Religion, community, and starting somewhere: How we can support minoritised ethnic men to have better mental health.

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Introduction from Ceri Durham, CEO, Social Action for Health

Thank you for your interest in our project which has been running over the last two years to investigate and support the mental health of men from minoritised ethnic groups in our local community. It is always interesting to emerge from the detail of day-to-day running and appreciate the bigger picture of what you have been working on. We sought funding for this work more than two years ago, thinking that life would be beginning to go back to so-called 'normal' post-COVID19 pandemic. Since this time, the country has continued to change: the way we live and work, the death of Queen Elizabeth II and coronation of King Charles III, the comings and goings of three prime ministers, and a massive cost-of-living crisis disproportionately impacting the people we exist to support.

A project of this nature cannot happen without a committed and dedicated team, those at the front line and those behind the scenes dealing with all sorts of hidden aspects, reporting, venue bookings, GDPR, health and safety and more. There are too many people to thank individually. Specific thanks must go to Johnson & Johnson who funded this project and without whom it would not have been possible. I also thank the team from Queen Mary University of London: Jennifer Randall, Disha Saran and Maria Camila Gomez Mojica. They supported us through literature reviews, ethics review and sign-off and data analysis. Also, and most importantly, thanks must go to the members of our communities who have trusted us to join our activities, told us when we have got it wrong, attended groups, shared findings and information about what they know will help them and their communities improve their health.

Ceri Durham
February 2024

Executive Summary

Social Action for Health is a community-based health charity providing services and support to people most affected by health inequalities. We are based in Tower Hamlets and work across east London. Our Mission is to support and address the priorities of those most affected by health inequalities, and to champion the case for wider structural and societal change.

We support this work through a community research strand, working with universities, institutions, and other charitable organisations to facilitate research that will leave communities stronger, more empowered, and with the information they need to address inequalities. This report offers an overview of the findings of our Men's Mental Health project, combining provision of social support services with community research to learn more about and support minoritised ethnic men's mental health in east London.

Alongside several large-scale community engagement events and a survey with over 1,065 responses from minoritised ethnic men in Hackney and Tower Hamlets, we delivered practical and creative group activities to over 325 men to facilitate discussion about mental health while providing activities intended to help improve mental health. We predominantly worked with Asian men in Tower Hamlets and Black men in Hackney.

Whilst this project largely confirmed the assumptions held around this topic from the start, we gained considerable insight which has informed a much fuller picture of how these communities interact with 'mental health' and how we might best provide support to address challenges. It has made us confident in our recommendations.

There have been four main sources of learning throughout this project:

1. Event and focus groups;
2. Social support groups;
3. Responses from a large-scale community survey; and
4. Delivery reflections.

In many ways, the experience of running and reflecting on the project has taught us as much as the activities themselves.

Key themes emerging:

a) **Religion and spiritual beliefs:** religion and spiritual beliefs cannot be separated from the conversation around minoritised ethnic men's mental health. If services are to fully engage with providing racially and culturally appropriate services in this area, they have to find ways to be able to reflect this core part of people's identity. We want to explore further how this might work – can we teach secular institutions to understand religion? How might we support religious spaces to understand secular support and recommendations?

b) **Trust:** trust is vital to engage communities around such a sensitive topic. Trust has to be earned and a relational approach is key. The area of mental health is full of taboos, stigma, different approaches and beliefs. Mistakes will be made. In order for these not to cause harm, but rather enable a further move towards improving mental health, trust and genuinely positive relations need to be established.

c) **Perception of mental health:** many people are living with what would be considered in a professional health context as 'mental health challenges'; but these are seen as so much part-and-parcel of everyday life, that many people do not see these challenges as something that could be improved. There is also limited awareness of 'low level' mental health conditions, or that improving general wellbeing might be associated with improving mental health.

d) **Options:** availability of varied activities to support people to maintain positive mental health is key. No two experiences are the same, and so flexibility is key in the support offer to cater for different people in different ways at different times across the mental health 'spectrum'.
e) **Community:** mental health challenges also impact the people around the person struggling. There is potential for the community to play a big role in helping to support people, although it can also present a barrier.
f) **Difficulty knowing 'how' to talk about mental health:** people generally want to be able to talk about mental health, especially when they realise that it can be considered part of everyday life and overall wellbeing. However, people do not know how, Conversations are not normalised and there isn't (yet)the language to discuss this topic openly and fully.

Key recommendations: where do we go from here?

a) **Get comfortable with being uncomfortable:** It is essential for providers to build cultural competence, and be able to bring religion, faith, and culture into the conversation around mental health. Be prepared to think about your own biases and what learning / un-learning you might have to do.
b) **Community Support will make the biggest improvement:** If people do not identify as suffering with mental health difficulties, they will not seek support in health settings until they reach crisis point. Funding has to be in communities at grass root level to ensure there are places and people around who can support, signpost and provide services where people are, not where the system expects them to be. **Ensure varied, relevant options:** Intersectionality is key. No one size will fit all. We need to ensure there are plenty and varied options for mental health management that are culturally accessible to the target groups. This aspect of 'culturally accessibility' will vary.
c) **Start somewhere**… and maybe somewhere unexpected?: The task of addressing this topic can feel overwhelming. We recommend the approach of starting somewhere and being open to change and adapting. It may be directly addressing a specific issue, or it may be something that helps someone to feel like more than the total of their issues, and feel like a person again. Can a short woodwork course improve mental health and be part of the journey of recognising mental health issues? Yes it can!
d) **Support the 'whole' person, and the community around them:** Women are carrying a disproportionate burden of supporting men with mental health difficulties. We must consider how we can support the community around men, encouraging and enabling conversations, openness and understanding that reaches homes, community spaces, and workplaces, and spans generations. We must also address mental health challenges alongside, or via, their potential root causes including social determinants of health.
e) **Commit to it… long-term**: In terms of engaging with the community, building trust and having a reputation for reliability is key to engaging on a large scale. Questioning our approaches and practices through this lens in all we do will make a huge difference. There are no silver bullets or quick-fixes.
f) **Funding** – it probably goes without saying that more funding is required. More research, more offering of activities. If we are to ensure sufficient opportunities to address poor mental health from low levels to prevent escalation to crisis support, funding needs to be long-term and consistent.

What next?

Stay in touch! We are looking for partners to work with us, fund us or to reflect and learn with us. If you would like a copy of the raw survey data on request for your own analysis, to consider partnership working or project ideas, please get in touch – email: info@safh.org.uk. It is only by working together with a joint aim of improving our communities' health, will we make the change we all want to see.

About Social Action for Health

Social Action for Health is a community-based health charity providing services and support to people most affected by health inequalities. We believe that poverty, discrimination, prejudice and inaccessible systems across society are leading to an unequal distribution of good health. Our Vision is a world where unfair and avoidable health inequalities no longer exist. Our Mission is to support and address the priorities of those most affected by health inequalities, and to champion the case for wider structural and societal change. We aim to:

- Increase people's ability to identify personal priorities and goals;
- Increase people's confidence to make decisions about their health and wellbeing; and
- Increase people's ability to act on their decisions.

