Ollscoil na Gaillimhe
University of Galway

Evidence Review of Community-based Mental Health Promotion Interventions for Priority Groups in Ireland

Final Report

Derval Gilmartin, Esther Mercado-Garrido, Patricia Harte, Tosca Keppler & Margaret M. Barry

Health Promotion Research Centre
University of Galway

October 2024

HPRC
Health Promotion Research Centre

HSE

Acknowledgments

This report was commissioned by the Health Service Executive (HSE).

We gratefully acknowledge the contribution of HSE colleagues on this project including Dr Aleisha Clarke, Ms Ann Scanlon, and Mr Derek Chambers.

We are especially grateful to all who participated in the consultations for their key insights, which informed this report, and a heartfelt recognition of their dedication to supporting the mental health and wellbeing of priority groups throughout Ireland.

We are grateful to the HSE, our funders and collaborators, for their support.

The views expressed in this report are those of the authors and do not necessarily represent those of the funders.

Suggested citation: Gilmartin, D., Mercado-Garrido, E., Harte, P., Keppler, T. & Barry, M.M. (2024). *Evidence Review of Community-based Mental Health Promotion Interventions for Priority Groups in Ireland.* A report prepared for the Health Service Executive, Ireland. Health Promotion Research Centre, University of Galway.

www.universityofgalway.ie/hprc/

Table of Contents

SUMMARY REPORT

Project Overview

This project concerns a review of the evidence on community-based mental health promotion interventions designed to meet the needs of population groups most at risk of developing mental health difficulties. This review set out to identify key priority population groups in the Irish context, together with examples of best practice, drawn from the literature and current practice, that could be feasibly implemented in Irish community settings. The study seeks to provide the necessary evidence to inform key actions recommended in current policy frameworks including; "Connecting for Life: Ireland's national strategy to reduce suicide 2015-2020" (Department of Health (DOH), 2015), "Sharing the Vision: A Mental Health policy for Everyone" (DOH, 2020) and "Stronger Together: The HSE Mental Health Promotion Plan 2022-2027" (HSE, 2022).

Background

Community-based mental health promotion

Conceptualising mental health as a positive resource for everyday life, mental health promotion is concerned with strengthening protective factors for good mental health and enhancing wellbeing for individuals, families, communities and society-at-large. This is achieved through socio-ecological and intersectoral strategies underpinned by values of empowerment, social inclusion, equity and collaboration (Barry et al., 2019; World Health Organization (WHO), 2021; WHO, 1986).

Communities are recognised as a powerful setting for mental health promotion (DOH, 2020; WHO, 2022). A community approach to mental health promotion means engaging the wider community composed of multiple actors, sectors, services and systems; where community members act as key stakeholders in mental health promotion programme design, planning, delivery and evaluation. Engaging the community in this way can foster a sense of ownership and connectedness and can create lasting positive change (Barry et al., 2019). Understanding the nuances of their local ecosystem, communities are well placed to recognise their challenges and opportunities, to understand the characteristics and preferences of their members, and to build on and strengthen local assets.

Community-based mental health promotion seeks to strengthen and enable communities to implement appropriate and acceptable interventions that most effectively address the social determinants of mental health within their local ecosystem (Barry et al., 2019; Kuosmanen et al., 2022: Rickwood & Thomas, 2109; WHO, 2022). In particular, adopting community mental health promotion strategies with priority

populations can foster a sense of trust and connectedness while addressing policy commitments to improve mental health and wellbeing for those at highest risk of poor mental health (DOH, 2020).

Community engagement and the wider context

The World Health Organization (WHO) highlights community engagement as being crucial not only to ensuring equity of health and wellbeing in communities but also as a means of achieving the broader health-related targets of the Sustainable Development Goals (United Nations, 2015; WHO, 2020). The WHO's Community Engagement Guide (WHO, 2020) adopts the Ottawa Charter Framework for Health Promotion (WHO, 1986), calling for actions that address community priorities intersectorally across many levels that include individuals and professionals, community groups, institutions and governments. Public Health England (PHE), likewise, calls for a whole system approach to community-centred public health (PHE, 2020). It is, therefore, crucial to position community-based mental health promotion within a wider policy context that addresses the social determinants of health, acknowledging the upstream support needed to build community capacity and empower communities to implement community-centred approaches.

The importance of mainstreaming community engagement in the promotion of health and wellbeing is outlined by WHO in their guidance document (WHO, 2020). These approaches are centred on the principles of mutual trust between all stakeholders through equity and transparency in decision-making, and ensuring that any health promotion action is geographically, linguistically, and culturally accessible to community members (WHO, 2020; 2022). The facilitators of successful community engagement are identified as including good governance, developing and defining roles within communities, effective leadership complimenting top-down with bottom-up approaches, joint-decision-making, open communication, collaboration and partnership, and mobilising community resources (WHO, 2020).

The Current Study

Within the context of Irish policy priorities and the internationally acknowledged importance of mainstreaming community engagement in the promotion of health and wellbeing, the current study aimed to identify the most robust evidence concerning effective community-based mental health promotion interventions, with a particular focus on population groups who are deemed to be most at risk of poor mental health outcomes.

Approach

The project involved four research objectives:

- Objective 1: To summarise the evidence around community-based mental health promotion interventions.

- Objective 2: To identify best-practice case examples of community-based initiatives in Ireland.
- Objective 3: To provide recommendations on community-based initiatives that could be appropriately resourced and scaled in the Irish context.
- Objective 4: To produce a report of evidence, current practice, and recommendations.

An understanding of the evidence base and existing practice would inform a set of key recommendations to support community-based mental health promotion implementation for priority population groups in Ireland. Each of the four phases of the study (Figure 1) are summarised in the following sections.

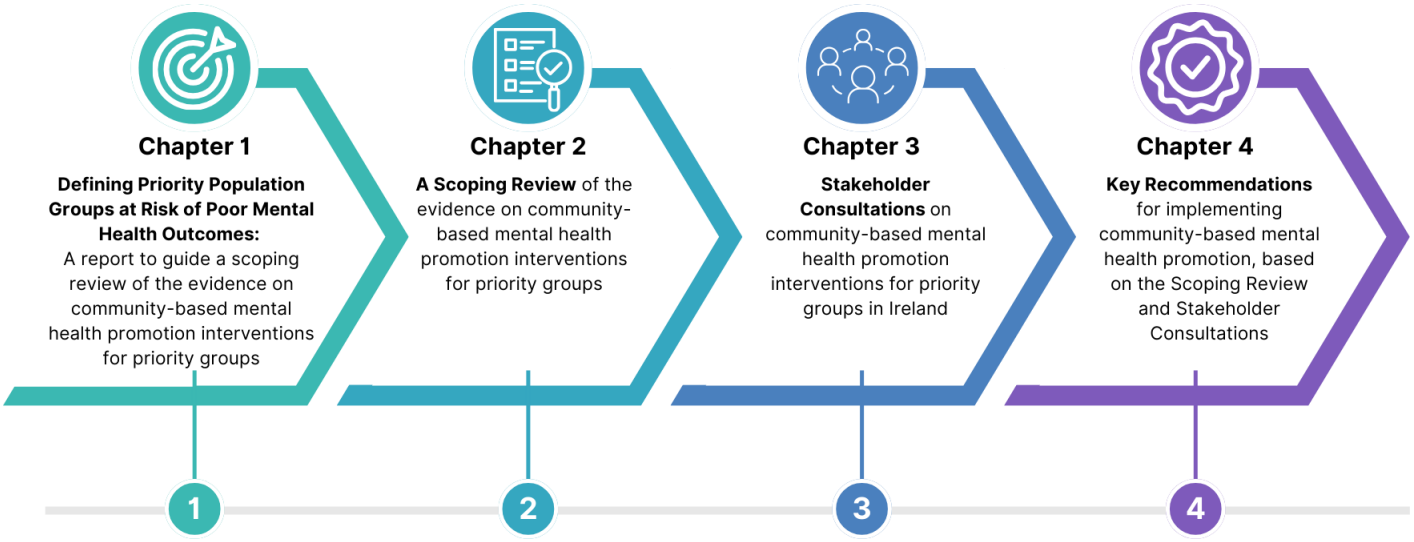


Figure 1. Overview of Chapters in the Final Report: Evidence Review of Community-based Mental Health Promotion Interventions for Priority Groups in Ireland

Chapter 1 – Defining Priority Population Groups at Risk of Poor Mental Health Outcomes

The first phase involved identifying key priority population groups in the Irish context. Current policy frameworks including; "Connecting for Life: Ireland's national strategy to reduce suicide 2015-2020" (DOH, 2015), "Sharing the Vision: A Mental Health policy for Everyone" (DOH, 2020) and "Stronger Together: The HSE Mental Health Promotion Plan 2022-2027" (HSE, 2022), list specific "at-risk" groups who are at increased risk of mental health difficulties and need more targeted mental health interventions. Additional groups were identified in a background paper that informed the development of the WHO Comprehensive Mental Health Action Plan 2013-2030 (WHO, 2021). Using these documents and definitions of priority population groups as a starting point, a further review was undertaken to identify other "at-risk" subgroups in both the national and international literature. A final outline was drafted and presented to key stakeholders for discussion. Based on this discussion, the priority population groups for this review were agreed (see Table 1) and directed the second and third phases of the project.

Table 1. Priority Groups Selected for the Purpose of this Study

- People living with disabilities and their families
- People experiencing social isolation and loneliness
- People living in deprived and disadvantaged communities
- Carers of people living with chronic illness
- Migrants and refugees
- Ethnic populations, including Traveller and Roma communities
- People with experience of domestic violence
- Members of the LGTBQI+ community
- Young people not in education, employment, or training (NEET)

CHAPTER 2 – SCOPING REVIEW OF THE EVIDENCE ON COMMUNITY-BASED MENTAL HEALTH PROMOTION INTERVENTIONS FOR PRIORITY GROUPS

The second phase included a scoping review of the national and international evidence on community-based mental health promotion interventions that have been implemented for the pre-defined priority population groups. The scoping review aimed to provide conclusions on the most effective community-based mental health promotion interventions that could be appropriately resourced and scaled in the Irish context.

Scoping Review: Methods

The scoping review followed the Preferred Reporting Items for Systematic reviews and Meta-Analysis extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). The search process was more broadly guided by the five main stages outlined in the Arksey & O'Malley framework (2005).

Sources and Search Strategy: A search of six electronic databases, PubMed, Scopus, PsycINFO, Embase, CINHAL and Cochrane, was conducted to retrieve relevant peer-reviewed papers pertaining to community-based mental health promotion initiatives for the priority groups of interest. Search limiters included English language text only and publications since 2014. Due to an unmanageable volume of articles (n=33,624), a further refinement was made to include only review papers (systematic reviews and meta-analyses, scoping reviews, rapid reviews and narrative reviews) in the scoping review.

