker mental health, counselling, and dedicated peer support groups.

> **"They can make support groups for graduates to join and focus on their mental health."** — *P3*

- **5.2 Purposeful Job Fairs:** Fairs specifically structured to grant direct hiring opportunities or skill-building.

> **"Making sure that those career fairs are impactful... granting free opportunities or free learning opportunities for graduates."** — *P4*

- **5.3 Structured Schemes:** City-level graduate schemes, apprenticeships, and job shadowing to provide crucial first-step experience.

> **"If there was a scheme from... that would have been way better... if you enter that scheme, it will take off the stress off... frantically applying for jobs."** — *P1*

- **5.4 Policy and Visa Reform:** Advocacy against high salary thresholds (£40,000) and sponsorship restrictions that disadvantage international graduates.

> **"UK government has increased the skilled worker visa thing to £40,000 as a starting range... If they find the same potential in a British guy, they will go for him because they don't need to pay him more because he's already a citizen." — P6**

5. Linking Findings to the Research Question

Job seeking severely erodes graduate mental health through persistent rejection, self-doubt, and a lack of entry-level pathways. Graduates survive using personal coping strategies (gym, faith, friends, non-graduate jobs), while relying almost entirely on university services. Support is currently perceived as invisible, but graduates strongly desire dedicated local graduate schemes, mental health resources, and visa-policy advocacy.

Surprises:

- The extent to which graduates feel forced to *hide* higher qualifications to gain basic employment.

- The near-total invisibility of local services for mental health support for postgraduate job-seekers.
- The massive structural wall created for international students by national visa/salary threshold changes.

6. Reflection, Limitations and Next Steps

Project Limitations:

- **Sample Size and Scope:** Small qualitative cohort (n=6) heavily skewed toward Master of Public Health graduates, making non-public health insights exploratory.
- **Selection Bias:** Half of the participants were recruited from immediate personal networks, introducing potential willingness bias.

Researcher Reflection:

- **Fieldwork and Positionality:** As a recent MPH graduate experiencing the exact same job-rejection cycle, I had to actively manage my own bias. For example, I had to restrain myself from imposing specific terminology (like "graduate scheme") onto participants during interviews.
- **Impact:** The process reaffirmed how Citizen Social Science empowers local researchers to transform personal community struggles into actionable local research.

Next Steps and Recommendations:

- **Future Research:** Expand studies across diverse academic disciplines beyond public health.
- **System Actions:** Nottingham City Council and partners should explore entry-level graduate traineeships, introduce targeted mental health support groups for job-seekers, and advocate nationally regarding international graduate employment barriers.



Women's Mental Health, Workplace Stigma, and Potential Links to Absenteeism in Healthcare

Bernice Edison

Local Priority Area

- Work and Health

1. Introduction: What I Wanted to Find Out

Workplace mental health is a pressing public health issue, particularly in healthcare where staff face high psychological pressures, heavy workloads, and extreme operational stress. While public conversations around mental health have progressed, talking about personal experiences at work remains difficult due to fears of social condemnation, career limitation, discrimination, or perceived professional inefficacy.

This research directly aligns with the "Work and Health" priority area outlined in the Joint Local Health and Wellbeing Strategy of Nottingham City Council.

My Research Question:

How do young women aged 20–25 working in healthcare settings across Nottingham experience and navigate mental health stigma, gender stereotypes, workplace discrimination, and their potential links to absenteeism?

Why I Chose This Topic:

I wanted to explore how stereotyping, institutional labelling, discrimination, and gendered social expectations shape an employee's willingness to discuss mental health problems, seek help, or access workplace support before reaching acute burnout.

2. Method: What I Did and How I Did It

To capture both broad baseline attitudes and detailed personal reflections, this study adopted an exploratory qualitative design.

Method Used: A structured digital questionnaire distributed via Microsoft Forms combining closed-ended categorical questions with open-ended qualitative prompts.

Why This Method Was Chosen: Digital questionnaires enabled participants to share sensitive, lived experiences safely and anonymously in their own words without fear of professional repercussions.

Sample and Target Strategy: Following an explicit digital consent protocol, 10 completed responses were received (four participants aged 20–23; six participants aged 24–25). To preserve analytical validity and tight alignment with research objectives, the thematic analysis filtered the cohort down to the seven core respondents currently working within the healthcare industry in Nottingham.

Questioning Route: The survey investigated eight core areas:

1. Psychological safety related to disclosing mental health struggles to managers.
2. Institutional perceptions of mental illness in clinical/care environments.
3. Gender issues and biased judgments of young female workers.
4. Labelling and cultural stereotypes.
5. Race, ethnic, religious, and cultural influences on perceptions of mental ill-health.
6. Barriers to accessing workplace help.
7. Preferred supportive measures for front-line workers.
8. Links between workplace pressures, stigma, and sickness absence.

3. Ethics: How I Conducted the Research Responsibly

Given the sensitive nature of workplace discrimination and psychological distress, ethical considerations were central to the design:

Informed Digital Consent: Participation was entirely voluntary, and explicit digital consent was obtained prior to questionnaire administration.

Anonymity and Confidentiality: No personally identifiable information (such as names, specific employers, or contact details) was collected to protect participants' identities.

Sensitivity Boundaries: Questions were crafted to allow participants to express their experiences freely without feeling pushed past comfortable boundaries.

4. Reflection on the Research Process

What Went Well: The structured digital format successfully yielded rich qualitative feedback and honest disclosures regarding systemic anxieties, professional risks, and intersectional discrimination.

Challenges Faced: The initial sampling target of 15–20 participants was capped at 10 (with seven meeting core criteria) due to real-world recruitment constraints—specifically acute time limitations and heavy shift schedules among healthcare staff.

What I Would Do Differently Next Time: I would extend the recruitment window, utilise flexible drop-in surgery sessions, and incorporate semi-structured focus groups or interviews to explore complex topics like racial discrimination in greater qualitative depth.

5. Data Analysis: How I Made Sense of My Data

I analysed the response data using categorical tallying for closed questions alongside thematic coding for qualitative text entries. Text responses were read repeatedly, coded for key concepts (e.g. "fear of career stagnation", "double burden", "understaffing"), and grouped into overarching themes.