Our free services and support equip communities across east London to manage their health, improve wellbeing, and make positive decisions for themselves, their families and communities. Activities are delivered in an accessible, sensitive, and culturally appropriate way, supported by staff who often speak at least one community language. We support this work through a community research strand, working with universities, institutions and other charitable organisations to facilitate research that will leave communities stronger, more empowered, and with the information they need to address inequalities.

This project, focusing on minoritised ethnic men's mental health, brings together our service delivery and community research strands of work, utilising traditional research methodologies, such as a survey and focus groups, a 'test-and-learn' approach to the provision of community activities, and a 'participatory action research' lens to ensure all findings were reviewed and tested by the communities we seek to support.

Through this project, we have decided to use the phrase 'minoritised ethnic' to enable the widest group of people to self-describe as belonging to a minoritised ethnic group if that is how they identify. Initially the phrase "Black, Asian and Minoritised Ethnic" sometimes shortened to the acronym "BAME" was used in answer to the funding call, but we are pleased to have moved away from this language which does not accurately reflect either our communities or our nuanced way of working and instead lumps people together in an impersonal way. We use "minoritised ethnic" rather than "ethnic minority" to reflect how people from different ethnic groups have been minoritised within our society, even where they represent the global or local majority. It is highly likely that an evolution in our language will continue.

What we thought we knew

Our 35+ year background supporting the health of local communities alongside academic literature has given us significant insight into the challenges associated with the mental health of minoritised ethnic men. The need for a renewed and targeted focus in this area became increasingly apparent during the COVID-19 pandemic, where we noted from our community engagement work that men from the Tower Hamlets Bangladeshi communities seemed to be suffering greatly. Many men reported stress from either loss of work from 'gig economy' jobs, or otherwise facing the stress of a being required to keep working outside of the home when the rest of the community was being

asked to work from home. This, combined with the loss of social times at mosques and other community spaces, families being ill with COVID-19 and pressures of multi-generational families being confined at home, led to further emotional and mental health difficulties. We were fortunate to secure long-term funding which allowed a multi-faceted approach to research and delivering social support groups, seeking to support and improve minoritised ethnic men's mental health whilst learning more about the challenges and realities of this issue.

We considered a number of assumptions, theories and anecdotal 'truths' as we began this piece of work, including:

- Significant stigma and taboo shaping understanding of mental health, which would have to be considered at all levels when engaging with this work; from the words used to describe 'mental health' in different languages to maybe not having specific words at all.
- People would be interested - we felt that as mental health challenges touch so many people's lives, and even more in light of COVID-19, there would be an appetite for community member and community partners to engage with this topic, if presented in a sensitive and appropriate way.
- Intersectionality – mental health is a complicated subject with multiple factors contributing to how people experience it on a personal and community level. Jobs, physical health, religious wellbeing, family relationships, childhood experiences all feed into what is generally described as 'mental health'.
- There is no one size fits all. Different communities and different spaces affect people's willingness to discuss this topic – or not – with different people. Sometimes people prefer to talk to someone 'like them'. Other times, people want to speak with someone from outside of 'the community' to mitigate fears of stigma and gossip.
- Language Barriers – both English and in terms of health literacy. We thought people might not know the words around 'mental health' in either their own language or English and also might have significant barriers knowing where to access support, how 'the system' works, how GPs might fit in with crisis mental health etc.

Whilst our assumptions were largely proved correct over the life of the project, we gained considerable insight not only from the activities themselves - survey, focus groups and discussions, social support groups - but from the way we conducted the activities and anecdotal feedback from delivery staff and members of the wider community collected along the way.

Methodology

There have been four main sources of learning throughout this project:

1. Events and focus groups;
2. Social support groups;
3. Responses from a large-scale community survey; and
4. Delivery reflections.

Below, we outline the methodology and/or approaches for each.

We predominantly worked with men who self-described as Bangladeshi in Tower Hamlets and Black men in Hackney throughout this project, seeking to understand the specific challenges and support needs of each community

through our work, and noting where there are commonalities and differences in the approaches required to better support minoritised ethnic men's mental health more broadly.

1. Events and focus groups

After initial project planning, we started our project with a 'Big Conversation' event in June 2022, which had good attendance from local community members, statutory and charity/community healthcare and health-related services. People attended to share their views on current barriers, enablers and topics about mental health along with recommended priorities for future work. 88 people attended in total to listen to the speeches and take part in table discussions:

- 67% of participants were male,
- 61% identified as being a man from a minoritised ethnic background.
- Overall, 82% were from minoritised ethnic communities.

Our initial 'Big Conversation' was extremely effective in engaging the target group in discussion around their mental health and wellbeing, and building trust with Social Action for Health which proved vital for subsequent engagement.

> *"I really found the speakers sharing their experiences, found their stories to be an inspiration. We need more people to be open and welcome this type of conversation".* Event attendee.

This event demonstrated the need and willingness for conversation and intervention around minoritised men's mental health within these communities. Insights from this initial discussion, as well as from the social support groups, informed our large-scale survey which was conducted in Summer 2023. Following this, we hosted two further community engagement events, one in Hackney and one in Tower Hamlets, returning the findings to the community and reflecting on the questions, process and results together. These events had 184 attendees in total. Including men from the target communities, GPs, community members, religious leaders, and those working in local health care and community organisations.

This feedback process is a very important part of our research process, creating opportunities for feedback from the community at every stage, and ensuring the research benefits and leaves communities stronger, rather than being an 'extraction'. People were comfortable and confident offering their feedback, and through these events, it became evident that the survey findings largely resonated with the community and with local council and social sector leaders, particularly the conclusion that there needs to be lots of different options available to these communities, as one approach will not work for all. There was a consensus that more of these conversations need to be available to open up discussion about this topic and support greater understanding across the community.

> *"This is a huge topic everyone needs to be involved in so we can make a change."* - Event attendee

We were also able to gain feedback on the questions asked and understand how we may have been able to reframe certain aspects to increase the accuracy of results (in particular the results from the question 'Where would you feel most comfortable talking about mental health?' would have been more revealing with ranked responses.) We posed additional 'messy questions' on the day for further discussion, specifically *'How do we equip men from minoritised*

ethnic groups to identify 'when something is not quite right-enough' to seek help and support and then to go and get that help?', responses to which echoed the survey findings (ie: no clear 'one-answer' emerging).