Framework for Presenting the Results: Aligning with a community-centred approach to health promotion practice, and based on a review of evidence and practice, PHE (2015) developed a framework of four evidence-based, community-centred approaches for promoting health and wellbeing, underpinned by equity, social connectedness and voice and control. This framework was used as an overarching frame to present the findings from the scoping review. These four strands of the PHE 'family of community-centred approaches' include:

- Facilitating access to community resources (pathways to participation, community hubs, and community-based commissioning)
- Volunteer and peer roles (bridging, peer interventions, volunteer health roles)
- Collaborations/partnerships (community-based participatory research (CBPR), co-production projects)
- Strengthening communities (community development, asset-based approaches, social networking).

Scoping Review: Results

After initial screening of the review papers (n=2,737) by two researchers, a total of 33 eligible review studies remained for data extraction. These reviews synthesised evidence on community-based approaches to promote the mental health of the following priority groups: people living with disabilities and their families (n= 2), people experiencing social isolation and loneliness (n= 8), people living in disadvantaged communities (n= 2), carers of people living with chronic illness (n= 4), refugees and migrants (n=7), ethnic minority groups (n= 5), people who experienced domestic violence (n= 4), and members of the LGBTQ+ community (n=1). No reviews were found that included NEET young people as participants. A narrative synthesis of the findings was undertaken to identify evidence-based practice for specific priority groups.

Key Findings from the Scoping Review

Figure 2 illustrates the most effective community-based approaches for the promotion of the mental health and wellbeing of each priority group of interest, as emerged from the findings of the 33 reviews of the evidence. Overall evidence in this area is emerging and this review found a lack of robust evidence specific to the identified priority population groups. Study quality varied across reviews, with many having a weak study design, small sample sizes and a lack of standardised outcome measurement. Additionally, no relevant reviews were found for NEET young people.

Figure 2. Effective approaches to community-based mental health promotion for priority population groups (for details on practice examples, please see case studies in main report)

Reviews were first grouped by the priority population group of interest. For the purposes of reporting, the community-based interventions relevant to each priority population were then grouped according to their focus by applying the framework of the family of community-centred approaches for health and wellbeing developed by PHE (2015). A summary of the key findings that emerged is outlined.

Increasing community members' access to community resources, including initiatives such as Social Prescribing services were found to yield positive programme effects among people who experience loneliness and isolation and disadvantaged families in particular. Collaborative community gardening and nature-based interventions were found to improve the mental health and wellbeing of deprived and disadvantaged communities, while digital initiatives show potential positive effects among caregivers, ethnic populations, survivors of domestic violence, and members of the LGBTQI+ community.

Peer-led and lay community member approaches to programme facilitation are considered most effective in the case of migrants, caregivers, people living with disabilities, those who experience loneliness and isolation, and survivors of domestic violence. In the case of groups such as migrants and refugees and ethnic populations, most robust evidence is found where participants are matched with peers of the same background or who speak the same language. Positive programme effects were found for both participants and lay community facilitators.

Collaborative practices involving co-production approaches in programme development and delivery, including co-design and community based participatory research (CBPR), resulted in more culturally accepted interventions. Evidence for the effectiveness of this approach was found among ethnic minorities, including the Irish Travelling community, migrants and refugees, survivors of domestic violence, and those living in deprived and disadvantaged communities.

Strengthening communities and approaches to community engagement that aim to build social capital reported positive social and emotional outcomes and were found to build and strengthen social networks. Evidence was found for the effectiveness of Men's Sheds among men experiencing loneliness and isolation, family-based interventions for migrants and refugees, and community-based wellbeing interventions for ethnic minority populations.

Implementation factors identified in the review of evidence included partnerships and collaborative work practices, together with peer-led models of delivery, which were found to promote active participation by community members and result in more acceptable interventions. Tailoring and culturally adapting evidence-based programmes with specific subgroups, including language translation, programme modifications, and culturally salient messaging, can ensure culturally appropriate

interventions. Additionally, review findings indicate that more structured programmes are better received and more effective.

Supportive infrastructure encompassing structured training and ongoing implementation support, including for peer and lay community facilitators, was found to be important for intervention efficacy. Policies and practices need to adopt a focus beyond the initial intervention development and delivery, and to prioritise the implementation of supportive structures that will ensure effective and sustainable intervention outcomes in the long-term.

Strengthening the evidence base on community-based mental health promotion interventions for priority groups emerges as a key finding from this review. Based on a synthesis of the evidence from a wide range of interventions, the findings highlight a lack of robust evidence across the priority groups examined. The findings, therefore, confirm the need to document the implementation of community-based mental health promotion interventions and evaluate their impact and outcomes for priority groups appropriately in order to strengthen the evidence base so that future action can build on this effectively.

Implications for Community-based Mental Health Promotion Practice for Priority Groups in Ireland

In the Irish context, infrastructure already exists for mental health promotion interventions that focus on increasing access to community resources, such as Social Prescribing services, digital initiatives, and peer support groups, and those that aim to build social capital and strengthen communities, such as Men's Sheds.

In particular, this review reports emerging but promising evidence for the impact of Men's Sheds on the mental health and wellbeing of older men. With the existence of the Irish Men's Shed Association, and subject to appropriate resources being made available, there is considerable potential for this initiative to be tailored to address the needs and preferences of other priority populations such as migrants and ethnic minorities, and those living with disabilities.

Although robust evidence for Social Prescribing services across priority populations is described as lagging behind its practice, this service is being rolled out across Ireland and is accessed by people with long-term conditions, those experiencing loneliness and isolation, and those who have complex social needs (HSE, 2024). Anecdotally, the service is well received in communities including deprived and disadvantaged areas and there is a clear opportunity to engage with other priority population groups if the service is further resourced.

Family-based initiatives providing support to new mothers in migrant and refugee populations and ethnic communities can be effective if culturally-adapted and peer-led, and consideration should be given to adapting the widely evaluated, evidence-based Community Mothers Programme (https://www.khf.ie/community-mothers-programme/)[1] for priority groups in Ireland. In keeping with the principles of the original programme and co-production approaches, community members of the priority groups should be engaged in programme adaptation and delivery as this is considered most acceptable and effective.

Consideration should also be given to the use of digital platforms in the promotion of the mental health of priority groups in Ireland. While evidence to support their use is evolving in the literature, adopting co-design approaches to programme development can ensure culturally appropriate content and positive outcomes across a variety of subgroups beyond those evidenced in this review (caregivers, ethnic populations, survivors of domestic violence, and members of the LGBTQI+ community).

Scoping Review: Conclusions

The scoping review found a paucity of robust evidence specific to the identified priority population groups. Promising findings to support implementation of community-based mental health promotion included:

- Partnership and collaborative practices involving co-production, co-design, co-delivery and community-based participatory research;
- Peer-led and lay community member approaches to programme facilitation (particularly pairing those with similar background and language);
- Culturally tailored approaches to evidence-based interventions;
- Community strengthening approaches such as Men's Sheds; Social Prescribing services; and
- Digital interventions.

Enabling factors identified included supportive infrastructure (including structured training, implementation support, and support beyond initial programme design and delivery) and strengthening the evidence base by documenting and evaluating community-based mental health promotion implementation. The findings from this synthesis of the evidence can serve as a useful base to guide, support and facilitate the development of a suite of effective community-based mental health promotion interventions for priority populations in Ireland. Overall key recommendations are outlined in Figure 3.

[1] recently updated as Community Families (https://www.communityfamilies.ie)

Figure 3. Key recommendations from the scoping review of the evidence on community-based mental health promotion interventions for priority groups

OVERALL KEY RECOMMENDATIONS

1 COMMUNITY ENGAGEMENT APPROACH

A community engagement approach is recommended for the mental health promotion of priority groups in Ireland. Strongest evidence is found for interventions that increase access to community resources, such as Social Prescribing services. Other effective approaches include interventions that strengthen communities such as Men's Sheds and those that adopt a co-production approach to programme development and implementation

2 CULTURAL ADAPTATION

Tailor mental health promotion interventions for specific priority populations to ensure their cultural appropriacy. Co-production approaches to programme development (shared decision-making, co-design, and CBPR) and adapting programme language, messaging, and content results in more culturally appropriate and acceptable interventions

3 ACCESSIBILITY

Interventions should be accessible and careful needs assessment and planning with communities is required to ensure that structural barriers to end-user engagement, such as transport and language, are identified and addressed

4 SUPPORTIVE INFRASTRUCTURE

Supportive infrastructure is needed to implement and sustain interventions, including adequate mental health promotion training and ongoing support for peer facilitators

5 SCALING UP EXISTING PROGRAMMES

In the Irish context, consideration should be given to adapting, resourcing, and scaling-up interventions for priority groups that have existing infrastructure, such as Men's Sheds, Social Prescribing services, and peer-led programmes such as the Community Mother's Programme

6 EVALUATION

Robust evaluation of community-based mental health promotion practice that documents the implementation process and outcomes of interventions, including ensuring that there are no adverse effects is required to strengthen the evidence base and ensure safe and effective interventions for priority populations

Chapter 3 – Stakeholder Consultations on Community-Based Mental Health Promotion Interventions for Priority Groups in Ireland

The final phase of this project aimed to identify best-practice case examples of community-based initiatives for the pre-defined priority groups in Ireland through a series of consultations with key stakeholders working with each priority group. The criteria for best practice are summarised below, followed by an overview of the methods used and key findings from this phase of the study.

Best Practice for Community-Centred Approaches

The PHE (2015) four-strands framework of community-centred approaches to health promotion practice, used to frame the findings of the scoping review in Chapter 2, also provide a base for identifying the criteria for best practice (i.e., approaches that facilitate; (i) access to community resources, (ii). volunteer and peer roles, (iii) collaborations/partnerships, and (iv) strengthening communities. Building upon this framework, in a call to action on their website, PHE outlined a set of overarching recommendations in implementing a community-centred approach:

- Develop a whole-system approach across sectors
- Map and mobilise local assets
- Ensure genuine co-design and co-delivery – with, not to, communities
- Commission across the four strands of the family of approaches
- Measure community outcomes
- Integrate community-centred, asset-based approaches as part of place-based commissioning and strategic planning. The PHE (2015) four-strands framework of community-centred approaches to health promotion practice, used in Chapter 2, was likewise used as a framework to guide the findings from the stakeholder consultations.

Stakeholder Consultations: Methods

This phase involved a series of one-hour online consultations with key stakeholders in statutory roles and in the community and voluntary sector. Participants were identified by senior HSE decision-makers and included coordinators of community-based mental health promotion supports in various locations in Ireland with a focus on the selected priority groups. Through the stakeholder consultations, researchers aimed to identify community-based mental health promotion initiatives for the pre-defined priority groups in Ireland and, specifically, which interventions work best and under which conditions, with insights into the feasibility of, and support needed for, scaling-up selected interventions in the Irish context. Each of the consultations were recorded and transcribed and the findings are presented as a descriptive narrative

of insights pertaining to each priority group. The narrative follows the framework of PHE's family of community-centred approaches.