Overview of Core Response Data (Core Healthcare Sample, n=7):

Measurement Category	Variable / Response Option	Response Count (n=7)	Cohort %
Workplace Perception of Mental Health	Yes, frequently	3	42.9%
	Yes, sometimes	2	28.6%
	Rarely	1	14.3%
	No	1	14.3%
Women Judged Differently for Mental Ills	Strongly agree	4	57.1%
	Agree	1	14.3%
	Neither agree nor disagree	1	14.3%
	Disagree	1	14.3%
Exposure to Mental Health Labelling	Experienced personally	2	28.6%
	Witnessed someone else experiencing it	2	28.6%
	Both experienced and witnessed	1	14.3%
	No exposure	2	28.6%
Types of Discrimination Witnessed/ Experienced (Multiple Choice)	Race or Ethnicity	7	100.0%
	Mental Health	3	42.9%
	Religion or Belief	1	14.3%
	Age	1	14.3%
Comfort Discussing Mental Health with Manager	Very comfortable	3	42.9%
	Somewhat comfortable	2	28.6%
	Neither comfortable nor uncomfortable	1	14.3%
	Somewhat uncomfortable	1	14.3%

6. Findings: What I Discovered

Theme 1: Mental Health Stigma and Fear of Judgment

Prevalence: Over 70% of core participants indicated that mental health conditions were viewed negatively within their workplaces either frequently (42.9%) or sometimes (28.6%).

Disclosure Barriers: Participants cited a pervasive fear of being labelled "weak," worries over career progression, differential treatment by peers, and concerns over professional competency ratings. Over half the cohort selected all available barrier options, showing that stigma operates as a multi-layered constraint.

Systemic Risks: Qualitative feedback highlighted deep anxieties surrounding "licensing and career risks, performative support, [and] lack of privacy."

Theme 2: Gendered Expectations and Professional Proving Grounds

Distinct Standards: 71.4% (5 of 7) agreed or strongly agreed that female staff face distinct standards of judgment regarding mental health at work.

The Double Burden: Open-ended reflections revealed that young women feel compelled to constantly demonstrate professional competence and emotional resilience to counter gendered stereotypes, while simultaneously balancing external domestic or caregiving responsibilities.

Theme 3: Negative Labelling and Cultural Stereotypes

Widespread Exposure: 71.4% of respondents had personally experienced or directly witnessed workplace labelling tied to mental health struggles.

Recurring Tropes: Staff experiencing psychological distress were frequently stereotyped as "unable to cope under pressure," "unreliable," "less capable," or "a potential risk to patient safety." In clinical environments where safety is paramount, these labels create a severe effect on early help-seeking.

Theme 4: Intersectional Discrimination and Organisational Hierarchy

Unanimous Findings on Race: Strikingly, 100% of core healthcare participants (n=7) reported witnessing or experiencing discrimination based on race or ethnicity in the workplace.

Intersectional Impact: 42.9% strongly agreed that cultural and racial backgrounds alter how an employee's mental health is interpreted by peers and managers. Narratives pointed to entrenched power dynamics, specifically "racism [and] male dominance over hierarchy when it comes to promotions."

Theme 5: Management Relationships and Desired Support Mechanics

Line Management vs. Culture: While 71.4% felt comfortable approaching immediate line managers to discuss mental health, confidence in broader institutional care was measured (42.9% remained neutral regarding whether their organisation would deliver appropriate long-term support).

Front-Line Priorities: When asked what concrete structural changes would help, respondents prioritised:

1. Stronger anti-discrimination policies
2. Accessible, confidential counselling services
3. Flexible working arrangements
4. Enhanced privacy standards and wellbeing resources

Theme 6: Operational Pressure, Burnout, and Absenteeism Pathways

Workplace Stressors: Narratives painted a vivid picture of clinical environments defined by "chronic understaffing," "day-to-day work pressure," and high baseline fatigue.

The Absenteeism Trajectory: Qualitative feedback points to a clear pathway: when staff feel that admitting distress invites professional doubt or career stagnation, they delay seeking support until their condition degrades into acute burnout—making sickness absence an inevitable outcome rather than an early, managed intervention.

7. Linking Findings to My Research Question

Did I answer the research question? Yes. The research identified that young women in healthcare face a complex, compound reality where mental health stigma, gendered expectations, and systemic racial discrimination intersect to hinder open communication and early intervention.

What surprised me? The unanimous reporting of racial discrimination in the workplace among core healthcare participants was a striking finding. It demonstrated that workplace mental health cannot be evaluated in isolation; psychological safety is deeply linked with racial equality, fair treatment, and institutional trust.

8. Limitations and Next Steps

Small Sample Size: Relying on seven core healthcare respondents means these qualitative insights are exploratory indicators rather than generalisable metrics across the entire Nottingham healthcare workforce.

Time Constraints: High operational pressures and shift schedules limited participant recruitment numbers.

Next Steps and Strategic Recommendations:

1. **Intersectional Policy Integration:** Merge local mental health strategies with robust anti-racism and equality frameworks to address compound workplace marginalisation.
2. **Managerial Capabilities:** Equip line managers with practical skills in maintaining confidentiality, managing workloads, and facilitating psychological safety beyond basic awareness training.
3. **Early-Intervention and Confidential Systems:** Establish confidential, third-party support routes that remove fears surrounding professional performance reviews or licensing risks.
4. **Normalised Flexible Working:** Implement temporary roster modifications to allow staff to manage distress proactively without resorting to formal sickness absence.
5. **Future Research:** Scale quantitative reach across Nottingham to track verified sick leave data against measured stigma indices and conduct deeper qualitative interviews.



Exploring the Role of Meaningful Family Conversations in Supporting Emotional Wellbeing and Reducing Feelings of Social Isolation: A Pilot Study with Nottingham Families

Deborah Omeni

Local Priority Area:

- Cross-Cutting

1. Introduction: What I Wanted to Find Out

My Research Question:

How do meaningful family conversations influence emotional wellbeing and feelings of social isolation among Nottingham families?

Why This Matters:

Emotional wellbeing, social connection, and healthy family relationships are closely linked, yet public health attention has tended to treat loneliness and social isolation as standalone problems, addressed mainly through community programmes, social prescribing, and organised activities. Less attention has been given to the role everyday family conversation might play as a source of emotional support and connection in its own right, not only as a tool for reducing loneliness, but as a contributor to broader emotional wellbeing, family closeness, and healthy family functioning.

Families are one of the most consistent relationships in a person's life, but consistent contact does not guarantee emotionally meaningful contact. Many family interactions remain practical or routine (arranging logistics, brief check-ins), while opportunities for deeper conversation about life experiences, emotions, memories, or personal challenges may be comparatively rare. Understanding whether the depth and quality of family conversation, rather than frequency alone, shapes emotional wellbeing and feelings of connection or isolation may point to a low-cost, accessible way of supporting mental health that complements existing community-based approaches.

This matters for Nottingham specifically because strengthening family relationships could complement the city's existing wellbeing and community support work without requiring new services or funding; family conversation is a resource that already exists within most people's lives, if practised with intention. The study also serves as a pilot for a longer-term interest of mine: understanding whether more structured, meaningful conversation during visits to older relatives in care home settings could support residents' emotional wellbeing, an area where visits are common but meaningful conversation is not guaranteed simply by a visit taking place.