Ultimately, the conclusion was that we have to continue to work in any way possible to:

- increase understanding of what 'mental health' is, beyond perceptions of 'craziness',
- have groups and services which can cater for the full range of mental health need; from keeping people in good mental health by provision of affordable and fun activities, to equipping people to name and be able to prioritise anxiety and depression, to being able to support safely in the community people who live with serious mental illness.
- recognise and discuss the barriers to men engaging with the topic of mental health and work together at all levels of the community and health care services to address the issue(s) at a local level.

2. Social support groups

From September 2022, we started running a series of social support groups designed to engage men on the topic of mental health. Knowing the challenges around engaging minoritised ethnic men on this topic due to the taboo and stigma prevalent in these communities, we decided to offer practical, creative or fun activities that would allow us to open up discussion about mental health in an indirect way, while simultaneously providing opportunities for activities known to help improve mental health. We ran and evaluated the following groups:

- Bengali Woodwork for Wellbeing (Tower Hamlets);
- ESOL Conversation Club (Tower Hamlets),
- Turkish / Kurdish Photo-Voice Workshops (Hackney),
- Wellbeing Wednesday Exercise Sessions (Tower Hamlets); and
- Black Men's Coffee and Conversation Club (Hackney).

Sessions began in Tower Hamlets with mostly Bengali participants, where this approach proved effective, and enabled us to highlight the relationship between 'wellbeing' and 'mental health' on a spectrum, as well as create a safe space in which men could explore their own relationships with mental health. As we expanded the groups to Hackney and a majority Black participant group, we found that being more explicit about offering groups to support with mental health was effective, and introduced a 'Black Men's Coffee and Conversation Club', specifically inviting men to come and talk. This reflects our 'test and learn' approach to running the activities - we listened to the feedback from participants and tailored the offer to include those activities most effective in engaging each community of men around the topic of mental health and supporting an improvement in mental health and wellbeing.

Men across the board have expressed a strong awareness of the importance of exercise on their mental health. Some talked about frustrations of being in mental health units, prescribed medication they did not want and not being able to get out and exercise. Others, particularly our Bangladeshi community talked about their preference for community-based exercise activity, particularly those that feel 'fun'. This feedback grew into our 'Wellbeing Wednesday' sessions in Tower Hamlets, focusing on physical activity in a group setting, and in emerging gym-based sessions in Hackney. It has also been vital to target and tailor different sessions to the specific nuances of each community (in terms of culture, status, perspective etc) to achieve consistent engagement. A key part of the

sessions is to be checking in and talking about how everyone's week has been, mentioning mental health explicitly and ensuring follow up with issues raised. This has been a very successful model.

> *"When we talked to each other on Wednesday at Brady Center and laughing during our exercise and discussion, we forgot our anxiety and stress. It is most beautiful moment."* - 'Wellbeing Wednesday' participant

To date, we have had 325 fully-registered participants across our social support sessions. Results from the short Warwick-Edinburgh Mental Wellbeing Scale, conducted at the start and end of workshop series, showed that the majority of participants progressed from low wellbeing scores to moderate wellbeing scores during the engagement. The findings of low wellbeing resonate with our wider findings that men are often living with mental health and other difficulties as part-and-parcel of 'normal' life. It is often only through participating in groups and conversations that people realise that they can do something about improving their mental health and emotional wellbeing. One participant shared with the group after one year of regular attendance that he suffers with anxiety. It took this long to be comfortable to share in the group.

100% of project participants who completed our evaluation all reported that:

- their health and/or wellbeing improved
- they gained helpful life skills and/or experiences
- their engagement had been a worthwhile experience for them overall.

Some illustrative comments from participants participating in the groups include:

> *"It is great for community and make happy everybody!"*
>
> *"I want to do more exercise and continue it. Because it will help my health i.e., reduce BP and good for reducing stress."*
>
> *"Events like this session would be needed for everybody across the community."*
>
> *"This workshop is not just about learning about photography. It's a great tool for us to regain our self-confidence and communicate healthily with others. Thanks to this workshop series, I have met many different people in my life that I could not have imagined meeting at the same table. And it's amazing to be able to all share things together. It's been three weeks since I started the workshop, but I've seen an incredible positive effect. It took me out of my little world and opened a different horizon. At the end of each session, I feel as comfortable as if I just got out of therapy.*
>
> *"Although my English was not good, I started to communicate with my customers in English more easily after the workshop. Because I started to look at life from a different angle and feel more comfortable.*
> *I also have personal stories to share with customers as you add colour to my routine and boring life. I think my customers' respect for me has increased."*

As we come to the end of this particular project, we are continuing and developing our social support group offer for minoritised ethnic men, maintaining Wellbeing Wednesday and Coffee and Conversation sessions. This is based on the extremely positive feedback received and funding available. We are also seeking funding to expand into Young Men's Gym access and provide more Photo-Voice opportunities. From all our work, we remain convinced that community based social support groups are effective to improve minoritised ethnic men's mental health. Peer-support, introduction of concepts of 'mental health' in a safe and culturally appropriate way and supported signposting to medical and other services by a trusted source do make a difference. As set out below, survey findings confirmed our expectation that many men do not know that they are living with difficulties which might be described in healthcare terms as a "mental health" related issues.

Anecdotal feedback from local GPs also confirmed that many people come to them with physical health concerns. When tests do not reveal underlying physical causes, people are often offended and / or confused that stress or other mental health difficulties might be a cause. Being able to refer to culturally appropriate social support groups has been very helpful, not only for the activity but also because they know the topic of mental health will be broached and explained and explored in a gentle and appropriate way. For this to continue, funding for community based social support activities also has to continue as priority and be recognised as a valuable contribution to the health economy.

3. Large Scale Community Survey

We surveyed over 1,078 Minoritised Ethnic Men from Hackney and Tower Hamlets about their mental health, with 1,065 being retained as the main data set because they were sufficiently complete and ensured sufficient quality and reliability. An even more refined data set of 986 was developed (Hackney = 489, Tower Hamlets = 497) to exclude limited representation in specific demographic categories. The survey could be completed online but most surveys took place in the community, conducted face-to-face by our community outreach team. To achieve these levels of engagement, we estimate we spoke to at least five times as many people about the survey.

To develop the survey, we engaged with a team at Queen Mary University of London, to ensure the process was rooted in academic rigour. The survey was informed by a literature review and passed through ethics approval before being administered. We wanted to ensure the approach was robust enough to offer reliable findings with the scope to influence decision-making in this area. However, given that this piece of work is rooted in one of our community support services and balanced with providing opportunities for improving mental health and wellbeing, the findings and report do not constitute a formal academic paper or follow a full academic process. We felt this risked being disproportionate to the scale of the project and would possibly limit us to take findings further and / or interrogate them in a way we need to be able to respond quickly and provide community services. We are nevertheless very open to the survey data being used and analysed through a more academic lens if this was felt to be useful to enable further understanding and commitment from an academic or medical audience.