Stakeholder Consultations: Results

Nine one-hour online consultations were hosted by one researcher and conducted from July until September 2024. Participants (n=13) included stakeholders involved in supporting the mental health and wellbeing of priority groups in Ireland. Participants were staff within the HSE (n=2) and the community and voluntary sector ("CVS"; n=11). A summary of the key findings are presented (details pertaining to each priority group, along with case studies of best practice, can be found in the full report).

It is important, from the outset, to understand the high degree of **intersectionality** when addressing the needs of priority groups. For example, ethnic minority communities will also present as carers, living with disabilities, experiencing loneliness, living in deprived communities, experiencing domestic violence, have personal gender orientations, and are experiencing their own stage within the life cycle. This was expressed by all participants and should be kept to the forefront while interpreting the findings of this report. Additionally, there seem to be discrepancies in **terminology**, where the CVS use the term 'community development' (Community Work Ireland, 2016) for their community-based mental health promotion activities.

Key Findings from the Stakeholder Consultations

Figure 4 provides an overview of existing community-based mental health promotion supports offered in Ireland grouped under the PHE (2015) framework of family of approaches. A summary of the key findings is presented specific to each approach. Overall, practice in Ireland is consistent with the findings of the scoping review, with note-worthy insights offered under each approach.

Interventions to increase access to community resources: Participants noted that the choices of community members are limited and dictated by the structure of the services, which oftentimes do not account for the social determinants of health and are not co-produced, thus there is a need to emphasise meaningful participation, so that priority groups have the capacity to direct their own services. Additionally, participants noted that inappropriate or untailored communication approaches can essentially 'lock out' those in most need of services, thus antiquated perceptions of 'accessible communication' should be revisited to include audio and video supports rather than solely 'plain English' written resources.

.

Access to Community Resources

- Informal community group gatherings (crafts, arts, book clubs, gardening, walking, mindfulness, fitness, social engagement etc.)
- Special-purpose projects: Ukrainian Project, Be Aware. Be Well Migrant Health Initiative, HealthConnect website (Cairde)
- Volunteer- & peer-operated national support lines
- Social prescribing services & link working including through FRC's
- Community Support Managers (Family Carers Ireland)
- Upskilling frontline staff to streamline referral pathways to specialised services (DSGBV).

Volunteer & Peer Roles

- Mental Health Advocacy & Support Volunteers for Ethnic Minorities, Ukranian Project, Roma Education Programme, skills-building classes (Cairde)
- Family support programmes: Community Mothers, Parents Plus, MindOut, Start from the Heart and Putting the Pieces Together (FRC's)
- Parents Plus for Children with Additional Needs, Mental Health & Family Carers programme & PPI Panel (Family Carers Ireland)
- The Saol Project's DAVINA peer-support initiatives (DSGBV)
- Married Women Peer Support Groups & First Out for Gay/Bi Men Peer Support Groups (LGBT Ireland)
- Staff-facilitated peer support groups & online Forum (Family Carers Ireland)

- Befriending Services (ALONE, FRC's, LGBT Ireland)
- Multi-lingual integration workers & migrant & refugee peer support work as a sub-group within many priority groups (e.g., Cairde, FRC's & LGBT Ireland).

Collaboration & Partnership

- Advocacy work
- Primary Health Care Project for Travellers & Mind Your Nuck website co-design (Pavee Point)
- Co-produced Mental Health Guide & Directory for Ethnic Minorities & HELLO, How Are You & Thrive Bilbraggin MHP initiatives (Cairde)
- Disabled Persons Organisations (Inclusion Ireland)
- Organisations are managed &/or staffed by priority group members (e.g., FRC's, Pavee Point, Cairde) &/or in the governance structure (Family Carers Ireland)
- MyMind programme and Irish Allied Group & Rainbow Internship programmes in workplaces (LGBT Ireland)
- Sláintecare Healthy Communities work alongside community organisations, in further partnership with FRC's
- Various CBPR (Cairde) & PPI (Family Carers Ireland)
- Criss Cross European project with participatory research to increase awareness & capacity of professionals (DSGBV)
- Enhanced Community Care Programme, Community Impact Network & National Network of Community Service Hubs (ALONE)

Strengthening Communities

- Assets-based approaches using FRC's
- Volunteer-led brunch meet-ups (DSGBV)
- Small, homogenous groups to be culturally appropriate (Sláintecare HC)
- Pathways to Wellbeing (Cairde)
- Minding Your Wellbeing Programme for older people in community settings & for carers (ALONE & Family Carers Ireland)
- New Communities Men's Sheds.

Figure 4. Overview of existing community-based mental health promotion supports offered in Ireland using PHE (2015) framework of family of approaches.

Interventions with volunteer and peer roles: Participants acknowledged that peer and volunteer roles are best practice but noted that training peers and volunteers is challenging and existing funding streams do not seem to account for this. It was also reported that volunteer-based models are unstable and difficult to manage. Success of these models can be based on appropriate volunteer matching, thus efficient resourcing to account for administration and coordination is a key enabler. The importance of understanding cultural preferences when assigning peer leaders was noted. Participants echoed the findings in the scoping review that peer-led and collaborative approaches are an effective way to ensure the cultural appropriateness of supports.

Interventions based on collaborations and partnerships: Participants noted that co-production approaches are most preferred, however, as with peer and volunteer approaches, the necessary training is underestimated, and existing resources do not reflect the complexity of the undertaking. Related is the importance of building capacity in communities so that they are enabled to meaningfully participate in collaboration and partnership to identify and set their own priorities and engage in solutions, implementation and evaluation.

With resources in place, there is scope to further adapt evidence-based programmes, such as Community Mothers, for co-delivery with priority groups. Additionally, it was reported that the true values of Community-Based Participatory Research (CBPR) should be emphasised; that is, meaningful participation and shared decision-making. It was noted that incorrectly implemented CBPR can become harmful, by exacerbating mistrust, if no further action is taken or if findings are not appropriately discussed with research participants.

Interventions to strengthen social networks: While there are many efforts to strengthen communities in Ireland, structured, tailored and documented approaches were rarely reported. Existing efforts align with the findings of the scoping review with opportunity for stronger emphasis, particularly in the case of ethnic minorities and migrants, on champions (representing the priority group) and community wellbeing champions ('lay providers'). Participants emphasised that while evidence-based programmes are best practice, the power of simply connecting peers in a social environment should not be overlooked. Coupling this with opportunities to celebrate culture and/or using empowerment and personal skills-building approaches is particularly promising. It was also noted that the most successful

approaches are ones that build on existing programmes or are embedded within existing services.

Supporting Community-based Mental Health Promotion Practice for Priority Groups in Ireland

Throughout the consultations, certain common implementation enablers and challenges were raised. These fell within five overarching categories: contexts, trust, involvement, funding and evaluation. Each are discussed in turn following.

Mapping the Contexts: In terms of the broader context, it is clear from the consultations that community development must occur within the backdrop of a whole-of-society approach. This is echoed in community engagement literature that calls for a whole systems approach (PHE, 2015; WHO, 2020), as well as evidence in the Irish policy sphere that calls for nationally stewarded, community-led population-level mental health promotion approaches that are underpinned by intersectoral, whole-of-government collaboration (Barry et al., 2023).

In terms of the local contexts, tailored, accessible and understandable communication that reflects the preferences of the local community is vital, and there may be need for a more sensitive understanding of what 'accessible' communication is. It was suggested that national strategies should include dedicated specialist groups for each priority group with specific actions in mental health promotion or community development. There is scope to incentivise intersectoral and multi-agency partnership for sharing of resources and comprehensive engagement of communities. Finally, participants mentioned that a key enabler of community-based mental health promotion is the freedom to co-design creative solutions and real-time responses to changing needs and contexts in the community. While project-specific funding is helpful in general, stable, core funding is more suited to this approach.

Building trust: Participants highlighted trust as a key ingredient to successful community-based efforts for priority groups and key to establishing the conditions for engagement. The most significant enabler was reported as core, stable funding. Meaningful participation and the capacity to direct their own supports and services were also mentioned as important ways to cultivate trust with priority groups. It was also highlighted that there is a need to build trust within the wider context. Upskilling service and health care providers to build meaningful

relationships with priority populations with culturally appropriate communication is one example of wider trust-building.

Encouraging community involvement and connectedness: It was clear from the consultations that a shared understanding of 'meaningful participation' is needed. Community development is a method of meaningful participation that ensures efforts are community-led in terms of identifying collective concerns and solutions, community strengths and weaknesses, disseminating accessible and culturally appropriate information, and delivering services and supports. National guidance, training in mental health promotion and capacity building at all levels including community organisation staff, volunteers and peers is important to enable successful community-led approaches.

Stable funding: Existing funding streams were reported as a major enabler of success, however, all participants note that they are under-resourced and under-staffed. Dedicated funding streams and permanent posts for mental health promotion within each priority group were commonly reported as an enabler to support activities that are not project-specific, such as awareness-raising and essential trust-building phases.

Strengthening the evidence base: Participants called for comprehensive, holistic indicators that adequately capture community-based efforts of mental health promotion. Disaggregated data was highlighted as a crucial way to inform targeted responses, evidence-based policy making and to capture the added value for investment. Participants were of the opinion that stronger commitment is needed for Irish research to develop and investigate specific, tailormade solutions and to contextualise the international evidence. Finally, it should be noted that in terms of identifying best-practice examples, a great deal of good practice is currently not well documented.

Stakeholder Consultations: Conclusions

The findings from the consultations generally align with the international evidence of best practice, both in terms of implementation and the foundational values, including meaningful participation, connectedness, trust, cultural and contextual appropriateness, and sustainability. Existing efforts could benefit from a more structured approach along with ensuring communication is culturally appropriate, empathetic and accessible. There is a crucial role for

health services in this regard, and an opportunity to support professional development. Peer-led and co-produced approaches require significant training, time, resources and core, stable funding and this may not be reflected in current policy priority setting and funding commitments. In general, positioning community-based efforts within the wider context of addressing the structural determinants of mental health is critical. Finally, considering the differences in the use of terminology that were observed in the community and voluntary sector, there is an opportunity to integrate mental health promotion actions within existing community development frameworks, namely the *All Ireland Standards for Community Work* (Community Work Ireland, 2016) that are currently used in the community and voluntary sector in Ireland, given the overlap in core principles and processes.

There are promising evidence-informed community-based initiatives in Ireland, and these could be enhanced through further co-adaptation and co-delivery with target populations in order to capture their specific needs and preferences. Family Resource Centres emerged as a vital asset in communities, both in terms of their physical presence and their ability to strengthen social connectedness within diverse priority groups. Building the capacity of communities to align with international best practice within the Irish context through commitment, guidance and sustainable resources is crucial, and key recommendations based on this study are included in Chapter 4. Finally, supporting the documentation and evaluation of community-based efforts and a commitment to strengthening research will ensure efforts contribute to a growing understanding of the impact of community-based mental health promotion for priority groups in Ireland.