Literature and Sources:

Existing research supports a link between family communication quality and wellbeing, though the literature is scattered across different life stages and contexts rather than treating meaningful family conversation as a single continuous idea:

Adult Family Relationships: Buehler et al. (2024) found that how parents and adult children communicate, and how well that communication is integrated across in-person and digital channels,

was linked to loneliness, psychological wellbeing, relational satisfaction, and closeness.

Adolescents: Favotto et al. (2019) found that the quality of family communication shaped how young people experienced loneliness in relation to their digital communication habits. Family communication acted as a protective backdrop that changed how other forms of contact affected wellbeing.

Emotional Quality of Conversation: Kahlon et al. (2021) found that empathy-focused telephone conversations delivered by trained laypeople significantly reduced loneliness, depression, and anxiety among at-risk older adults. In a family context, Bergersen et al. (2024) found that a structured Family Talk Intervention helped families facing life-threatening illness prevent feelings of loneliness over time.

Population Level: Hilliard et al. (2026), using UK Biobank and genetic data, confirmed that loneliness and social isolation are directly linked to poorer mental health and reduced wellbeing.

However, this research remains fragmented. Comparatively little research asks, in participants' own words, what makes an everyday family conversation feel meaningful, and whether that depth shapes emotional wellbeing in ordinary family life. This pilot study seeks to address that gap through qualitative interviews with Nottingham families.

2. Method: What I Did and How I Did It

The Participants:

Seven participants (**P001** to **P007**) were recruited through a community organisation I am part of here in Nottingham. Participants were aged between 30 and 50, with living arrangements including living with a spouse, living with a spouse and children, and living with extended family.

Research Approach and Data Gathering:

This study used a qualitative approach based on semi-structured interviews to explore participants' own accounts and interpretations of family conversation and emotional wellbeing. A qualitative approach was chosen because the research question is concerned with meaning and lived experience—how people describe and make sense of conversations—rather than measuring predefined variables.

Data was gathered through seven semi-structured interviews (35 to 58 minutes) conducted online and transcribed with permission. Each interview began with brief demographic and contact-pattern questions, followed by six open interview questions exploring meaningful conversation, emotional impact, and barriers, closing with an open invitation to add further thoughts.

Piloting and Refinement:

The interview guide was piloted and refined after the first interview. Initial feedback showed that the opening question (asking participants to recall a conversation they had "always kept close to their heart") was too broad and difficult to answer without prompting. The question was restructured to give participants a clearer emotional entry point, asking about a time they felt low or alone and a family conversation that helped. This revised version was used for interviews P002 through P007.

3. Ethics: How I Conducted the Research Responsibly

Consent and Information: Participants were provided with a Participant Information Sheet explaining the study's purpose, what participation involved, and their right to withdraw without giving a reason. Participants were given up to one week to decide before completing a Consent Form.

Formal Approval: The study was reviewed and approved through Coventry University's formal research ethics procedure, with no significant risks identified.

Anonymity and Data Protection: Each participant was assigned a unique ID (P001 to P007) used in place of their name. Names of other individuals mentioned were redacted. Consent forms were stored separately from interview responses. Data was processed in accordance with UK GDPR and the Data Protection Act 2018, with Nottingham Community and Voluntary Service (NCVS) acting as Data Controller.

4. Reflection on the Research Process

Conducting these interviews highlighted how much interview design shapes the richness of qualitative data:

What Went Well: Actively transcribing interviews, rather than relying solely on handwritten notes, allowed for far richer data and deeper thematic insights than originally anticipated.

Challenges and Adaptations: The initial opening question proved too abstract. Learning to pivot and reframe the question around a specific feeling (a moment of feeling low or alone) made it much easier for participants to engage and respond with rich emotional detail.

Future Adjustments: In future iterations, I would build in more specific prompt structures around care settings earlier in the guide to better draw out perspectives on elder care.

5. Data Analysis: How I Made Sense of the Data

Interview transcripts were anonymised, cleaned for readability, and coded using a reflexive thematic analysis approach. Codes were grouped into five overarching themes reflecting patterns of shared meaning across participants, directly linked back to the study's research objectives.

6. Findings: What I Discovered

Theme 1: Meaningful conversation is defined by mutual investment and vulnerability, not by subject matter

Participants consistently rejected the idea that a meaningful conversation had to be about a specific topic or a rare, memorable event. What made a conversation count was whether both people were genuinely present and willing to be personal.

> **"Both parties communicating are invested in the conversation [not that] I'm talking and the other person is not really interested."** — *P001*

> **Being able to "share my vulnerabilities" with someone is what made him feel closest to them.** — *P003*

Theme 2: Family conversation functions as a real-time emotional regulator

The strongest and most consistent pattern was that conversation visibly changed participants' emotional state in the moment. Presence often mattered more than active problem-solving.

> **P001 shared how her husband's encouragement during a difficult job search "helped me trust myself again and kept me going."**

> **P006 described a difficult decision that felt like it had been "opened up" after talking it through with his mother and partner.**

P002 explained that after a bereavement, her husband **"didn't try to fill the silence with words... his presence alone told me he was there for me."**

P005 observed that support was often **"less about advice and more about having somebody to listen."**

Theme 3: Conversational depth is inherited in childhood, then actively defended in adulthood

Barriers and enablers proved to be two sides of the same coin. Participants from families that modelled openness found it easier to sustain deep conversation as adults (P003 noted: **"how a child is raised shapes how willing they are to open up later"**), whereas others had to consciously build it.

P007 recalled his family **"focused on providing practically rather than checking in emotionally,"** leading him to deliberately build a different, more open relationship with his father and children.

P006 noted: **"people avoid difficult conversations because they don't want to offend the other person, but avoiding them is what causes people to drift apart."**

P001 observed that spending more time with colleagues than family can cause people **"to slowly drift without realising it until the gap has already grown."**

Theme 4: Shared memory, more than presence alone, reconnects isolated or older relatives

Speaking directly to care home contexts, participants pointed to reminiscence and tailored engagement as what actually helps isolated relatives:

P003 explained that asking older relatives **"about their life experiences, their stories"** keeps them, **"in a sense, alive."**

P005 suggested revisiting old memories **"can help trigger and reset parts of their memory,"** especially for those living with dementia.

P002 (drawing on her professional background working in a care home in Scotland) described how looking through old photographs and letting residents **"tell stories, without rushing them"** visibly changed their mood.

Theme 5: Family conversation is positioned as a trusted, free alternative to therapy

Emerging completely unprompted across nearly half the sample (P001, P002, P006, P007), participants compared family conversation to professional therapy, consistently favouring family.

"Family conversation carries more weight than something like therapy, because your family already knows your history and capability, you don't have to start from the beginning." — *P001*

"I don't really believe in speaking to therapists, I feel like I'd end up performing rather than really opening up." — *P006*

7. Linking Findings to the Research Question

Meaningful family conversations influence emotional wellbeing and social isolation primarily through two mechanisms: acting as a **real-time emotional regulator** in moments of difficulty (Theme 2), and reinforcing a **durable sense of being known and not alone** over time (Themes 1 and 3). Depth and vulnerability, not mere frequency of contact, are what create connection. For older relatives, shared memory and tailored interaction, rather than presence alone, make the true difference (Theme 4).