We recruited and trained a team of 16 outreach workers to conduct the survey, ranging from 18-65 years old, male and female. People were recruited to ensure representation and familiarity of local communities, their abilities to establish trust and rapport with potential participants and willingness to be part of our learning process. In order to ensure the questions were accessible and appropriate to the community, we undertook considerable testing and re-

testing, and trial and error. We spent a lot of time considering the questions to ask, the language choices and nuance, and the way they would be translated into community languages, aiming to facilitate engagement with the topic in a familiar, understandable, and non-threatening way. This process could be ever-refined, and whilst we had a set script and questions, we had to be able to continue to adjust our approach on the ground in response to how the survey was being received, allowing updates to our language use and engagement techniques with real-time feedback. This included the way we introduced the survey to certain communities, and where we went to do outreach and meet people.

We ensured we went to trusted places with engagement teams who were confident and able to get men talking about the issues which they are facing. It was necessary to recruit additional members to the team from different ethnic backgrounds who felt comfortable with the topic, and to provide lots of staff training to support them. We found a need to be adaptable in this approach too - as some people would only talk with people from their community in familiar spaces, whereas others preferred to speak to someone from outside their community in a place they wouldn't be seen, reflecting the stigma barrier regarding this topic. In Hackney, participants found it easy to communicate with people from their community or ethnic background and were more open to having conversations on mental health. Tower Hamlets participants interacted better with people from their community and ethnic background to a certain extent, but were much more reticent to provide further information or additional comments where this opportunity was offered. We have concluded this is because the close-knit nature of the Tower Hamlets Bengali community and related stigma / fear of gossip. This is reflected in some of the key survey findings at page 13 onwards, below.

We took different approaches to try to engage with as many people as possible in the places they were and the places they felt comfortable talking to us. We received a small number of online responses, though this engagement was limited as expected. A full copy of the final survey is reproduced in the Appendix. Full breakdowns of each question responses can be provided on request and we are happy to discuss further why certain questions were asked or phrased in specific ways if this is of interest.

4. Delivery reflections

This project has resulted in organisational learning for us, as well as offering insight into the topic. In many ways, the experience of conducting the project has taught us as much as the activities themselves. The process of implementing the survey, in particular, has been revealing for individual staff members and at an organisational level. One community worker reflected on how similar the stigma associated with mental health is in the Bengali community to the one which used to surround diabetes 20 years ago- with shame, taboo, and a lack of understanding feeding into it. If diabetes was once a topic to be kept discrete and hidden from the community, but has since become much more acceptable to discuss as understanding, awareness of the condition and its management has become commonplace, it is hoped that the topic of mental health will follow the same trajectory. Staff members also developed their skills, confidence and understanding of how to approach different people around uncomfortable topics, considering the sensitivities of both the giver and receiver of information. This highlights the need for a flexible approach to cater for different people in different ways at different times - a key takeaway has been that there is no single way to engage minoritised ethnic men around mental health, necessitating a varied approach.

Conducting the survey also opened up conversations with the wider community, and enabled us to gather insights from a range of people not captured through the results themselves. This included conversations with men who did not wish to participate in the survey, but were happy to explain and discuss their reasons for this, and with women who wanted support for the mental health of the men in their community, and for themselves to be able to better support them. These additional conversations and insights demonstrate a demand for further research into mental health within minoritised ethnic communities as a whole, and the interactions and dependencies between members of the community to support an effective and 'big picture' strategy for mental health support.

Our delivery reflections and learnings have also fed into our recommendations to “Get comfortable with uncomfortable conversations” and “Starting somewhere”. Sometimes we found it difficult to have conversations about how we would start this work (did we have the right team? Right terminology? Right ideas to make a difference?) but we also felt that the work was too important not to try to do something and move the conversation on.

Key survey findings

Ethnicity

Our data set is from 1,065 completed surveys of men who identified as being from a Black, Asian and / or Minoritised Ethnic Group. Of these:

- 503 people in Tower Hamlets,
- 494 people in Hackney
- 68 people from Barking and Dagenham, City of London, Newham, Redbridge and Waltham Forest

Overall ethnic distribution was as follows:

- 44% - Asian / Asian British
    - 28% - Bangladeshi
    - 3% - Chinese
    - 4% - Indian
    - 4% - Pakistani
    - 2% - Vietnamese
    - 3% - any other Asian background
- 37% - Black / Black British
    - 14% Black / Black British - Caribbean
    - 16% Black / Black British – Other African
    - 3% - Black / Black British – Somali
    - 4% - Black / Black British – Any other Black Background
- 8% - Mixed
- 7% - any other ethnic group
- 3% - White
- 1% - Arab
- 1% - Prefer not to say

- Tower Hamlets: 57% Asian / Asian British
- Hackney: 72% Black / Black British

The ethnic distribution observed in the survey aligns closely with official data from the boroughs (Office for National Statistics, 2021a; 2021b.)

Mental Health / Wellbeing

More people know the phrase ‘Mental Health’ rather than ‘Wellbeing’ or similar:

- 86% of people have heard the term ‘mental health’,
- 70% of people are familiar with the term ‘wellbeing’.

We asked people to explain by what they understood by these terms:

- Hackney: ‘strong resilience and doing well in life’,
- Tower Hamlets: ‘capacity to navigate life's stresses’

There are concerns with the stigma around 'mental health', and difficulty knowing how to talk about it.

We found that in Tower Hamlets, the term 'wellbeing' was more well-received, and allowed conversations to continue, whereas the term 'mental health' would often lead to the interaction being shut down.

In Hackney, we found people were more receptive to both terms. We therefore adapted our approach based on location and the feedback received.

55% were comfortable with the survey process, 38% were very comfortable, although we are aware that those who were not at all comfortable are unlikely to have reached the point of giving us this feedback.

What do you think causes people to have poor mental health?

We asked respondents “What do you think causes people to have poor mental health?” and received a broad range of responses. We provided a list of possible responses but also provided space for other examples, additional information and free text. There was no limit on the numbers of responses which could be chosen.

Key factors identified by borough:

Hackney:

1. Stress
2. Addiction
3. Childhood trauma
4. Physical health
5. Social isolation.

Tower Hamlets:

1. Stress
2. Social isolation
3. Physical health
4. Addiction
5. Social expectations.

Overall, we recognised the intersectionality of a range of factors:

- Health Conditions – mental and physical; Approximately 35% reported long-term health conditions, with 10% reporting three or more.
- Money struggles and difficulties with employment: 17% unemployment (compared with c. 4% nationally), combined with 37% single-income households.

Accessing Support around Mental Health / Wellbeing

Approximately 27% are uncertain about whether they would reach out for support.

- Hackney: 34% have accessed mental health support, 54% are willing to tell someone or seek support.
- Tower Hamlets: 26% have accessed mental health support, 57% are willing to tell someone or seek support.