Chapter 4 – Key Recommendations to Support Implementation of Community-Based Mental Health Promotion Interventions for Priority Groups in Ireland

At the conclusion of this project, findings and insights from all phases of the project were synthesised in order to provide a set of key recommendations to support effective implementation of community-based mental health promotion interventions that could be feasibly adopted and scaled-up in the Irish context. These recommendations are presented below to conclude this report.

KEY RECOMMEDATIONS

- A whole-systems approach is needed to ensure that community-based mental health promotion is positioned within a broader plan to address the social determinants of health that are at the root of the health discrepancies experienced by priority population groups.
- Policy action planning and dedicated funding streams should reflect a commitment to community development and partnership approaches. As meaningful participation is central to these approaches, these commitments will also foster meaningful participation within priority communities.
- Supporting organisations, and particularly smaller organisations, with national training and guidance on mental health promotion will help ensure they have the capacity to pro-actively address the needs of their communities while ensuring cohesion across communities in Ireland. This is particularly important given that the terminology used is so different in the Community and Voluntary sector.
- Commitment to an initial trust-building phase that establishes the optimal conditions for engagement is critical for future community-based mental health promotion efforts. Effective implementation is enhanced with the ability to respond to changing contexts and community dynamics. Core, stable funding and resources enable initial community engagement and a level of autonomous problem solving.
- Sustainable resourcing that reflects the long-term nature of community-based mental health promotion outcomes will ensure that efforts maintain integrity and consistency. Additionally, supportive infrastructure beyond the initial intervention development and delivery is key to ensure community engagement is supported sustainably.
- Streamlined referral pathways and upskilling for health services is needed so that frontline staff are aware of community services and can engage appropriately with an intercultural and gender-affirming approach.
- Building upon existing initiatives for priority groups that have existing infrastructure in Ireland can afford ‘early wins’ that can help establish momentum. This includes co-adapting existing evidence-informed programmes and co-delivering them with priority groups. Social Prescribing services, Men’s Sheds, and Community Mothers are a few examples. Efforts that are not currently evidence-informed should endeavour to be more structured and documented, to build the evidence base.
- Mapping community assets collaboratively will strengthen asset-based approaches to promoting community mental wellbeing, such as identification of the key role of Family Resource Centres.
- To be most effective, peer- and volunteer-led approaches should be supported with training, upskilling, supervision and other intervention supports.
- Methods of communication should be tailored to ensure that information is accessible, culturally appropriate and reflects the preferences and needs of priority groups.
- Community-led evaluation will encourage ownership, strengthen the evidence base and ensure that efforts are on-track, while reinforcing political commitment. Communities will need guidance and resources to build their capacity for meaningful evaluation of community-based mental health promotion.

References

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodologicalframework. *International Journal of Social Research Methodology, 8*(1), 19-32.

Barry, M.M., Keppler, T. & Sheridan, A. (2023). *Development of a National Mental Health Promotion Plan: Report prepared for the Department of Health, Ireland.* HPRC, University of Galway. Accessible at https://www.gov.ie/en/policy-information/706608-healthy-ireland-policies/#mental-health-promotion-plan

Community Work Ireland (2016). *All Ireland Standards for Community Work.* Galway: All Ireland Endorsement Body for Community Work Education and Training. Accessible at https://www.cwi.ie/wp-content/uploads/2016/03/All-Ireland-Standards-for-Community-Work.pdf

Department of Health (DOH). (2015). *Connecting for life : Ireland's national strategy to reduce suicide 2015-2020*. Dublin: Department of Health.

DOH. (2020). *Sharing the Vision: A mental health policy for everyone.* Retrieved from Dublin:

DOH. (2021). *Healthy Ireland Survey 2021: Sumary Report*. Retrieved from Dublin: https://www.gov.ie/en/publication/9ef45-the-healthy-ireland-survey-2021/

Gilmartin, D., Mercado-Garrido, E., Harte, P., & Barry, M.M. (2024). *A Scoping Review of the Evidence on Community-based Mental Health Promotion Interventions for Priority Groups.* A report prepared for the Health Service Executive, Ireland. Health Promotion Research Centre, University of Galway.

Gilmartin, D., Mercado-Garrido, E., Harte, P. & Barry, M.M. (2024a). *Defining Priority Population Groups at Risk of Poor Mental Health Outcomes: A* report *to guide a scoping review of the evidence on community-based mental health promotion*

interventions for priority groups. Report prepared for the Health Service Executive, Ireland. Health Promotion Research Centre, University of Galway

Health Service Executive (HSE). (2022). *Stronger Together: The HSE Mental Health Promotion Plan 2022-2027*. Retrieved from Dublin:

HSE. (2024). Social Prescribing. Accessed 22 August 2024 at: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/social-prescribing/

Public Health England (PHE) (2015). *A guide to community-centred approaches for health and wellbeing.* London: Public Health England. Available at: https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches

Public Health England (PHE) (2020). *Community-centred Public Health: Taking a Whole System Approach.* London: Public Health England. Available at: https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., . . . Straus, S. E. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine*(169), 467-473. doi:10.7326/M18-0850

United Nations (2015). *Transforming our world: the 2030 Agenda for Sustainable Development*. Sustainable Development knowledge platform. New York: United Nations. https://sustainabledevelopment.un.org/post2015/transformingourworld

World Health Organisation (WHO) (1986). *Ottawa Charter for Health Promotion*. Geneva, Switzerland: World Health Organization. Accessible at: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

WHO. (2012). *Risks to mental health: An overview of vulnerabilities and risk factors. Background paper by WHO secretariat for the developemnt of a comprehensive mental health action plan*. Retrieved from Geneva: https://cdn.who.int/media/docs/default-source/mental-health/risks_to_mental_health_en_27_08_12.pdf?sfvrsn=44f5907d_10&download=true

WHO. (2020). *Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the People*. Geneva, Switzerland: World Health Organization. Accessible at: https://www.who.int/publications/i/item/9789240010529

WHO. (2021). *Comprehensive Mental Health Action Plan 2013-2030*. Retrieved from Geneva: https://iris.who.int/bitstream/handle/10665/345301/9789240031029-eng.pdf?sequence=1

WHO. (2022). *World Mental Health Report: Transforming mental health for all.* Geneva: World Health Organization.

WHO. (2022a) guidance document ???

WHO. (2023). *Mental Health of Older Adults*. https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

WHO. (2024). *Mental Health*. https://www.who.int/health-topics/mental-health#tab=tab_1.

MAIN REPORT – INTRODUCTION & PROJECT OVERVIEW

This project concerns a review of the evidence on community-based mental health promotion interventions designed to meet the needs of population groups most at risk of developing mental health difficulties. This review set out to identify key priority population groups in the Irish context, together with examples of best practice, drawn from the literature and current practice, that could be feasibly implemented in Irish community settings. The findings will inform the development of community-based mental health promotion initiatives for priority groups in Ireland, based on the community development principles of empowerment, community participation and social inclusion. Integrating a focus on mental health and wellbeing within community development programmes that promote community engagement, connectedness and social inclusion, can enhance the social and emotional wellbeing of community members and create more supportive living environments that will improve people's mental health and wellbeing and reduce inequities, especially for those at highest risk of poor mental health. This section will outline the concepts of community-centred and will conclude with an outline of the project approach.

Background

Community-based mental health promotion

Conceptualising mental health as a positive resource for everyday life, mental health promotion is concerned with strengthening protective factors for good mental health and enhancing wellbeing for individuals, families, communities and society-at-large. This is achieved through strategies that include strengthening individuals and communities, creating supportive environments and implementing intersectoral actions to reduce inequities and remove the structural barriers to mental health at a population level (Barry et al., 2019; World Health Organization (WHO), 2021; WHO, 1986).

Communities are recognised as a powerful setting for mental health promotion (DOH, 2020; WHO, 2022). A community approach to mental health promotion means engaging the wider community composed of multiple actors, sectors, services and systems; where community members act as key stakeholders in mental health promotion programme design, planning, delivery and evaluation. Engaging the community in this way can foster a sense of ownership and connectedness and can create lasting positive change (Barry et al., 2019). Understanding

the nuances of their local ecosystem, communities are well placed to recognise their challenges and opportunities, to understand the characteristics and preferences of their members, and to build on and strengthen local assets.

Community-based mental health promotion maintains the values of empowerment, social inclusion, equity, participation and collaboration to strengthen and enable communities to implement appropriate and acceptable interventions that most effectively address the social determinants of mental health within their local ecosystem (Barry et al., 2019; Kuosmanen et al., 2022: Rickwood & Thomas, 2109; WHO, 2022). In particular, adopting community mental health promotion strategies with priority populations can foster a sense of trust and connectedness while addressing policy commitments to improve mental health and wellbeing for those at highest risk of poor mental health (DOH, 2020).

Community engagement and the wider context

The World Health Organization (WHO) highlights community engagement as being crucial not only to ensuring equity of health and wellbeing in communities but also as a means of achieving the broader health-related targets of the Sustainable Development Goals (WHO, 2020). Community engagement is defined in WHO's Community Engagement Guide as both a dynamic process and an outcome, underpinned by principles including trust, accessibility, contextualization, equity, transparency and autonomy (WHO, 2020). Key enablers identified in the report include governance, leadership, joint decision- making, communication, collaboration and partnership, and resources. The WHO guide adopts the Ottawa Charter Framework for Health Promotion (WHO, 1986), calling for actions that address community priorities intersectorally across many levels that include individuals and professionals, community groups, institutions and governments. Public Health England (PHE), likewise, calls for a whole system approach to community-centred public health (PHE, 2020). In PHE's model (Figure 1), values such as trust, power and relationships form the heart of the approach that aims to involve, strengthen, sustain and scale community efforts. This model also identifies the underlying principles of shifting mindsets, leadership and radical change, collective bravery, co-production and complex systems-thinking. It is, therefore, crucial to position community-centred mental health promotion within a wider policy context that addresses the social determinants of health, acknowledging the upstream support needed to

build community capacity and empower communities to implement community-centred approaches.