Surprises:

The biggest surprise was Theme 5: the unprompted, repeated comparison between family conversation and formal therapy. Because it emerged naturally across independent interviews, it represents the study's most original contribution. It strengthens the case for treating family conversation as a legitimate, low-cost complement to formal mental health services.

8. Limitations and Next Steps

Limitations:

Small Sample Size: A pilot study of seven participants recruited via convenience sampling from a single community organisation.

Potential Researcher Bias: Personal connections to some participants through the organisation may have influenced recruitment and openness.

Demographic Narrowness: Participants were concentrated in the 30–50 age range (working-age adults), missing direct first-hand accounts from older adults themselves. Findings are indicative rather than fully representative of Nottingham.

Next Steps:

The clearest next step is extending this pilot into care home settings.

Building on Theme 4 and P002's insights, a future study could explore whether equipping visiting family members with **simple, structured conversation prompts** (focused on shared memories and personality-tailored activities) measurably improves care home residents' mood and sense of connection following a visit.



Perceptions, Knowledge, Barriers and Uptake of Mental Health Services amongst Asian or Asian British Men (18+) in Nottingham and Nottinghamshire

Elina Ifeoma Ugwu, M.D.

Local Priority Area:

- Mental Health and Wellbeing (Cross-cutting priority addressing healthcare access and community support)

1. Introduction: What I Wanted to Find Out

My Research Question:

What are the perceptions, lived experiences, knowledge levels, and perceived barriers that influence the uptake of mental health services among Asian or Asian British men (18+) in Nottingham?

Why This Matters:

Mental health disparities and low uptake of support services among ethnic minority communities remain critical local public health challenges. Understanding specific community needs is vital for co-designing accessible, effective care.

As a qualified medical doctor, I was particularly interested in trying out social science approaches and methodologies to improve my clinical practice and build deeper, more empathetic relationships with patients. Engaging with citizen social science allows clinicians to step outside purely biomedical frameworks and understand patient choices through a broader cultural and social lens.

Literature / Sources Basis:

This work builds upon existing public health and socio-medical literature surrounding cultural stigma, masculinity, religious beliefs, and systemic barriers (such as language access and cultural competency) that historically impact ethnic minority communities in the UK.

2. Method: Who, What, and How

The Participants:

- **Sample Size:** Six participants
- **Demographics:** Asian or Asian British men, aged 18–54, all currently employed and educated.
- **Religious Diversity:** Three Islam, one Sikhism, two no religion.
- **Recruitment and Location:** Based across Nottingham and Nottinghamshire, reached through local community networks.

Research Approach:

A mixed-methods citizen social science approach, using structured survey questions alongside qualitative open-ended responses.

Data Gathering Methods:

Data was collected using community-based surveys/questionnaires containing both closed checklist selections and qualitative comment fields to capture lived experiences and written feedback.

Preparation and Piloting:

The survey and outreach framework were designed with guidance from mentor Dr Sinead Ouillon to ensure cultural sensitivity, clarity, and ease of engagement for community participants.

3. Ethics: Researching Responsibly

Consent and Safety:

Participants were fully informed about the study's purpose prior to engagement. Participation was entirely voluntary, and explicit consent was gathered before data collection began.

Privacy:

Strict confidentiality was maintained throughout the project. No identifiable personal information was attached to responses, ensuring total participant anonymity in data storage and reporting.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed:

Quantitative survey choices (ticked checklist barriers and preferences) were calculated and categorised, while qualitative text responses and comments were analysed thematic-style to identify common patterns, shared cultural sentiments, and systemic challenges.

Key Findings and Themes:

Theme 1: Barriers to Care

- **Practical and Systemic:** Long waiting times, extreme difficulty securing appointments, lack of service awareness, and concerns over medication.
- **Language Access:** Fluency issues and lack of non-English language provision make communicating with health professionals intimidating or inaccessible.
- **Cultural Stigma and Self-Reliance:** Traditional expectations around masculinity led two participants to state men should handle emotional problems alone. Three participants experienced mental health issues but never sought help.
- **Faith and Social Burden:** Concerns about burdening others, combined with a preference to seek spiritual support from God rather than human healthcare professionals.

Theme 2: Enablers and Service Adjustments

- **Practical Fixes:** Shorter waiting times, proper counselling, and flexible scheduling (evening and weekend appointments).
- **Representation:** Strong preference for male therapists and professionals from similar ethnic or cultural backgrounds.
- **Language Alignment:** Access to mental health workers fluent in the patients' native languages to overcome shyness and communication barriers.

Theme 3: Awareness, Culture and Trust

- **Cultural Competence:** A clear demand for care that respects individual religious and belief systems.
- **Community Links:** Desire for better awareness campaigns, stronger partnerships with religious/community support networks, and assured confidentiality.

5. Linking Findings to the Research Question

Uptake of mental health services among Asian and Asian British men in Nottinghamshire is heavily hindered by a combination of systemic barriers (long wait times, language gaps) and deep-seated cultural/religious factors (masculine self-reliance, stigma, preference for faith-based coping). However, men are open to receiving support if services are restructured to be timely, culturally representative, language-accessible, and integrated with community networks.

Surprises:

Despite experiencing mental health struggles, participants frequently chose spiritual reliance or total self-management over medical care, not out of opposition to therapy, but due to a perception that human services lack the necessary cultural and spiritual understanding.

6. Reflection, Limitations and Next Steps

Project Limitations:

Small sample size (n=6), limited to employed and educated participants, which may not capture the full diversity of experiences across all socioeconomic strata in Nottinghamshire.