54% of men surveyed knew someone who struggled with their mental health:

- Hackney:
    - 58% know of men who may be struggling with mental health
    - 67% of men rarely or never discuss mental health.
- Tower Hamlets:
    - 49% know of men who may be struggling with mental health,
    - 66% of men rarely or never discuss mental health.

Overall, 30% knew someone who had accessed mental health support
Hackney, 66% did not know anyone / were not sure,
Tower Hamlets, 78% did not know anyone / were not sure

Approximately 16% are unaware of men encountering mental health challenges.

60% of participants rarely or never discuss mental health issues with friends, family or anyone else.

We found that in Tower Hamlets in particular, community can be a way into the conversation, or a barrier. One response showed that the place they would seek support would be 'out of the city', highlighting the extent to which this stigma impacts behaviour and willingness to seek support.

Snap-shot of community mental health

Our survey explained “As part of our work, we are gathering an anonymous ‘snap shot’ of how people are feeling at the moment. Thinking back over the past two weeks, have any of the following impacted negatively on your daily life?” A list of options was provided along with the opportunity for free text / additional information.

The list was based on academic literature review of clinical factors which may indicate certain conditions, adapted to enable us to ask the questions in a community setting with limited scope for follow-up.

Key findings include:

- 6% struggle with motivation,
- 29% are overwhelmed by daily tasks,
- 22% feel afraid, as if something bad might happen.

Hackney:

- 31% experience repetitive negative thoughts

- 27% feel bad about themselves,
- 25% do not have a deep bond with friends and family.

Tower Hamlets: 42% ‘N/A’ / ‘prefer not to say’.

An average of 20% of men identified as being negatively impacted by mental health indicators in the previous two weeks. The majority of these respondents did not identify as having mental health issues / knowing anyone who did.

We also wanted to know what people currently did (if anything) to support positive mental wellbeing and how aware were they about perceived mental health benefits in these areas.

Activities to support positive mental health and wellbeing included:

- 75% rely on social networks
- 51% access green spaces
- 50% participate in individual activities
- 25% join community-based activities
- 22% look to mental health professionals or religious leaders
- 21% regularly attend places of worship.

Seeking help and / or barriers to support

In the social support groups, the ONS Wellbeing scores (ONS4) used to evaluate mental health of the Tower Hamlets group, which focused on indirect activities to support mental health, remained in the mid-range, whereas in Hackney, where the group was more overtly 'mental health'-oriented and there was more openness to conversation around the topic, scores showed greater improvement. This potentially represents a challenge of working towards a time of greater openness and direct discussion, particularly in Tower Hamlets, around mental health.

Despite relatively high levels of mental health struggles and barriers to seeking support, when asked at the end of the survey who might like to hear about services and other offerings, 70%+ of respondents said no. This could reflect the severity of the barriers at play, and/or a lack of understanding that mental health is something that can be addressed and improved, stigma or simply not wanting to be on a mailing list.

- 55% would seek help if they were struggling. In terms of barriers to seeking support:
- 76% were uninterested in community mental health training, workshops or focus groups
- 23% didn't know how to talk about it
- 16% felt issues should be dealt with privately
- 14% felt embarrassed
- 12% didn't know what support is available
- 11% felt ashamed
- 5% had a language barrier with doctors.

- 59% reported a lack of time
- 31% financial constraints
- 31% a lack of information on the topic,
- 21% a lack of motivation.

Hackney:

- 121 respondents stated stigma as a barrier to engaging in activities that support positive mental health and wellbeing
- 80 highlighted a lack of confidence.

Tower Hamlets:

- 89 stigma
- 140 a lack of confidence.

Hackney:

- 56% felt comfortable discussing mental health and wellbeing in GP surgeries
- 30% in religious spaces.

Tower Hamlets:

- 42% in GP surgeries
- 39% in religious spaces.

Hackney participants expressed the need for support to self-improve in terms of childhood trauma, drugs, police system to better achieve policy changes and improve their physical and mental health. Tower Hamlets participants showed interest in having more community services.

Both boroughs showed awareness and interest in physical exercise as a means of supporting positive mental health, with Tower Hamlets wanting culturally appropriate services in the community and Hackney being more interested in gym-based activities. This finding from the survey has been reinforced in feedback from our social support groups.

Key themes emerging

Pulling together all our work across this project, we identified six key themes emerging which are expanded on below:

a) Religion and spiritual beliefs
b) Trust
c) Perception of mental health
d) Options available to support the spectrum of mental health needs
e) Community
f) Difficulty knowing 'how' to talk about mental health

a) Religion and spiritual beliefs

Religion is intrinsic to the conversation around minoritised ethnic men's mental health. Although related, we do not feel this is exclusively a matter of faith, but the structures around religion that contribute to perception and behaviours around mental health. Religion is so central to daily life for many in these communities - it shapes how people think and live, and influences ideas around mental health and how to respond to challenges. For some, this may be a source of solace and strength - a way to get through difficult times, whereas for others it may provide a barrier to support - for example through social and religious restrictions in terms of where people may be comfortable discussing the topic, or a fear that seeking additional support signifies a lack of faith or not following religious guidance.

At our initial 'Big Conversation', "having a religious leader, a trustworthy source" was one of the positive reflections from the event. One of the speakers, the Head Imam at East London Mosque, reflected on how mental health can be seen as a taboo topic within the community, and that it is important to consider both faith-based and medical approaches when supporting community members that experience difficulties with their mental health. He emphasised that medical professionals should be willing to engage in spiritual and faith-based approaches. Based on the findings and reflections, we again invited an Imam from East London Mosque to our Tower Hamlets Big Conversation in summer 2023 where we fed back our survey and other research findings. Again, this was seen as a highlight by the men attending.

Although we did not have a religious leader attend our Hackney Big Conversation, the importance of God as a source of strength and of religious communities embracing the topic of mental health was considered key. We would go as far as to say that for the communities we have engaged with, a purely medical model of mental health care will fail to understand how spiritual matters contribute to the cause and care of mental health.

b) Trust

Trust is an ongoing theme across all our community work. Particularly with such a sensitive topic, it is vital for people to be able to trust people they are engaging with. Doing much of our work, we encountered significant fear that information collected, such as ethnicity and postcode, will be used against a person or passed to the local authority. Fortunately, we are well represented in the community, and were able to build on this so that people could develop the level of confidence in us required to engage. We received some online responses to our survey, but knew that

this would not be a significant source of responses. This could reflect the lack of opportunity to build trust with people before asking them to respond.

c) Perception of mental health

We found an emerging theme (often associated with language) that perceptions of 'mental health' would often centre around serious mental illness ("craziness"/ "madness") without awareness of a wider spectrum of mental ill-health. There appears to be much less awareness of 'low level' mental health conditions such as stress, anxiety and low mood, or that maintain general wellbeing could be considered part of looking after 'mental health. We found that mental health challenges are a part of everyday life for many men in these communities; ie many are suffering with different aspects of life that in medical sense would be described as living with a 'mental health difficulty' but they do not necessarily know any different or have reason to believe things could improve for them.