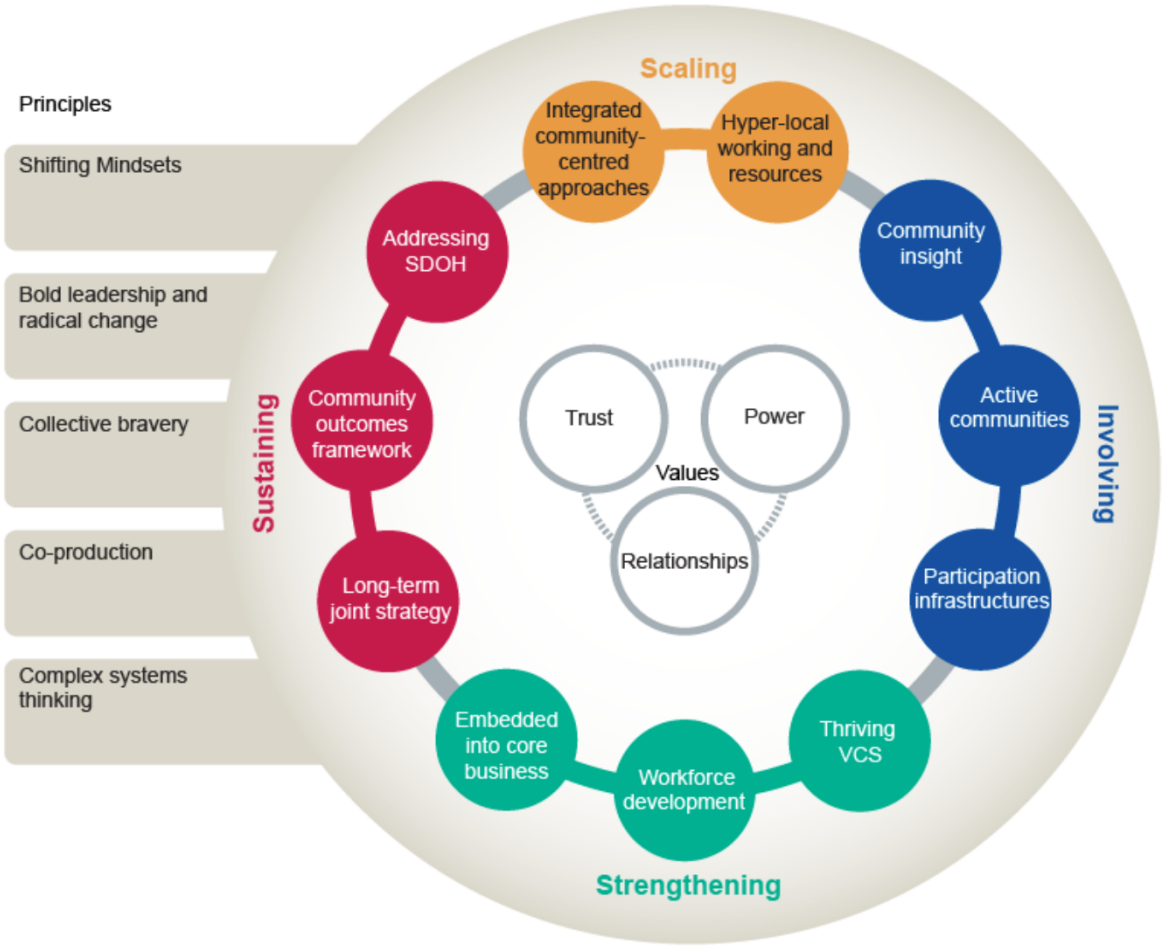


Figure 1. Eleven elements of community-centred public health: a whole system approach (from PHE, 2020)

The importance of mainstreaming community engagement in the promotion of health and wellbeing is outlined by WHO in their guidance document (WHO, 2020), which identifies four interrelated conceptual approaches for community health promotion practice depending on the objectives of community engagement. These approaches include:

- Community-oriented: the community is informed and mobilized to participate in addressing immediate short-term concerns with strong external support.

- Community-based: the community is consulted and involved to improve access to health services and programmes by locating interventions inside the community with some external support.
- Community-managed: there is collaboration with leaders of the community to enable priority settings and decisions from the people themselves with or without external support of partners.
- Community-owned: community assets are fully mobilized, and the community is empowered to develop systems for self-governance, establish and set priorities, implement interventions and develop sustainable mechanisms for health promotion with partners and external support groups as part of a network.

These approaches are centred on the principles of mutual trust between all stakeholders through equity and transparency in decision-making, and ensuring that any health promotion action is geographically, linguistically, and culturally accessible to community members (WHO, 2020; 2022). The facilitators of successful community engagement are identified as including good governance, developing and defining roles within communities, effective leadership complimenting top-down with bottom-up approaches, joint-decision-making, open communication, collaboration and partnership, and mobilising community resources (WHO, 2020).

The Current Study

Within the context of the internationally acknowledged importance of mainstreaming community engagement in the promotion of health and wellbeing, the current study aimed to build upon the existing evidence to identify the most robust evidence concerning effective community-based mental health promotion programmes, with a particular focus on population groups who are deemed to be most at risk of poor mental health outcomes. Furthermore, the study aimed to understand existing community-based mental health promotion best-practice in Ireland. An understanding of the evidence base and existing practice would inform a set of key recommendations to support community-based mental health promotion implementation for priority population groups in Ireland. Details of the study's approach are presented, following.

Approach

The project involved four research objectives, which are outlined below followed by a brief discussion of each:

- Objective 1: To summarise the evidence around community-based mental health promotion interventions.
- Objective 2: To identify best-practice case examples of community-based initiatives in Ireland.
- Objective 3: To provide recommendations on community-based initiatives that could be appropriately resourced and scaled in the Irish context.
- Objective 4: To produce a report of evidence, current practice, and recommendations.

Objective 1: To summarise the evidence around community-based mental health promotion interventions.

1.1 Defining Priority Population Groups

Current policy frameworks including; "Connecting for life: Ireland's national strategy to reduce suicide 2015-2020" (DOH, 2015), "Sharing the Vision: A Mental Health policy for Everyone" (DOH, 2020) and "Stronger Together: The HSE Mental Health Promotion Plan 2022-2027" (HSE, 2022), list specific "at-risk" groups who are at increased risk of mental health difficulties and need more targeted mental health interventions. A background paper that informed the development of the WHO Comprehensive Mental Health Action Plan 2013-2030 (WHO, 2021) identified additional groups as being at increased risk of developing mental health difficulties. Using these documents and definitions of priority population groups as a starting point, a further literature review was undertaken to establish any other "at-risk" subgroups for inclusion.

1.2 Scoping Review

A scoping review of the national and international evidence on community-based mental health promotion interventions that have been implemented for the selected priority population groups was conducted. The review aimed to build upon the findings on community-based mental health promotion initiatives reported in previous studies in order to address the research question: *What effective mental health promotion interventions have been implemented in community-settings for priority population groups?*

Objective 2: To identify best-practice case examples of community-based initiatives in Ireland.

2.1 Consultations with Key Stakeholders

In order to understand existing practice in Ireland, national organisations that have implemented evidence-based mental health initiatives for the selected priority groups were consulted to ascertain what interventions work best for which priority groups and under which conditions. The consultations aimed to outline best-practice case examples of community-based mental health initiatives for priority groups in Ireland along with an understanding of challenges and opportunities for effective implementation.

Objective 3: To provide recommendations on community-based initiatives that could be appropriately resourced and scaled in the Irish context.

3.1 Key Recommendations

Recommendations identifying evidence-based interventions that could be feasibly adopted and scaled-up in the Irish context were drafted, drawing on the following sources:

- Scoping review conclusions on the most effective community-based mental health promotion interventions for the selected priority groups.
- Best-practice case examples of community-based initiatives implemented in Ireland for the selected priority groups.
- Stakeholder consultation on the feasibility of, and support needed for scaling-up selected evidence-based interventions in the Irish context.

Objective 4: To produce a report of evidence, current practice, and recommendations.

4.1 Final Report

The current report is the deliverable for this final objective. Ultimately the project consisted of four phases: defining priority groups, a scoping review of the evidence, stakeholder consultations and providing key recommendations (see Figure 2). Thus, this report will be structured accordingly.

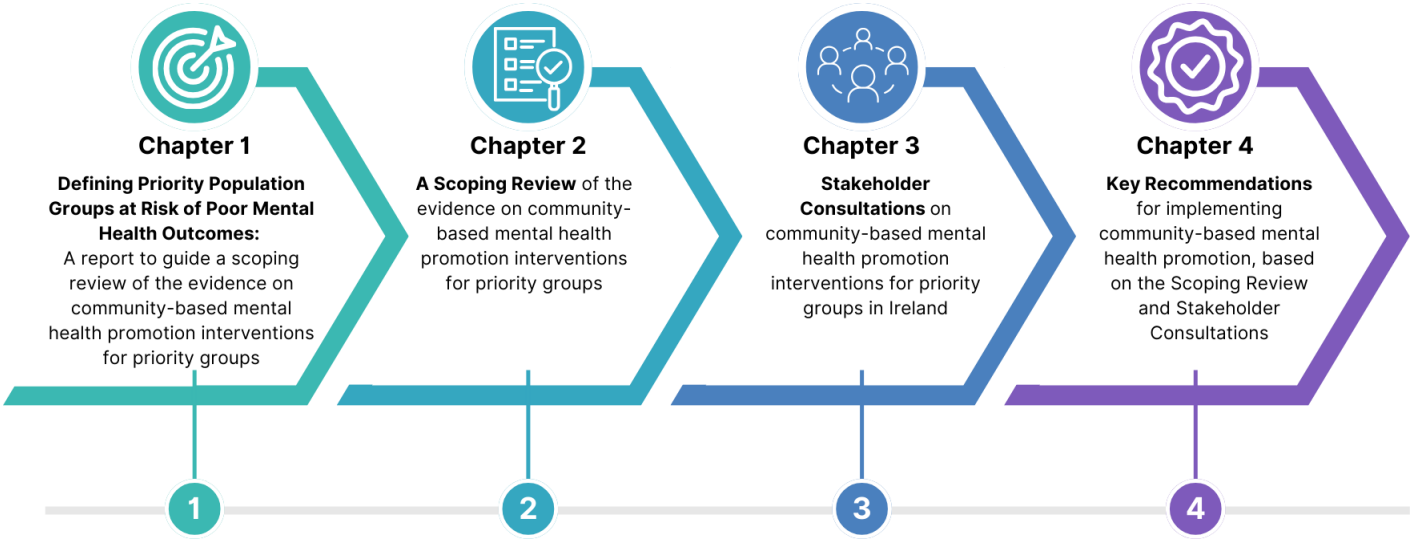


Figure 2. Overview of Chapters in the Final Report: Evidence Review of Community-based Mental Health Promotion Interventions for Priority Groups in Ireland.

Chapter 1 will offer the details of the process of formally defining the priority population groups in Ireland. Chapter 2 will detail the scoping review of the international and national evidence on community-based mental health promotion interventions implemented for priority groups. Chapter 3 will detail the consultations with key stakeholders who support the mental wellbeing of priority groups in communities in Ireland. The report will conclude with Chapter 4, which provides the key recommendations concerning implementing community-based mental health promotion for priority groups in Ireland.

References

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodologicalframework. *International Journal of Social Research Methodology, 8*(1), 19-32.

Auerswald, C. L., Piatt, A. A., & Mirzazadeh, A. (2017). *Research with Disadvantaged, Vulnerable and/or Marginalized Adolescents*. Retrieved from ?????

Barry, M. M., Clarke, A. M., Petersen, I., & Jenkins, R. (2019). *Implementing Mental Health Promotion.* (Second edition). Cham, Switzerland: Springer Nature. https://www.springer.com/in/book/9783030234546 doi:10.1007/978-3-030-23455-3

Davidson, L. (2019). *The Routledge Handbook of International Development, Mental Health and Wellbeing* (1st ed.). London: Routledge.