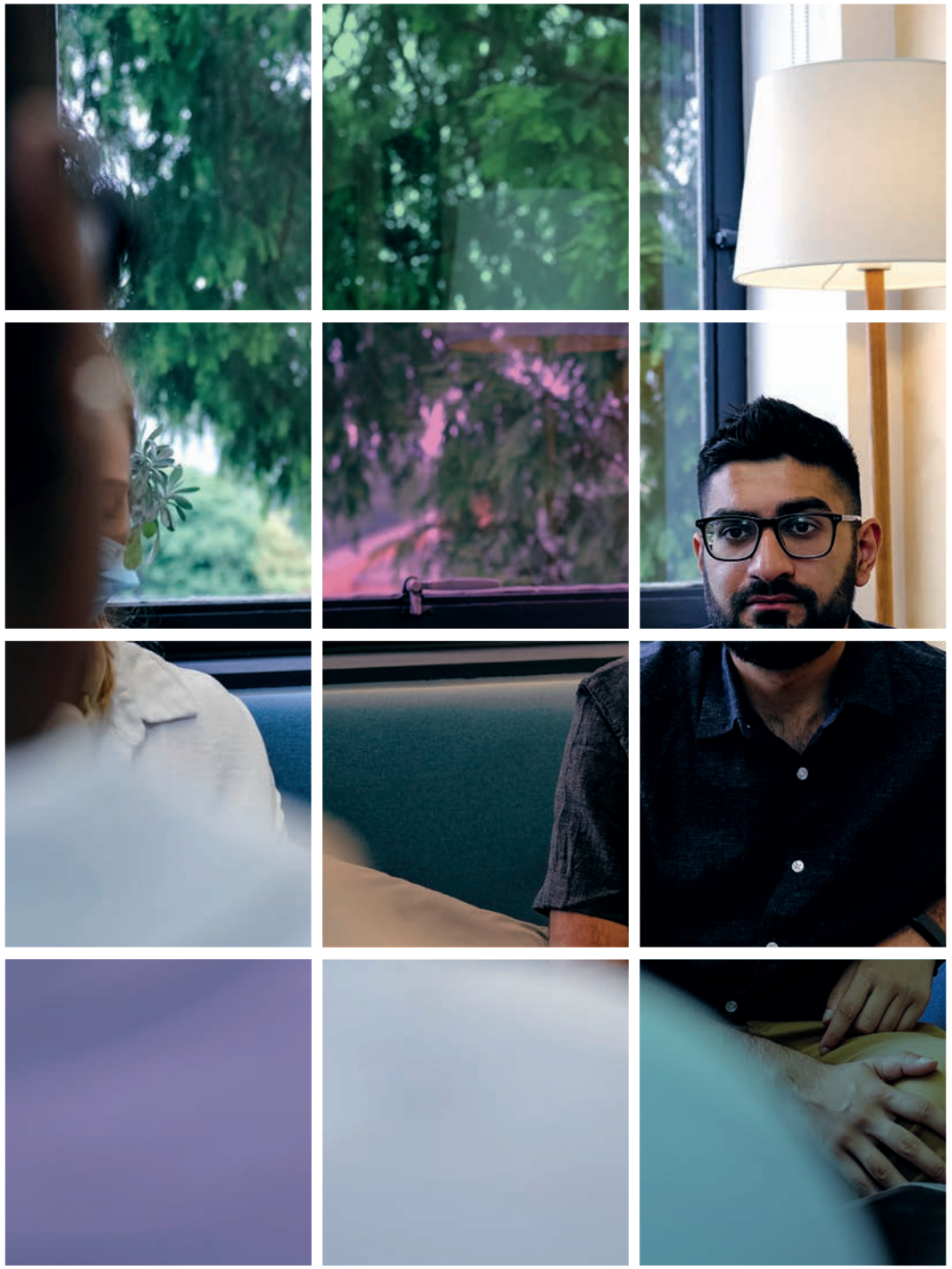
Researcher Reflection:

Fieldwork Successes: Participants engaged openly and expressed sincere gratitude for the opportunity to share their voices. Building rapport created a comfortable space for honest dialogue.

Practice Impact: As a doctor, testing social science methods reinforced that healthcare extends far beyond clinical diagnoses, understanding cultural, linguistic, and religious context is essential for building patient trust and effective clinical relationships.

Next Steps and Recommendations:

- **Expanded Research:** Conduct a larger-scale study across diverse Asian subgroups in Nottinghamshire to strengthen the evidence base.
- **Community Co-Design:** Partner with local faith groups, community leaders, and NHS teams to deliver anti-stigma workshops and co-design culturally competent services.
- **Workforce and Access:** Recruit diverse, multilingual therapists, offer evening/weekend slots, and train staff in cultural competence.



Arab Women's Health in Nottingham

Marwa Soliman

Local Priority Area

- Cross-cutting

1. Introduction: What I Wanted to Find Out

My Research Question:

For Arab women in Nottingham: What public health messages do they use? What barriers to access do they face? And what kind of public health messages do they want to receive?

Why This Matters:

As a founder and leader of a group for Arab women (Heya Group), I wanted to make sure that the lived experiences of Arab women actually shape the research. It is about amplifying voices that are too often overlooked by the system. It matters that these women are heard, seen, and have equal opportunities—not only for themselves, but for their children too.

Literature and Sources Used:

Grounded in grassroots community practice and informed by direct engagement through the Heya Group network in Nottingham.

2. Method: Who, What, and How

The Participants:

Who: Seven Arab women based in Nottingham.

Reaching them: I reached out to women from the Heya Group via phone calls and messages, inviting them to take part in either a focus group or a one-to-one conversation. Appointments were set up with those who expressed interest.

Research Approach:

- Qualitative research approach.

Data Gathering Methods:

- Conducted one focus group and one interview.

Preparation and Piloting:

- I tested the research structure and questions with my mentor prior to conducting the fieldwork.

3. Ethics: Researching Responsibly

Consent and Safety:

- Informed participants via phone calls and provided an Information Sheet.
- Explicit consent was established, ensuring participants understood the voluntary nature of the project.

Privacy and Data Protection:

- Kept participant names completely anonymous.
- Assigned alphanumeric codes (e.g. **P1**, **P2**) to transcripts and interview notes to protect individual identities.

4. Data Analysis and Findings: What I Discovered

How Data Was Analysed:

Transcribed recorded/noted sessions and highlighted key themes across focus group and interview transcripts.

Key Findings and Themes:

Theme 1: Barriers (Language, System Navigation, Lack of Trust, and Unmet Mental Health Needs)

Language and Digital Navigation: Language barriers and a profound lack of initial guidance upon arriving in the UK were widespread. Newer digital platforms (such as the NHS app) left participants feeling lost.

System Delays and Cultural Friction: Women described long waits, brief appointment slots, and an invitation system that stops when cultural boundaries are met. Example: One woman in her 50s had never been invited for a health check. Her daughter received a cervical screening letter, but when she expressed she wasn't ready due to cultural reasons, all proactive contact simply ceased.

Feeling Unheard or Judged: Women repeatedly noted that their symptoms were minimised, or they were perceived as "exaggerating" their pain.

Mental Health Gaps: While physical health pathways were generally understood, there was a complete lack of awareness regarding where or how to access mental health support services.

Theme 2: Enablers (Community Trust and Shared Cultural Backgrounds)

Trust, strong community relationships, and community-led support emerged as primary enablers.

Having access to healthcare practitioners or representatives who share their language and understand their cultural background significantly improved confidence and engagement.

Theme 3: Awareness and Interest (Desire for Early Prevention and Clear Guidance)

Participants expressed a strong appetite for clear guidance on what to expect when arriving in the UK and how to navigate health systems.

High demand for preventative health education, including regular check-ups, screening, and recognising early warning signs.

Need for culturally sensitive, reassuring women's health information that empowers rather than induces judgment.