We noticed a theme emerging of it often taking someone external to recognise and present it as a mental health challenge rather than considering it 'normal', 'how it is', or 'bad luck'. Before even becoming an issue of taboo, many people are not seeing mental health challenges as 'separate' from their life or who they are. Therefore, we are suggesting that only by discussing and starting it to name challenges as 'mental health' do we feel that we can start to introduce this distinction, and then enable people to decide if they want to consider issues in this way, and to consider options that may be available.

d) Options being available to support the spectrum of mental health needs

As set out above, the association with the term 'mental health' is often quite extreme, connoting the need for medication or hospitalisation.. Increasing understanding to cover the whole spectrum of mental health, as well as ensuring a range of interventions at all stages that can support improved mental health would help to rebalance this narrative, and encourage more people to seek support as needed.

Having lots of varied options of activities people can participate in as part of the 'healthy habits' to maintain positive mental health as well as more targeted support for those with known or more serious mental health difficulties seems important. Different styles of groups, language and activities all seem very important to reflect the findings that different people will seek different types of support at different times.

e) Community

Mental health challenges aren't limited to the person directly affected - they also impact those around them, particularly within family and household units. Even when people cannot speak about their challenges to family and friends, the burden is often still shared, subsequently affecting the mental health of those around them. This silent problem can spread through the community, without being addressed, compounded by a lack of wider knowledge around where to go or how to get help for another adult.

In Hackney, the sense around talking about mental health was one of shame - men want to talk to their friends or the GP, but feel ashamed and do not know how to. For young Black men in Hackney in particular, there was some sense that they would feel comfortable discussing mental health at the gym and possibly the barbers, demonstrating

a role for the wider community in addressing men's mental health. Black women in the borough were very keen to find ways to support men's mental health, eager to encourage them to access whatever provisions might be available.

In Tower Hamlets, there is a tension between community helping or being a hindrance to mental health support. Whilst some men would only talk to other men from the community, others would not engage with the topic with anyone or in any places that might link them back to the community or risk their personal business getting back to the community. The same seemed true about religious settings. Although there was much positive feedback about religion and the mosques being involved in mental health more generally, people did not always feel that their religious communities would be conducive to positive mental health discussions. We therefore suggest there is a hidden need in the community to talk about mental health, but not to be seen talking about it, which is even more entrenched than the general stigma and taboo which surrounds this topic.

We feel strongly that the role of women in managing men's mental health needs to be considered further. It is often them who are trying to broach the subject that something is not right, trying to encourage appointments or similar, and / or living with the day-to-day management of mental health conditions - medication, household dynamics, community shame.

f) Not knowing how to talk about it

There were a number of questions in the survey that did not get a full response, particularly in Tower Hamlets. In addition, the results around barriers show that people do not feel comfortable discussing mental health and do not know how to talk about it. Conversations are not normalised and there isn't (yet) the language to discuss this topic openly and fully. We found an appetite for this work. People are interested and want to engage on the topic. A key theme is therefore about being able to move from talking about concerns in an abstract / community level, to talking both about the issues affecting communities and giving individuals the tools to knowing how to talk about their personal mental health.

Key recommendations: where do we go from here?

Our recommendations below detail how policy makers, healthcare and community services can endeavour to better support men's mental health within minoritised ethnic communities of Hackney and Tower Hamlets, with a tentative suggestion that these recommendations are likely to be appropriate for men from a wider cross-section of minoritised ethnic communities.

a) Get comfortable with being uncomfortable

Conversations around mental health, and the considerations required to meaningfully engage with communities (for example around religion) are not always easy or comfortable. It is essential for providers to build cultural competence, and be able to bring race, ethnicity, religion, faith, and culture into the conversation around mental health to engage holistically with communities. This is likely to be awkward for many, involve making mistakes and having to learn, apologise, and re-learn continually. We all have something to learn, and somewhere we can share that learning. Whether it is families being able to build the confidence to bring these discussions into the home and back to the community, or we as providers overcoming the pressure of competition to share our learning and resources to support the bigger picture. The only way we will create a shift in our communities is by becoming comfortable with the uncomfortable. If we accept that there are health inequalities within our communities around mental health, and we want to do something about it, we cannot continue to act as we always have. Do not be afraid of adopting a 'test and learn' approach to ensure delivering of activities which best meet the needs of the target group.

In the first instance, the terminology used to open the discussion can impact whether people are willing to continue to engage. Given the adoption of the phrase 'mental health' in health services, policy and similar, we endorse an approach which moves towards using the phrase 'mental health', to normalise and demystify the topic, and build familiarity and understanding of the broad spectrum it covers. However, our experience also showed us that this can be alienating to some people and prevent us from being able to initiate a conversation. We therefore intend to move towards and encourage using the term 'mental health', whilst acknowledging a transitional period will be required for some communities who are uncomfortable and not (currently) responsive to this term. Our approach across all of our work is not to tell people what to do, but to equip them with the knowledge and confidence to make their own informed decisions. We hope that by having some uncomfortable conversations, this in turn will empower and equip people to find out the information they want and be able to take action to prioritise their own and their community's health.

b) Community Support will make the biggest improvement

We feel strongly that if people do not identify as suffering with mental health difficulties, do not know the language around it, are faced with stigma, and do not appreciate the benefits of looking after their mental health, they will not be seeking support in health settings until they reach crisis point. Funding must be in communities at grass root level to ensure there are places and people around who can support, signpost and provide services where people are, not where the system expects them to be.

In light of the recommendations above, recognising that there are many stages and potential challenges when it comes to mental health, we need to ensure there are plenty and varied options for management and prevention that are culturally accessible to the target groups. We need to ensure they are as accessible as possible, with lots of possible contact points and routes in to minimise barriers to engagement. There seems to be a widespread fear that seeking any support with mental health will lead to medication and/or being taken away from home. More emphasis on exercise, creativity, and social groups, with a link back to mental health, will help people to build confidence in seeking support.

c) Start somewhere… and maybe somewhere unexpected?