DOH. (2015). *Connecting for life : Ireland's national strategy to reduce suicide 2015-2020*. Dublin: Department of Health.

DOH. (2020). *Sharing the Vision: A mental health policy for everyone.* Retrieved from Dublin:

DOH. (2021). *Healthy Ireland Survey 2021: Sumary Report*. Retrieved from Dublin: https://www.gov.ie/en/publication/9ef45-the-healthy-ireland-survey-2021/

HSE. (2022). *Stronger Together: The HSE Mental Health Promotion Plan 2022-2027*. Retrieved from Dublin:

IUHPE. (2021). *Critical Actions for Mental Health Promotion* Retrieved from Paris www.iuhpe.org

Kuosmanen, T., Keppler, T., Dowling, K., & Barry, M. M. (2022). *Evidence Synthesis of Impact of Mental Health Promotion: A systematic rapid evidence assessment of the effectiveness of mental health promotion interventions across the lifecourse*. Health Promotion Research Centre, University of Galway.

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., . . . Straus, S. E. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine*(169), 467-473. doi:10.7326/M18-0850

WHO. (2012). *Risks to Mental Health: An overview of vulnerabilities and risk factors. Background paper by WHO secretariat for the developemnt of a comprehensive mental health action plan*. Retrieved from Geneva: https://cdn.who.int/media/docs/default-source/mental-health/risks_to_mental_health_en_27_08_12.pdf?sfvrsn=44f5907d_10&download=true

WHO. (2021). *Comprehensive Mental Health Action Plan 2013-2030*. Retrieved from Geneva: https://iris.who.int/bitstream/handle/10665/345301/9789240031029-eng.pdf?sequence=1

WHO. (2022). *World Mental Health Report: Transforming mental health for all*. Retrieved from Geneva:

CHAPTER 1 – DEFINING PRIORITY POPULATION GROUPS AT RISK OF POOR MENTAL HEALTH OUTCOMES

This phase of the research sought to identify priority groups at risk of poor mental health outcomes. The priority groups defined in this phase of the research will inform the remaining phases of the project, with the ultimate aim of identifying the most robust evidence concerning effective community-based mental health promotion programmes, with a particular focus on population groups who are deemed to be most at risk of poor mental health outcomes.

Context

With reference to the key Irish policy frameworks and WHO background paper listed below, an initial list of population groups at risk of poor mental health outcomes was identified and is presented in Table 1:

- Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020 (DOH, 2015)
- Sharing the Vision: A Mental Health Policy for Everyone (DOH, 2020)
- Stronger Together: The HSE Mental Health Promotion Plan 2022-2027 (HSE, 2022)
- Risks to mental health: An overview of vulnerabilities and risk factors (WHO, 2021), a background paper by the WHO secretariat for the development of the WHO Comprehensive Mental Health Action Plan 2013-2030 (WHO, 2021).

Table 1. Defining Priority Groups

Priority Groups (DOH, 2015; DOH, 2020; HSE, 2022):
Members of LGBTQ+
Members of the Travelling community
People who are homeless
Drug users
People who come in contact with the criminal justice system
People who have experienced abuse (domestic, clerical, sexual or physical)
Asylum seekers
Migrants
Sex workers

Table 1. Defining Priority Groups (*Continued*)

Additional groups:
Children in care
Care leavers
People with disabilities
People with severe to profound deafness
People with co-occurring mental health and substance misuse problems

Additional Priority Groups (WHO, 2012):
Children and adolescents of parents with a mental health disorder
Children and adolescents who have experienced family conflict
Children and adolescents who have experienced playground bullying
Adults recently bereaved
Adults living with chronic illness

Methods

This review provides evidence from the international and national literature, identifying population groups considered most at risk of poor mental health outcomes. Evidence was sourced from review studies and grey literature, including key websites and reports, published within the last 10 years, with the primary outcomes of interest being risk factors associated with poor mental health outcomes amongst population groups.

Search Strategy

Search terms were identified (see Appendix 1.1). Abstracts and titles of journals were searched using combinations of search terms with Boolean operators in the electronic databases of PubMed, PsychInfo and Google Scholar. Given the large literature return and the limited time scale, the literature search was an iterative process, and the initial search was further limited to review papers only. Reference lists of key review studies were screened for further relevant studies. In addition, specific populations namely, migrants, LGBTQ+ groups and disability groups, were each searched individually to ensure population-specific risk factors were captured. Key websites and policy reports were searched for relevant grey literature.

Inclusion and Exclusion Criteria

Studies were included if they were:

- were published in English between 2014-2024
- were peer reviewed
- identified vulnerable population groups at risk of poor mental health outcomes
- identified risk factors to mental health associated with population groups
- focused on prevalence of poor mental health within population groups
- focused on post Covid-19 related mental health in population groups
- international surveys and reports that provided evidence of populations at risk of poor mental health outcomes (Grey Literature)

Studies were excluded if they:

- had a country-specific focus (e.g. people living in remote Australia)
- were from lower income countries (LICs)
- focused on treatment or intervention
- had a medical or clinical focus
- focused on mental health in patients with Covid-19 or related to the period of the Covid-19 pandemic.

Study Selection

Initial screening of review studies was conducted by title and selected studies were exported to Endnote reference manager where, after removal of duplicates, 694 references remained. These references were then screened by abstract and categorised in population groupings based on the life course (children, adolescents, adults, and older adults) and on specific population groupings (migrants, LGBTQI+ groups, those with disabilities, etc). The final studies (n=36 peer reviewed and n=10 grey literature) were prioritised and chosen as evidence, based on the relevance of full texts and the dates of the publication, thereby being the most recent relevant studies.

Data Presentation

Findings from the review are presented in tables and narrative form to outline the evidence of populations at risk of poor mental health outcomes. Risk factors to mental health are reported

using a life course framework, together with presentation of examples of vulnerable populations and their associated specific risk factors.

Results

Priority groups identified in national policies

In the landscape of mental health policies in Ireland, priority groups have been defined in different national plans and actions (see Table 2 in Appendix 1.2). The cornerstone document, "Connecting for Life (2015-2020)", delineates priority groups based on risk of suicidal behaviour as stated by CSO suicide statistics and National Registry of Deliberate Self-Harm. These groups encompass:

- People with mental health problems of all ages
- People with alcohol and drug problems
- People bereaved by suicide
- Members of the LGTB community
- Members of the Traveller community
- People who are unemployed
- Healthcare professionals
- Prisoners

Other groups with potentially increased risk of suicidal behaviour, where the research evidence is either less consistent or limited, included:

- Asylum seekers
- Refugees
- Migrants
- Sex workers
- People with a chronic illness
- People with a disability

Risk factors for poor mental health outcomes - evidence from international studies and reports

Table 3 in Appendix 1.2 outlines recent findings from global, European, and country-specific (UK, Australia, and Canada) international surveys and reports, which highlight key risk factors for poor mental health. These are discussed below.

The global burden of disease study (GBD) (2019) provides an epidemiological overview of mental health from a worldwide perspective. Figure 1.1, on the following page, illustrates global disability-adjusted life-years (DALYs) by mental disorder, sex, and age (GBD 2019 Mental disorders Collaborators, 2022). Mental disorders remain among the top ten leading burden of disease globally. Other key findings of the GBD (2019) study relevant to this report include:

- Globally, anxiety and depression are the most common mental disorders.
- The burden of mental disorders spans the entire life course.
- The greatest burden is carried in adulthood.
- A variance in mental disorders based on sex is evidenced, with females at greater risk of poor mental health outcomes. 57.4% of females and 47.6 % of males globally, live with mental disorders.
- Evidence is provided of the rate and significance of early onset of mental disorders in childhood, adolescence, and young adulthood with half of people who develop a mental disorder before 75 yrs. having a first onset by 19 yrs. (male) or 20 yrs. (female).
- GBD (2019) analysis indicates that depressive disorders and anxiety disorders rank 5th and 9th respectively among the top ten causes of DALYs in Ireland.
  (GBD collaborators, 2022; McGrath et al., 2023).

The **Eurobarometer Flash report, Mental health (2023)**, provides an overview of the views of EU citizens towards mental health. Key findings relevant to this report include:

- 46% of EU respondents experienced a psychosocial problem within the 12 months prior to the survey. 63% of respondents from Ireland experienced a psychosocial problem in the same period.
- Women were more likely than men (52% women vs 39% men) to have experienced a psychosocial problem (feeling anxious or depressed) in the 12 months prior to the survey.
- By percentage of response, EU citizens attribute good mental health to the following factors: living conditions (60%), financial security (53%), physical activity (41%), social contact (41%), work environment (18%), health care facilities (17%).

Figure 1.1. *Global DALYs by mental disorder, sex and age, 2019* (GBD 2019 Mental Disorders Collaborators, 2022)

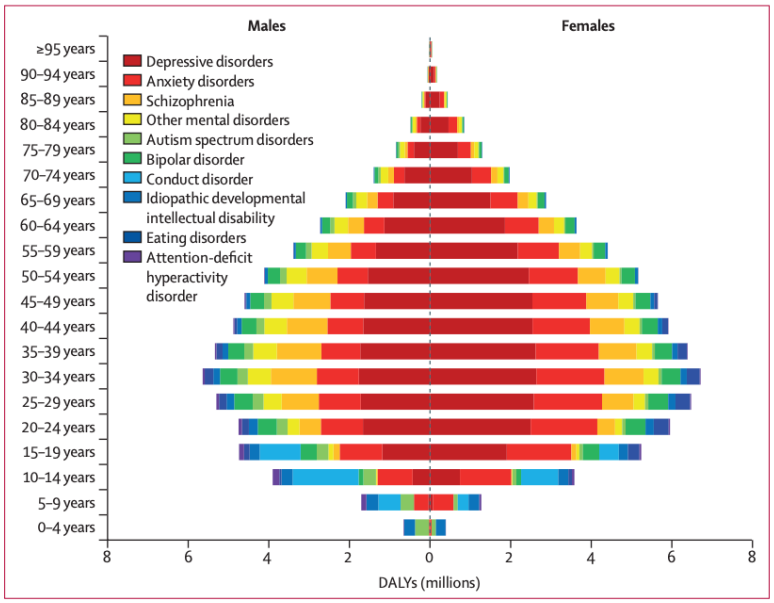


Figure 1: **Global DALYs by mental disorder, sex, and age, 2019**
DALYs=disability-adjusted life-years.

Risk factors for poor mental health evidenced in other surveys, conducted in the UK (Newlove-Delgado, 2023), Australia (Mental Health Australia, 2023), and Canada (Mental Health Research Canada, 2024), included: socioeconomic factors, housing crisis, cost of living, climate change concerns, experiences of bullying, personal screen time usage, living with chronic pain and reduced access to affordable mental health support. The Australian study highlighted vulnerable populations as those who are: indigenous people, carers, LGBTIQ+ groups and people with experience of poor mental health.