5. Linking Findings to the Research Question

Arab women in Nottingham face significant barriers due to language, digital systems, cultural misunderstandings, and feelings of being judged or unheard. To overcome this, there is an urgent need for community-led public health approaches. Public health communication must be co-designed with Arab women, delivered through trusted grassroots organisations, community researchers, and community interpreters. This structural shift will ensure information is accessible, culturally responsive, and effective at building long-term trust.

Surprises:

Pervasive Lack of Trust Across Diverse Backgrounds: It was surprising to see how consistently women, regardless of whether they arrived as refugees, came with spouses, or had lived in the UK for decades, shared identical experiences of feeling disbelieved or judged by healthcare providers when reporting health concerns for themselves or their children.

6. Reflection, Limitations and Next Steps

Project Limitations:

Sample Size and Scope: Small qualitative sample size (one focus group, one interview), meaning findings cannot be generalised to all Arab women across Nottingham or the UK.

Single Perspective: Data captures service-user perceptions only; it does not incorporate perspectives from healthcare workers, interpreters, or NHS commissioners.

Time Constraints: Fieldwork timeframe was very short.

Researcher Reflection:

What Worked Well: Building on pre-existing community trust. Participants felt safe to speak openly because they trusted the process and wanted their experiences to influence real policy changes.

Challenges Faced: Securing suitable venues, navigating personal loss (the death of a father-in-law during the research period), and managing emotional reflexivity so personal feelings did not sway the analytical process.

Next Steps and Actionable Goals:

Short-Term: Disseminate findings to local organisations to drive structural changes.

Methodological Improvements: Allow longer timeframes (beyond a few days) for community fieldwork and ensure community participants are financially compensated for their time and lived expertise.

Long-Term Vision: Develop a co-produced, community-led health communication model. Expand this line of enquiry into a broader, multi-year study (potentially a PhD project) evaluating trust, system access, and preventative health communication among diverse Arab migrant cohorts.



Migration Impact on Family Unity and Identity in Nottingham

Nnanna Adim

Local Priority Area

- Cross-cutting

1. Introduction: What I Wanted to Find Out

This project set out to answer a single research question: how has migration affected family unity and identity among members of Nottingham's African and Caribbean diaspora community?

I chose this topic because, through my role as a Nottingham Community Champion, I regularly meet migrant families who describe feeling caught between two worlds, proud of where they come from, but reshaped, sometimes painfully, by the experience of building a new life in the UK. I wanted to move beyond assumption and ask people directly what migration had actually done to their family, and to their sense of who they are.

To do this, I partnered with the African Women's Empowerment Forum (AWEF), a Nottingham-based charity supporting African and Caribbean women and families which gave me access to a community of migrants willing to share their experiences.

2. Method: What I Did and How I Did It

My original plan, set out on my project planning sheet, was to use a mixed-methods approach with a target cohort of around six participants drawn from the African community in Nottingham via a charity contact. In practice, I carried out seven individual, semi-structured conversational interviews, recorded on video in an informal style, and I also recorded one multi-generational group discussion at a community gathering involving participants from Ghana, Sudan, Jamaica and Zimbabwe.

I chose interviews rather than a written survey because I wanted participants to be able to speak freely and at length, in their own words, about experiences that are often personal and emotionally difficult — family separation, immigration status, bereavement, racism. A conversational, informal format seemed more likely to put people at ease than a formal questionnaire, and this proved to be the case: several participants disclosed sensitive experiences (a parent's death, deportation, domestic difficulties) that I do not think a written survey would have captured.

No formal piloting phase was carried out, given the small scale of the project; the question guide was adjusted as the interviews progressed. For example, after gender roles emerged strongly and unprompted in my first interview, I made a point of asking later participants more directly about how migration had affected the roles of men and women within the family.

The seven individuals I interviewed one-to-one are summarised below. Real names have been replaced with participant codes.

Characteristic	Number of Participants
Female	5
Male	2
UK-born	1
Migrant background	6
Southern African background	3
Caribbean background	1
Arrived in childhood/adolescence	1
Arrived in adulthood	5

These participants were adults of varying ages, drawn mainly from Southern Africa and Caribbean, plus one UK-born participant of mixed Caribbean and Commonwealth heritage. This reflects the composition of the community accessing the charity I had access to, rather than a deliberately representative sample of Nottingham's wider African and Caribbean population.

3. Ethics: How I Conducted the Research Responsibly

This project was conducted under the ethical framework of the Citizen Social Science course, delivered by Coventry University. Participants were given a Participant Information Sheet explaining the purpose of the research, and asked to complete an Informed Consent Form confirming that they understood their right to withdraw, that their data would be held securely, and that they were content for their anonymised contributions to be used in course-related reports and presentations.

To protect participant anonymity in this written report, I have referred to each interviewee using a generic code (**P1**–**P7**) rather than their name. I have not anonymised the host organisation, AWEF, because it is a named community partner central to the research context rather than an individual participant, and several interview questions were specifically about that organisation's public work. Where participants disclosed sensitive personal information — bereavement, immigration enforcement, domestic difficulties, mental health — I have handled this material carefully, reporting only what is necessary to answer the research question.

4. Reflection on the Research Process

Overall, the process went well. Access through a trusted charity partner meant participants were open and candid, and I collected considerably richer data than the six interviews I had originally planned for. Nearly every participant, without being specifically asked to comment on the charity in every case, chose to speak about the value of community support — an unplanned finding in itself.

The main challenges were practical. Several disclosures were emotionally heavy — one participant described losing her father, her mother becoming a widow, and later losing her husband, all while she was unable to travel home during a delayed immigration process — and I had to be mindful of not pressing participants further than they were comfortable going.

If I were to repeat this project, I would use a quieter, private setting for interviews, apply a single consistent question guide across every interview (some conversations, particularly with charity staff, focused more narrowly on the organisation's work than on family and identity), and try to recruit participants through a second, different community organisation to reduce the extent to which my sample reflects one charity's specific membership.

5. Data Analysis: How I Made Sense of My Data

I reviewed the video and transcript of each interview and used basic manual coding, highlighting words and ideas that came up repeatedly — such as “belonging”, “identity crisis”, “racism”, “separation”, “support” and “community” — and grouping related codes into broader themes. Because this was a small qualitative sample rather than a survey, I have not produced charts or statistics; instead, the findings below summarise the patterns, and the differences, that emerged across the conversations.