In many cases, people are facing multiple challenges across a range of areas in life that contribute to poor mental health. It can be difficult to access support in this situation, as dealing with everything feels overwhelming and it can be unclear where to start. We suggest the care needs to just start somewhere. It may be directly addressing one of the issues (housing, benefits, medication), or it may be something that helps someone to feel like more than the total of their issues, and feel like a person again. This could be understanding what skills, interests or creativity they had before things became overwhelming, and supporting them to access opportunities to - for example - paint, read, exercise, meet up with others, or be in nature again. The things that help here are not necessarily the obvious 'fixes' - they do not solve a housing or debt crisis, however they can be vital to giving people the peace, headspace and humanness to be able to reduce overwhelm and become aware of the importance of looking after their mental health. Furthermore, consideration should be given to offering these activities in a variety of accesible community and health spaces.

d) Support the 'whole' person, and the community around them

In addition to seeing and supporting people as 'more than their problems', we must also consider their social context. People exist within their families, jobs, religions and communities, and all of these factors will impact on their experience of mental health and their ability to seek and access support as needed. Women are carrying a disproportionate burden of supporting men with mental health difficulties. We must consider how we can support the community around the men - both within their roles as potential enablers for accessing support, and as people likely to be absorbing the effects of men's mental health and finding an impact on their own. This is especially risky in more severe cases where people may be discharged from care back to the home, into an environment where people do not know what signs to look out for to indicate relapse and do not know how to have important and supportive conversations. To see a real shift in the approach to mental health, we must encourage and enable conversations, openness and understanding that reaches homes, community spaces, and workplaces, and spans generations. We must seek to understand and work within the cultural, power and community dynamics that shape the way mental health is dealt with in the target communities, and reduce the shame and stigma attached.

It's also important to address mental health challenges alongside, or via, their potential root causes (such as long-term health conditions and unemployment), and consider the intersectionality of various disadvantages, including discrimination, social isolation, and limited access to necessary services. As far as possible, we need to take a person-centred approach and support people to be able to navigate and find the right support from the right places, equipping people to know the questions they can ask. This approach enables us to ensure we are being as mindful as

possible of the culture, religion, age, ethnicity and any other relevant considerations of the person we are supporting.

e) Commit to it… long-term

This project has been conducted over an almost two-year period, and taken lots of testing, learning and revising to be successful and provide services that we feel work and to gather much data and insight. Yet, this is still not giving us a 'magic bullet' of how to improve mental health at a stroke for these communities. It can only be part of an ongoing conversation which seeks to make positive change in incremental ways. Putting in the time required to build trust with the relevant communities, and understand the language and approaches to use is vital to successful engagement. Running long-term projects that people can rely on and that support you to build trust within communities is a key part of this. This is the challenge for funders, charities and governments. There are no quick fixes. The work is not quick and not cheap; rather it takes time, investment and representation to be done in a meaningful way and to make a difference in the long-term.

f) Funding

It probably goes without saying that more funding is required if we are going to implement the above. If we are to ensure sufficient opportunities to address poor mental health at all levels and take steps to prevent escalation to crisis to the greatest extent possible, funding needs to be long-term and consistent. All our recommendations are designed to give realistic possibilities (even with minimal funding) for further actions for researchers, community organisations and public bodies. However, unless sustained funding is available even the smallest steps become unrealistic and unsustainable.

What next?

It is only by working together with a joint aim of improving our communities' health, will we make the change we all want to see.

Could we support your research in this area? We have strong community links, and a proven record facilitating community research since our inception in 1986. We operate a 'Fairtrade' model of research, which focuses on leaving the community stronger, and want to work with people and organisations who share this approach.

We will continue offering relevant community services to support men's mental health across our communities. You can find more details of our offer at www.safh.org.uk. We are always keen to know what other organisations are doing so we can refer people to them. We want everyone to be able to access the support they need at the time and in the way they need it. This will not always be with us. Please feel free to share about activities you are offering.

Stay in touch! We are looking for partners to work with us, to fund us or to reflect and learn with us. If you would like a copy of the raw survey data on request for your own analysis, to consider partnership working or project ideas, please email info@safh.org.uk. We are hoping to set up some informal discussions to think about how we can take some of our ideas forward. Please let us know if you would like to be part of the conversation. Thank you so much for being part of this project.

Appendix

[This is a copy of the survey questions which were asked. Different spacing / fonts were used but this has been altered to save space.

Social Action for Health is a community-based health charity working in Tower Hamlets, Hackney and across East London.

As part of our work, we gather views from local communities to shape our current and future work and to make recommendations to others, such as the NHS or local authority.

We are currently working on a project about the **mental health of men (aged 18+) from Minoritised Ethnic communities who live and/or work in east London**, and invite you to take part in the survey on an anonymous (non-name) basis.

After you have completed the survey, if you would like to be contacted about our findings or to take part in a discussion group or any future work, you will be able to provide your contact details separately. They will not be linked to your answers to the survey and will be stored separately.

First of all, we will ask you for some basic information about you. This is so that we can ensure a wide group of people are taking part.

We ask that you complete all questions marked with an asterix*

1. **Is someone helping you complete this survey (eg: because of language or other support requirement)?***

   - ❑ Yes
   - ❑ No

2. **How do you describe your gender?***

   - ❑ Male
   - ❑ Female
   - ❑ Prefer to self-describe
   - ❑ Prefer not to say

3. **What is your age?***

   - ❑ 16-17
   - ❑ 18-29
   - ❑ 30-39
   - ❑ 40-49
   - ❑ 50-59
   - ❑ 60-69
   - ❑ 70+

4. **How would you describe your ethnicity? ***

   - ❑ Arab
   - ❑ Asian / Asian British
     - Asian / Asian British – Indian
     - Asian / Asian British – Pakistani
     - Asian / Asian British – Bangladeshi
     - Asian / Asian British – Chinese
     - Asian / Asian British – Vietnamese
     - Asian / Asian British - Any other Asian background

- ❑ Black / Black British
  - Black / Black British – Somali
  - Black / Black British - Other African
  - Black / Black British – Caribbean
  - Black / Black British - Any other Black background
- ❑ Mixed
  - Mixed - White and Black Caribbean
  - Mixed - White and Black African
  - Mixed - White and Asian
  - Mixed - Any other Mixed background
- ❑ White
  - White – British
  - White – Irish
  - White - Traveller of Irish heritage
  - White - Gypsy / Roma
  - White - Any other White background

- ❑ Any other ethnic group
- ❑ Prefer not to say

5. Please indicate in what borough you live or work in. If more than one, please choose the one where you spend most of your time*

- ❑ Barking and Dagenham
- ❑ City of London
- ❑ Hackney
- ❑ New Ham
- ❑ Red Bridge
- ❑ Tower Hamlets
- ❑ Waltham Forest
- ❑ Other- We are only collecting survey information from people who live in the above-mentioned boroughs. If you would like to provide information but do not live or work in these boroughs, please email info@safh.org.uk.

6. Please provide your full postcode. This does not identify you but helps us check we are gathering responses from across the area. *

7. Do you have one or more long health term conditions? *

- ❑ No
- ❑ Yes

If yes, how many long-term conditions do you have?

- ❑ 1
- ❑ 2
- ❑ 3+
- ❑

Are your long-term conditions physical or mental?

- ❑ Mental
- ❑ Physical
- ❑ Mental and physical
- ❑ Not sure

8. Are you the sole earning member of the family?

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

9. What is your salary bracket for how much you earn each year?*

- ❑ Up to £12,000
- ❑ £12,000 - £30,000
- ❑ £30,000 - £50,000
- ❑ £50,000 - £70,000
- ❑ £70,000 - £1,00,000
- ❑ £100,000 or more
- ❑ Unemployed
- ❑ Prefer not to say

The survey is now moving to ask you about mental health and well-being and what you associate with these terms.