Life stage specific risk factors to mental health - evidence from international literature

Mental health is experienced across the life course and risk factors for mental ill health are apparent at all life stages (WHO [World Health Organization], 2012; WHO 2022). Table 4 in Appendix 1.2 outlines examples of risk factors for poor mental health, as they occur across the life course. Intersectionality among factors, which increases the risk of poor mental health outcomes, is evidenced throughout the literature across population groups. Adopting a life course perspective highlights vulnerable or critical periods across the lifecycle when risk to mental health is greater. The life course perspective also highlights the risk of a predisposition towards poor mental health outcomes in later life (Clarke & Lovewell, 2021;

Schilling et al., 2007). Common risk factors for poor mental health occur across adolescents, and adulthood including, but not limited to:

- Prior adverse childhood experiences (ACE's),
- Socioeconomic status
- Educational attainment
- Employment status

and can co-occur with specific risk factors associated with specific life circumstances including, but not limited to:

- Experiences of bereavement
- Becoming a carer
- Living with a chronic illness

Childhood is widely evidenced in the literature as a critical period of development, whereby exposure to adverse childhood experiences (ACEs) determine health and wellbeing in childhood and in later life (Felitti et al., 1998 & Mersky et al., 2013). Children who grow up with exposure to childhood maltreatment and household dysfunction are at greater risk to poor mental health outcomes with intergenerational transmission of maternal ACEs also evidenced in the literature (Ishikawa et al., 2022).

Adolescence is another developmentally critical period where an increased risk of poor mental health outcomes is widely evidenced (Blakemore, 2019). The WHO (2021) indicate that risk factors arising during this formative period include; pressure to conform, exploring of identity and negotiating peer relations, all with a dependency on the quality of home life. Poor physical health, time spent online, experiences of bullying and victimisation, sleep disturbance, climate concern, isolation and loneliness are also identified as risk factors particularly associated with this population group (WHO 2022). Early mental health and behavioural problems in the adolescent population places them at increased risk of becoming NEET (not in education, employment, or training) (Veldman et al., 2022). Young adults who are NEET are at increased the risk of falling into social disadvantage and social isolation, thereby increasing their risk to later poor mental health outcomes (Rodwell et al., 2018). Evidence of the association between substance misuse, including drugs and alcohol, amongst

adolescent populations, and risk to mental health is well documented in the literature (Nath et al.,2022; Gobbi et al., 2019; Sæther et al., 2019).

Adulthood - study findings from the GBD (2019) study indicates that females have a higher risk of poor mental health outcomes when compared with men in the midlife period. The risk of different types of mental health conditions varies by sex, with females presenting with a greater risk of depressive disorder and anxiety, while males present with a greater risk of impulse disorders and substance abuse (GBD, 2019). Regarding women, the perinatal period is a particularly vulnerable time and is cited as a significant risk factor for female mental health (Agrawal et al., 2022; Wong et al., 2023), as is exposure to intimate partner violence (White et al., 2024). Lack of employment is widely evidenced as a significant risk factor for poor mental health outcomes in adult life.

According to the WHO (2023), 14% of **older adults**, that is over 60 years of age, live with a mental disorder. Specific risk factors for poor mental health at this life stage include experiences of ageism (Lyons et al., 2018) and social isolation and loneliness (Teo et al., 2023). According to the WHO (2023), one in six older adults experience abuse of some form – physical, verbal, psychological, sexual, or financial. Such abuse is often carried out by a carer and is a recognised risk factor for depression and anxiety (WHO, 2023). The WHO (2023) remind us that the number of people living longer is increasing and estimate that by 2030, one in six people will be classified as older, leading to an associated burden of care. The WHO (2023) highlight that many older people become carers, for example, of spouses with chronic health conditions, creating a risk factor to carers' own mental health.

Risk factors for poor mental health of vulnerable population groups – evidence from international literature

Considering risk factors for poor mental health beyond a life course approach, the WHO (2022) emphasise the existence of 'spheres of influence', underpinned by a complex interplay of specific life circumstances. The WHO (2022) highlight exposure to adversity as a significant determining factor of mental health outcomes, emphasising that those who experience the most unfavourable circumstances are at greatest risk of poor mental health outcomes. Adverse conditions **include exposure to poverty, violence, inequality, and disability** (WHO, 2024). Additional adverse conditions include exposure to **marginalisation, discrimination, social injustice, and environmental deprivation** (WHO, 2022).

Examples of population-specific risk factors for poor mental health among migrants, LGBTQI+ groups and disability groups are presented in Table 5 in Appendix 1.2. These three groups represent examples of population groups identified in the literature as being vulnerable to experiences of adversity by means of marginalising behaviours such as discrimination, stigma, bullying, social exclusion and experiences of loneliness. A study by Kirkbride et al. (2024) also identifies ethnic minority groups and those living in poverty as marginalised and vulnerable populations. Kirkbride et al. (2024) highlight that marginalised groups are at increased risk of poor mental health outcomes given their frequent exposure to a multitude of intersecting risk factors.

The intersection of risk factors is evidenced by Hill and colleagues (2020) who highlight the increased risk of poor mental health for LGTBQI+ groups when, for example, their community members also present with a disability and/or live in rural areas. Tankersley et al. (2021) also highlight the existence of variations in risk factors across subgroups within the LGBQI+ population. Across vulnerable population groups more broadly, subgroups are also identified for which associated specific risk factors for poor mental health is evidenced in the literature. By way of example, the literature widely supports the increased risk of poor mental health for those living with disabilities and neurodiversity (Mahjoob et al., 2024), with evidence of subgroup-specific risk factors, including but not exclusive to, those living with ADHD (Agnew-Blais et al., 2018), intellectual disability (Totsika et al., 2022), autism (Lai et al., 2019) and physical disability (Downs et al., 2018).

Life course risk factors for poor mental health outcomes – national evidence

Following a comprehensive review of key longitudinal and empirical studies carried out in Ireland, a range of risk factors have been identified and classified. These risk factors can be categorised according to the life stage of the individual (Table 6 in Appendix 1.2), or alternatively, they can be organised based on risks affecting any demographic group, situational factors, or factors pertaining to racism or discrimination, as shown in Table 7 in Appendix 1.2. Concerning life stages (Table 6 in Appendix 1.2), distinct risk factors are more closely associated with childhood, while others are more prevalent during adolescence, adulthood, and older age.

- During childhood, various risk factors can significantly impact a child's mental health and well-being. These include experiencing negative life events such as family violence, lacking a strong connection to schools, being subjected to bullying, etc.
- During adolescence and young adulthood, individuals face various risk factors such as transitioning out of the care system, leaving school early, not pursuing higher education after secondary schooling, and specific health and social challenges among women aged 15-24.
- During adulthood, individuals facing unemployment, financial insecurity, and residing in rural or urban areas may encounter distinct challenges. Additionally, parents or guardians of children with disabilities and carers may be at a higher risk.
- Finally, among older individuals, issues such as social isolation and a history of childhood sexual abuse represent significant challenges.

Risk factors among other groups - national evidence

Regarding risks that may affect any group, as outlined in Table 7 in Appendix 1.2, two distinct categories emerge: those at risk due to experiences of racism or discrimination, and those at risk due to situational factors.

Discussion

This report provides a summary from national and international sources of the evidence identifying risk factors for poor mental health outcomes among different population groups. Herein, it is highlighted that risk factors to mental health are found across all ages and a wide range of population groups, with the complexity of context and intersectionality of risks, influencing the impact of risk factors to mental health outcomes. Specific population groups at risk of poor mental health outcomes identified in this report include; people with mental health problems, people with alcohol and drug problems, people bereaved by suicide, members of the LGBTQ+ community, members of the Traveller and Roma community, people who are unemployed or homeless, healthcare professionals, prisoners; asylum seekers, refugees and migrants, sex workers, people with a chronic illness, and people with disabilities and their families.

The complexity of defining priority population groups is captured herein, with the evidence illustrating that risk factors for poor mental health present with a both commonality and a

specificity across population groups. Commonality of factors are highlighted with presentation of findings using a life course approach. While specific factors are evident in the presentation of findings relating to vulnerable population groups and subgroups (e.g., migrants, LGBTQ+, disability groups), the report also highlights the existence and impact of intersectionality between risk factors. The WHO (2024, 2022) advocate for populations who are most at risk of poor mental health outcomes, that is, those exposed to adversity such as living with: poverty, violence, environmental deprivation, and disabilities and those who experience inequality, discrimination, and marginalisation. The evidence identified in this report was evaluated and priority populations defined, with reference to direction from WHO (2022), and the focus of this study, that being community-based mental health promotion interventions.

Conclusion

In keeping with recommendations by the WHO (2022), that highlight adversity as one of the most influential risk factors to mental health, conclusions were made following a presentation of the findings of this review and a discussion with the Health Service Executives (HSE) stakeholders, that the next stage of research should focus on vulnerable population groups who live with, or experience adversity in its many forms.

As presented in Table 2, on the following page, it was concluded that the groups most at risk of poor mental health outcomes and suited to a community-based mental health promotion approach were: members of the LGTBQ+ community; members of the Traveller and Roma community; asylum seekers, refugees and migrants; people living with a chronic illness; carers; people not engaged in education, employment or training (NEET); people who experience social isolation and loneliness; and people who experience or have experienced domestic violence. These populations will form the focus of the scoping review to follow: An evidence review of community-based mental health promotion interventions for priority groups.

Table 2. Priority Groups Selected for the Purpose of this Study

- People living with disabilities and their families
- People experiencing social isolation and loneliness
- People living in deprived and disadvantaged communities
- Carers of people living with chronic illness
- Migrants and refugees
- Ethnic populations, including Traveller and Roma communities
- People with experience of domestic violence
- Members of the LGTBQI+ community
- Young people not in education, employment, or training (NEET)

References

Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., . . . Zhou, S. (2018). The UCL & Lancet Commission on Migration and Health: The health of a world on the move. *The Lancet, 392*(10164), 2606-2654. https://doi.org/10.1016/S0140-6736(18)32114-7

Agnew-Blais, J. C., Polanczyk, G. V., Danese, A., Wertz, J., Moffitt, T. E., & Arseneault, L. (2018). Young adult mental health and functional outcomes among individuals with remitted, persistent, and late-onset ADHD. *The British Journal of Psychiatry, 213*(3), 526-534. . https://doi.org/10.1192/bjp.2018.97

Agrawal, I., Mehendale, A. M., & Malhotra, R. (2022). Risk factors of postpartum depression. *Cureus, 14*(10). https://doi.org/10.7759/cureus.30898

All Ireland Traveller Health Study Team. (2010). *All Ireland Traveller Health Study: Summary of findings.* Dublin: Department of Health and Children. http://hdl.handle.net/10147/111897

Berry, A., & Frazer, P. (2021). How sex workers understand their experiences of working in the republic of Ireland. *Sexuality Research and Social Policy*, *18*, 869-884.