6. Findings: What I Discovered

Eight themes emerged consistently across the interviews.

a) Fractured family units

Several participants described family unity being damaged by physical separation. P2 described leaving three young children behind after being removed from the UK in 2009, only reuniting with them in 2021; rebuilding that relationship, he said, **“was really difficult. It's still difficult”**, though he added that things were slowly improving. P1 recalled the pain of being separated first from her own parents and then from her own children while they waited to join her:

> **"I felt so lonely, so isolated. I feel like I'm in the middle of nowhere."** - *P1*

For P5, migration coincided with a string of bereavements at home — her father's death, her mother becoming a widow, and later her husband's death — none of which she could properly grieve while still awaiting leave to remain: **"A broken journey, a broken life, and a broken family."** P6 arrived with his mother, who died six months later, leaving him without family in the UK. P7 did not see her daughter, sister or wider family for almost ten years while her asylum claim was processed.

b) Divided and hybrid identities

Several participants described their identity as split between two places rather than settled in either. P5 put this most directly:

> **"It's kind of a divided identity really... it's almost like you don't belong here nor there."** - *P5*

P5 added that she felt she suffered from an **"identity crisis"** because her identity was **"not defined the way I want it."** P1 used a similar phrase to describe her children rather than herself, saying they **"suffer, like identity crisis"** as they try to fit in at school, while she has kept her own sense of self intact: **"you can't take the Shona out of me."**

c) Second-generation identity and language loss

A recurring worry among the parents interviewed was that their children were losing language and cultural grounding. P1 explained that children pick up English so gradually that **"by the time they realise they know English, they've lost their language,"** and described children visiting Zimbabwe being treated as outsiders by their peers there. This theme also emerged in the community group session, where several younger participants and parents spoke about wanting shared spaces to learn traditional cooking, dance and language, precisely because these were not being passed on automatically.

d) Racism and the burden of self-defence

Racism was named directly as a major and ongoing barrier. P3 described it as the toughest thing she has faced in the UK, explaining a particular double-bind: **"even though you're defending yourself, you might end up being the culprit,"** meaning she felt she had to carefully manage how she expressed herself to avoid being labelled aggressive. P2 listed racism alongside peer pressure as defining features of settling in Nottingham as a young man.

e) Shifting gender roles and family strain

P1 gave the most detailed account of how migration reshaped roles within families. She described men losing status because professional qualifications from home were often not recognised, forcing many into industrial or care work, while women in her community moved disproportionately into care and nursing roles. She linked this shift to increased strain and, in some cases, domestic difficulty, contrasting men's reluctance to seek help with women's greater openness to informal support networks such as church groups and **"girl talk."**

f) Community and the charity as protective anchor

Every interviewee, without exception, spoke positively about AWEF. Participants described it as a **"safe space"** (P1), a source of confidence when navigating immigration processes (P2), and a rare space specifically addressing migrant women's needs that mainstream funding does not reach (P6, P7). P4, who was born in the UK but has extensive migrant heritage in her own family, described the charity as giving her **"a good sense of well-being and**

community”, and P5, the charity's founder, explained it was built to give women **“this space of being us in our own corner.”**

g) A contested sense of belonging

Belonging emerged as genuinely disputed rather than settled. P2 concluded that he does belong in Nottingham, reasoning that being allowed to return after removal was itself evidence of acceptance. P5, by contrast, described living **“a double life”** — feeling she belongs in the UK only on the surface while her “heart belongs” with family still in Zimbabwe. P3 went furthest, stating she has **“never supported”** migration and arguing that the stresses she associates with life in the UK would not exist at home, where community support is close at hand.

h) Structural and economic barriers

Several participants pointed to obstacles beyond personal experience: substandard temporary housing without heating or hot water (P7), a slow and uncertain immigration process that kept people apart from family for years (P1, P5, P7), the “no recourse to public funds” restriction that leaves many unable to access mainstream support (P6), and the low level of financial support for asylum seekers, which P7 argued the UK government should raise.

7. Linking Findings to My Research Question

This project asked how migration has affected family unity and identity in Nottingham's African and Caribbean community, and the interviews go a long way toward answering that. Family unity was consistently described as something migration disrupts rather than simply relocates: separation from children, parents and spouses — sometimes for a decade or more — was a near-universal experience among the participants who had migrated as adults, and several described bereavements that could not be properly mourned because of immigration restrictions. Identity, meanwhile, emerged as something migrants actively renegotiate rather than lose outright: most first-generation participants described holding on firmly to their identity of origin, while worrying that their children risk losing that connection through language loss and pressure to conform at school.

What surprised me most was how consistently participants pointed to community organisations, and specifically AWEF, as the thing that made the impact of migration more bearable — this came up unprompted in almost every interview, regardless of the specific question asked. I was also struck by how differently belonging was experienced even within the same broad community: P2's confident sense of belonging sits alongside P5's description of a **“double life”** and P3's explicit rejection of migration altogether, which shows that the migrant experience in Nottingham is not one story but several.

8. Limitations and Next Steps

This was a small, opportunistic sample: seven individual interviews and one group discussion, recruited entirely through a single charity partner. This means the sample is skewed toward women (five of seven individual interviewees) and toward people of Southern African origin (four of seven), and it says more about AWEF's specific community than about Nottingham's African and Caribbean population as a whole. Interviews were recorded in an informal, semi-public setting rather than a controlled research environment, and automated transcription introduced some errors that had to be manually corrected. Working within a short course timeframe, I was also not able to follow up with participants after the initial conversation, so this is a single snapshot rather than an account of how views change over time.

For future research, I would like to run a dedicated focus group with second-generation young people, since this project relied on parents' accounts of their children's experience rather than young people's own voices. I would also like to recruit through a second, different community organisation to broaden the sample beyond one charity's membership, and to explore whether the strong, consistent finding about the value of community organisations like AWEF holds true more widely across Nottingham's migrant communities.

Exploring Social Integration and Community Support at Harvest Community Café, Nottingham: A Multicultural Setting

Sadia Tahiru

Local Priority Area:

- Community Support and Social Cohesion (Local Hub / Health and Wellbeing Strategy)

1. Introduction: What I Wanted to Find Out

My Research Questions / Aims:

- To examine how the café facilitates interaction among a diverse population of participants.
- To identify the activities and informal support systems that enable such integration to take hold.
- To highlight the social and personal barriers that continue to limit fuller participation for some visitors.
- To consider practical opportunities through which future inclusivity might be strengthened.

Why this matters:

Community cafés serve as vital spaces where individuals from diverse cultural, social, and economic backgrounds meet, interact, and access practical support. Far beyond providing food, these spaces are mechanisms for combating loneliness and building relationships across diverse populations. Harvest Community Café in Beeston, Nottingham (run by Harvest Chapel International) functions as an inclusive indoor space offering shared meals, informal support, and a buffer against the cost-of-living crisis. However, while some attendees build strong networks, others simply collect food parcels and leave. This study explores what factors encourage or hinder deep community engagement within such spaces.

Literature and Sources Used:

The study is grounded in research on community spaces, social inclusion, and commensality (Brito et al., 2023; Sumpter et al., 2024).

2. Method: Who, What, and How

The Participants:

Sample Size: N=7 participants (plus one individual used for piloting).