10. Before taking the survey today, please tick if you had heard of the following terms.*

- ❑ Mental Health
- ❑ Well-being
- ❑ Neither

11. Do you think it matters whether the term 'mental health' or 'wellbeing' is used for these types of discussions / surveys?

- ❑ Yes - they mean different things
- ❑ Yes - it depends on the context
- ❑ No - they mean the same thing
- ❑ Don't know
- ❑ Other

12. Please explain your answer

_____

_____

13. **Which of the following do you associate with mental health and/or wellbeing? * (Select all that apply.)**

- ❑ A state of mind
- ❑ The ability to cope with the stresses of life
- ❑ The ability to realise one's abilities
- ❑ The ability to learn well and work well
- ❑ The ability to contribute to one's community
- ❑ Emotional, psychological, and social well-being
- ❑ A result of a spirit, curse or jiin
- ❑ A result of genetics
- ❑ The state of being comfortable, healthy, or happy
- ❑ Feeling generally good
- ❑ The state of being or doing well in life
- ❑ Having strong resilience
- ❑ Other. Please give details.

_____

_____

14. **What do you think causes people to have poor mental health? * (Choose as many as you like)**

- ❑ Genetics
- ❑ Poor physical health
- ❑ Spirit, curse or Jinn
- ❑ Stress
- ❑ Social Isolation
- ❑ Bad luck
- ❑ Social Media
- ❑ Addiction
- ❑ Community/ family expectations
- ❑ Childhood trauma
- ❑ None of the above
- ❑ Don't know
- ❑ Other

Please provide any further information you think is relevant.

_____

_____

15. **In general, thinking about your day-to-day life, how comfortable are you discussing your mental health/ well-being?**

- ❑ Very comfortable
- ❑ Comfortable to some extent
- ❑ Slightly uncomfortable
- ❑ Very uncomfortable

16. **How often do you discuss these topics with your friends/family/anyone else?***

- ❑ Very Often
- ❑ Often

- ❑ Rarely
- ❑ Never

17. Would you be comfortable discussing mental health/wellbeing in any of the following places? (Select all where you might be comfortable)|*.
(Choose as many as you like)

- ❑ Mosque/ Church/ Place of Worship
- ❑ Gym
- ❑ Barber shop
- ❑ GP surgery
- ❑ Community Groups arranged for this purpose
- ❑ General Community Groups
- ❑ None

Please feel free to give further detail.

_____

_____

18. Do you know of any men that may be struggling with their mental health / wellbeing?*

- ❑ Yes
- ❑ No
- ❑ I don't know

19. Have you, or do you know anyone who has, accessed support for their mental health/wellbeing?*

- ❑ Yes
- ❑ No
- ❑ Not sure

Do you want to tell us any more about this?

_____

_____

20. If you were struggling with your mental health/wellbeing, might you tell anyone or ask for support?

- ❑ Yes
- ❑ No
- ❑ Not Sure

If No or Not Sure, please explain your answer.* (Choose as many as you like)

- ❑ I would feel embarrassed
- ❑ I would feel ashamed
- ❑ I would feel guilty
- ❑ I don't know how to talk about it
- ❑ I don't have anyone I could talk to about it
- ❑ I don't know what support there is
- ❑ I have had / I know someone who has had negative experiences when sharing these struggles or accessing support
- ❑ I think these things should be dealt with privately

- ❑ I feel there is a language barrier between me and my doctor
- ❑ The waiting times are too long to obtain help
- ❑ Other (please specify)

_____

_____

_____

_____

As part or our work, we are gathering an anonymous 'snap shot' of how people are feeling at the moment.

21. Thinking back over the past two weeks, have any of the following impacted negatively on your daily life?* (Choose all the apply)

- ❑ Having no motivation
- ❑ Noises are particularly irritating and feel louder than usual
- ❑ A feeling of being overwhelmed by daily tasks
- ❑ Feeling afraid, as if something bad might happen
- ❑ Feeling like you cannot control emotions as you would like
- ❑ Feeling like you do not have a lot in common with people around yourself
- ❑ Feeling like you have no interest or pleasure in doing things
- ❑ Feeling like relationships with family, friends and/or colleagues are superficial
- ❑ Feeling like here has been a cloud of bad temper over yourself
- ❑ Spending a lot of time thinking about the same things over and over
- ❑ Feeling bad about yourself- or that you're a failure or have let yourself or your family down.
- ❑ A feeling of not being able o control your own thoughts
- ❑ Feeling like there is a curse over you or you are being controlled by jins or evil spirits or similar
- ❑ Prefer not to say
- ❑ Not applicable

22. Do you do any of the following to support positive wellbeing?*(Choose as many as you like)

- ❑ Talking to family, friends, neighbours, co-workers, etc.
- ❑ Speaking to religious leaders (such as a priest or imam)
- ❑ Speaking to a mental health professional (such as a counsellor or GP)
- ❑ Accessing green spaces like a park
- ❑ Taking part in individual activities such as exercising, meditating, writing, journaling, reading or taking a relaxing bath
- ❑ Joining community-based activities such as volunteering or pursuing creative interests
- ❑ Calling anonymous support helplines or similar
- ❑ Regularly attending a place of worship- mosque, church, etc.
- ❑ None of the above
- ❑ Other (please share below)

_____

_____

23. What might prevent you from carrying out activities which support positive well-being?* (Choose as many as you like)

- ❑ Lack of time
- ❑ Lack of money
- ❑ Lack of confidence
- ❑ Lack of motivation – for example, due to existing conditions(s)
- ❑ Language barriers
- ❑ Lack of information on the topic
- ❑ Stigma
- ❑ Other (please give details)

_____

_____

24. How comfortable did you feel taking part in this survey?*

- ❑ Very comfortable
- ❑ Comfortable
- ❑ Uncomfortable
- ❑ Very uncomfortable

25. Would you be interested in attending training, workshops or focus groups about mental health issues in the local community or hearing about our findings?

- ❑ No
  Yes

If yes, please provide your phone number and email address. We will contact you with further information, and you will be able to decide whether to take part.*

First Name: _____

Last name: _____

Phone number (country code and number): _____

Email address: _____

26. Do you want to share any other information?

_____

_____

Thank you so much for your support of our work.

If you have any queries or would like any additional information, please contact info@safh.org.uk or call/message 07944 966 141, and we will get back to you as soon as possible.

Here are some websites and contact details for organisations which might be useful if you are struggling with your mental health:

[NOT REPRODUCE IN THE INTERESTS OF SPACE. We also gave out 'thank you' postcards containing similar information and staff were trained to explain the different options.]