Demographics and Roles: Included regular attendees, volunteers, and university students across various ages and cultural backgrounds with direct experience of the café.

Recruitment: Combined voluntary and convenience sampling. Three participants volunteered after hearing about the study at the café, while four were directly invited by the researcher due to their regular attendance.

Research Approach:

Qualitative research design using semi-structured interviews to afford participants the flexibility to articulate their perspectives in their own words.

Data Gathering Methods:

Face-to-face, semi-structured interviews conducted in English, recorded, and transcribed verbatim.

Preparation and Piloting:

The interview schedule was piloted with one individual (excluded from the final sample) to assess question clarity, relevance, and flow, leading to reworded questions and additional follow-up prompts.

3. Ethics: Researching Responsibly

Consent and Safety:

Ethical approval was granted by Coventry University. Participants received a Participant Information Sheet detailing the study's purpose and voluntary nature. Written informed consent was obtained prior to interviews, including separate consent for audio recording. Participants were informed of their right to decline questions or withdraw at any time.

Privacy:

To protect confidentiality, participants were assigned anonymised codes (Participant 1 to Participant 7 / P1–P7). No real names were used in transcripts or reports, and data were securely stored with password protection.

4. Reflection on the Research Process

What Went Well:

Pre-existing familiarity as a regular visitor helped establish immediate trust, allowing participants to speak candidly about sensitive topics like financial hardship, loneliness, and grief.

Semi-structured interviews allowed natural conversations, uncovering unexpected insights such as informal academic writing help and career advice.

Challenges and Adaptations:

Background Noise: Conducting interviews on-site during active operational hours created environmental distractions and transcription challenges.

Scheduling: Was challenging due to café opening hours not always aligning with individuals' schedules.

Managing Bias: Required constant self-awareness so that findings reflected participant accounts rather than personal expectations.

Future Improvements:

- Arrange fully private, enclosed rooms or schedule interviews outside peak hours.
- Establish alternative contact methods earlier to avoid reliance on weekly sessions.
- Dedicating specific recruitment toward first-time or newer visitors.

5. Data Analysis and Findings: What I Discovered

How Data Was Analysed:

Reflexive thematic analysis (Braun and Clarke) was used to transcribe, code, and group data into four overarching themes.

Key Findings and Themes:

Theme 1: Building Social Connections and a Sense of Belonging

Regular attendance fosters repeated contact that develops into meaningful, cross-cultural relationships.

> **"It has afforded me the opportunity to learn about different cultures... I think it has actually helped me to understand others as well."** — *P2*

> **"Interacting with people from different backgrounds seems a bit challenging at first... but going forward, if you get to know the person better, you are able to find common ground."** — *P3*

> **"The sense of belonging means a lot to me... makes me not miss home too much, if I should say."** — *P4*

> **"Initially, when I came, I was very sad because I didn't have anybody to talk to. And now I feel at home."** — *P5*

> **"Most of us came here as visitors, but now we don't see ourselves as visitors anymore. We see ourselves like family."** — *P6*

> **"Everyone from here has took everyone under their wing. So, it makes me feel happy... It's like a close-knit thing."** — *P7*

Theme 2: Environmental Mechanisms and Shared Activities as Enablers

Shared food, affordable meals (e.g. £1 breakfast), round-table seating, volunteering, and activities (Zumba) act as key connection channels.

> **"Where there's food, there's conversation. Once there's food available, people come, people eat, and you end up talking to the person beside you."** — *P5*

> **"What place can you get breakfast for 1 pound, seriously?... that's really good value for money... and meals change every week to suit everybody."** — *P7*

> **"You're not sitting in isolation... you're sitting around different people that you didn't think you'd be able to sit next to. And that's how communication starts..."** — *P7*

> **"It's brought me out of my shell to communicate with all different types of people... It gives me that confidence talking to a completely different stranger."** — *P7*

> **"Zumba helps the women to come together and exercise... and it helps them interact."** — *P6*

Theme 3: Community Support, Empowerment, and Practical Benefits

Food assistance reduces financial pressure, while informal networks offer emotional support, assignment/academic writing help, and CV/employability skill-building.

> **"The community supports me in a lot of ways... helping me manage my finances because I am able to get a lot of things here for free..."** — *P3*

> **"I've had grief... and coming here, I know I have support, that I'm not grieving on my own."** — *P7*

> **"They have these programmes or activities where they help with school assignments and academic writing... it's really helped me."** — *P6*

> **"I placed this volunteering on my CV... and customer care experience helped open more doors for me."** — *P5*

> **"I would never say, oh I will do that for you, but now I always stand up and say, 'I'll take part.... it just makes me feel like I'm somebody and not nobody."** — *P7*

Theme 4: Barriers and Opportunities for Strengthening Inclusion

Barriers: Language/accent friction, established subgroup clustering (church members vs. outsiders), social anxiety, and irregular attendance.

> **"The intensity of your accent may not be understood by me... the conversation ceases because we can't flow..."** — *P7*

> **"Difference in mindset, because we all come from different countries... Sometimes you meet someone and the initial feeling you get from that person, it doesn't allow you to continue."** — *P5*

> **"The most consistent people are mostly from the church... I don't think social interaction is 100%... others don't interact as much as we interact with each other."** — *P5*

> **"I don't like socialising, because I have anxiety... before I came to community café, I never used to speak to people that I didn't know."** — *P7*

Participant Recommendations: Formal greeters, multicultural food events, indoor family games, and digital channels (Facebook/WhatsApp) for quieter attendees.

> **"It would be good if someone welcomed new people when they arrive and introduced them to others, so they don't feel alone."** — *P6*

> **"Games and activities... bring people together... that day I spoke to someone I didn't speak to before..."** — *P4*

> **"People who are very quiet and cannot interact face to face can utilise the media to interact."** — *P4*

6. Linking Findings to the Research Question

Harvest Community Café functions as a vital catalyst for social integration and wellbeing. Integration is a dynamic process facilitated by shared seating, cheap meals, volunteering, and activities. However, co-location alone does not guarantee integration; language barriers and church-subgroup clustering can leave some attendees peripheral.

Surprises and Deeper Insights:

The extent of organic peer-to-peer practical support—specifically spontaneous mentoring around academic writing, assignments, and CV building—was an unexpected, significant finding showing the café functions as a broader hub for personal development.

7. Limitations and Next Steps

Project Limitations:

Small convenience sample (n=7) from a single site.

Captured mostly highly engaged, active visitors rather than disengaged or short-term attendees.

Risk of insider bias due to researcher familiarity.

Cross-sectional design capturing a single point in time.

Next Steps and Recommendations:

For Practice: Introduce a dedicated greeting role for newcomers, organise multicultural food/game events, and maintain active social media spaces (e.g. Facebook/WhatsApp).

For Future Research: Explicitly recruit first-time visitors and non-English speakers; utilise longitudinal designs to track integration over time; compare multiple community hubs.