Blakemore, S.J. (2019). Adolescence and mental health. *The Lancet, 393*(10185), 2030-2031. https://doi.org/10.1016/S0140-6736(19)31013-X

Brady, C., Fenton, C., Loughran, O., Hayes, B., Hennessy, M., Higgins, A., & McLoughlin, D. M. (2023). Dublin hospital workers' mental health during the peak of Ireland's COVID-19 pandemic. *Irish Journal of Medical Science (1971-)*, *192*(3), 1293-1302.

Castelpietra, G., Knudsen, A. K. S., Agardh, E. E., Armocida, B., Beghi, M., Iburg, K. M., . . . Monasta, L. (2022). The burden of mental disorders, substance use disorders and self-harm among young people in Europe, 1990-2019: Findings from the Global Burden of

Disease Study 2019. *The Lancet Regional Health – Europe, 16*. https://doi.org/10.1016/j.lanepe.2022.100341

Clarke, A., & Lovewell, K. (2021). *Adolescent Mental Health Evidence Brief 2: The relationship between emotional and behavioural problems in adolescence and adult outcomes.* London: Early Intervention Foundation. https://www.eif.org.uk/report/adolescent-mental-health-evidence-brief2-emotional-and-behavioural-problems-in-adolescence-and-adult-outcomes

Cleary, A., Feeney, M., & Macken-Walsh, A. (2012). *Pain and Distress in Rural Ireland. A qualitative study of suicidal behaviour among men in rural areas. Summary of report*. Dublin: University College Dublin & Teagasc, Agriculture and Food Development Authority.

College of Psychiatrists of Ireland. (2019). *The physical, Mental and Psychological Impact of Caring.* https://irishpsychiatry.ie/wp-content/uploads/2019/05/Paying-the-Price-The-Physical-Mental-and-Psychological-Impact-of-Caring.pdf

Coulter, S., Mooney, S., & MacDonald, M. (2020). *The Mental Health Needs of Children in Care and Children Adopted in Counties Louth and Meath: Exploring Current Service Provision. Report prepared for Louth and Meath Children's Services Committees funded by Pobal under the Healthy Ireland programme*. https://pure.qub.ac.uk/en/publications/the-mental-health-needs-of-children-in-care-and-children-adopted-

Department of Children, Equality, Disability, Integration, and Youth (DCEDIY). (2023). *State of The Nation's Children: Key Findings.* https://www.gov.ie/en/publication/79897-state-of-the-nations-children-key-findings/

Dooley, B., O'Connor, C., Fitzgerald, A., & O'Reilly, A. (2019). *My World Survey 2.* https://myworldsurvey.ie/

Downs, J., Blackmore, A. M., Epstein, A., Skoss, R., Langdon, K., Jacoby, P., Whitehouse, A. J. O., Leonard, H., Rowe, P. W., & Glasson, E. J. (2018). The prevalence of mental health disorders and symptoms in children and adolescents with cerebral palsy: A systematic review and meta-analysis. *Developmental Medicine & Child Neurology, 60*(1), 30-38. https://doi.org/10.1111/dmcn.13555

Economic & Social Research Institute (ESRI). (2021). *Risk and Protective Factors for Mental Health and Wellbeing in Childhood and Adolescence.* https://www.esri.ie/publications/risk-and-protective-factors-for-mental-health-and-wellbeing-in-childhood-and

Economic and Social Research Institute (ESRI) and Trinity College Dublin (TCD). (2023). *Growing up in Ireland. Key findings: Cohort '08 at 13 years old.* https://www.esri.ie/publications/growing-up-in-ireland-key-findings-cohort-08-at-13-years-old#:~:text=New%20research%20shows%20that%20the,adolescence%20caused%20by%20the%20pandemic.

European Commission (2023). *Eurobarometer Flash Report -Mental Health.* https://europa.eu/eurobarometer/surveys/detail/3032

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258. https://doi.org/10.1016/s0749-3797(98)00017-8

Gallagher, S., & Hannigan, A. (2014). Depression and chronic health conditions in parents of children with and without developmental disabilities: The growing up in Ireland

cohort study. *Research in Developmental Disabilities*, *35*(2), 448-454. https://doi.org/10.1016/j.ridd.2013.11.029

Gariépy, G., Danna, S. M., Hawke, L., Henderson, J., & Iyer, S. N. (2022). The mental health of young people who are not in education, employment, or training: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 57*(6), 1107-1121. https://doi.org/10.1007/s00127-021-02212-8

Gleeson, C., Frost, R., Sherwood, L., Shevlin, M., Hyland, P., Halpin, R., Murphy, J. & Silove, D. (2020). Post-migration factors and mental health outcomes in asylum-seeking and refugee populations: a systematic review. *European Journal of Psychotraumatology, 11*(1), 1793567. https://doi.org/10.1080/20008198.2020.1793567

Global Burden of Disease (GBD) 2019 Mental Disorders Collaborators. (2022). Global, regional and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: A systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry,* 9(2), 137-150.

Gobbi, G., Atkin, T., Zytynski, T., Wang, S., Askari, S., Boruff, J., Ware, M., Marmorstein, N., Cipriani, A., Dendukuri, N. & Mayo, N. (2019). Association of cannabis use in adolescence and risk of depression, anxiety, and suicidality in young adulthood: A systematic review and meta-analysis. *JAMA Psychiatry, 76*(4), 426-434. https://doi.org/10.1001/jamapsychiatry.2018.4500

Higgins, A., Downes, C., Murphy, R., Sharek, D., Begley, T., McCann, E., Sheerin, F., Smyth, S., De Vries, J. & Doyle, L. (2021). LGBT+ young people's perceptions of barriers to accessing mental health services in Ireland. *Journal of Nursing Management*, *29*(1), 58-67. https://doi.org/10.1111/jonm.13186

Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia.* Australian Research Centre in Sex, Health and Society, La Trobe University.

Hou, W. K., Liu, H., Liang, L., Ho, J., Kim, H., Seong, E., Bonanno, G. A., Hobfoll, S. E., & Hall, B. J. (2020). Everyday life experiences and mental health among conflict-affected forced migrants: A meta-analysis. *Journal of Affective Disorders, 264*, 50-68. https://doi.org/10.1016/j.jad.2019.11.165

Institute for Health Metrics and Evaluation (IHME). (2019). *Global Burden of Disease..* https://www.healthdata.org/research-analysis/health-by-location/profiles/ireland

Ipsos MRBI. (2023). *Healthy Ireland Survey.* https://www.gov.ie/en/publication/73c9d-healthy-ireland-survey-2023/

Irish Department of Health. (2020). *Shaping the Vision. A Mental Health Policy for Everyone.* https://www.hse.ie/eng/about/who/mentalhealth/sharing-the-vision/

Ishikawa, K., Azuma, N., & Ohka, M. (2022). Intergenerational transmission of maternal adverse childhood experiences on next generation's development: A mini-review. *Frontiers in Psychology, 13*, 852467. https://doi.org/10.3389/fpsyg.2022.852467

Jannesari, S., Hatch, S., Prina, M., & Oram, S. (2020). Post-migration social–environmental factors associated with mental health problems among asylum seekers: A systematic review. *Journal of Immigrant and Minority Health, 22*(5), 1055-1064. https://doi.org/10.1007/s10903-020-01025-2

Kamiya, Y., Timonen, V., & Kenny, R. A. (2016). The impact of childhood sexual abuse on the mental and physical health, and healthcare utilization of older adults. *International Psychogeriatrics*, *28*(3), 415-422. https://doi.org/10.1017/S1041610215001672

Kattari, S. K. (2020). Ableist microaggressions and the mental health of disabled adults. *Community Mental Health J, 56*(6), 1170-1179. https://doi.org/10.1007/s10597-020-00615-6

Kieling, C., Buchweitz, C., Caye, A., Silvani, J., Ameis, S. H., Brunoni, A. R., . . . Merikangas, K. R. (2024). Worldwide prevalence and disability from mental disorders across childhood and adolescence: Evidence from the Global Burden of Disease Study. *JAMA Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2023.5051

Kirkbride, J. B., Anglin, D. M., Colman, I., Dykxhoorn, J., Jones, P. B., Patalay, P., Pitman, A., Soneson, E., Steare, T., Wright, T. & Griffiths, S. L. (2024). The social determinants of mental health and disorder: evidence, prevention and recommendations. *World Psychiatry, 23*(1), 58-90. https://doi.org/10.1002/wps.21160

Kotera, Y., & Maughan, G. (2020). Mental health of Irish students: Self-criticism as a complete mediator in mental health attitudes and caregiver identity. *Journal of Concurrent Disorders*. http://hdl.handle.net/10545/624480

Lai, M.-C., Kassee, C., Besney, R., Bonato, S., Hull, L., Mandy, W., Szatmari, P., & Ameis, S. H. (2019). Prevalence of co-occurring mental health diagnoses in the autism population: a systematic review and meta-analysis. *The Lancet Psychiatry, 6*(10), 819-829. https://doi.org/10.1016/S2215-0366(19)30289-5

Lyons, A., Alba, B., Heywood, W., Fileborn, B., Minichiello, V., Barrett, C., Hinchliff, S., Malta, S. & Dow, B. (2018). Experiences of ageism and the mental health of older adults. *Aging & Mental Health, 22*(11), 1456-1464. https://doi.org/10.1080/13607863.2017.1364347

Mahjoob, M., Paul, T., Carbone, J., Bokadia, H., Cardy, R. E., Kassam, S., Anagnostou, R., Andrade, B. F., Penner, M. & Kushki, A. (2024). Predictors of health-related quality

of life in neurodivergent children: A systematic review. *Clinical Child and Family Psychology Review, 27*(1), 91-129. https://doi.org/10.1007/s10567-023-00462-3

Marquis, S., McGrail, K., & Hayes, M. V. (2020). Using administrative data to examine variables affecting the mental health of siblings of children who have a developmental disability. *Research in Developmental Disabilities*, *96*, 103516. https://doi.org/10.1016/j.ridd.2019.103516

McGrath, J. J., Al-Hamzawi, A., Alonso, J., Altwaijri, Y., Andrade, L. H., Bromet, E. J., . . . Zaslavsky, A. M. (2023). Age of onset and cumulative risk of mental disorders: a cross-national analysis of population surveys from 29 countries. *The Lancet Psychiatry, 10*(9), 668-681. https://doi.org/10.1016/S2215-0366(23)00193-1

McMahon, E. M., Corcoran, P., Keeley, H., Cannon, M., Carli, V., Wasserman, C., ... & Wasserman, D. (2017). Mental health difficulties and suicidal behaviours among young migrants: multicentre study of European adolescents. *BJPsych open*, *3*(6), 291-299. https://doi.org/10.1192/bjpo.bp.117.005322

Mental Health Australia. (2023). *Report to the Nation 2023. Ipsos public affairs.* https://mhaustralia.org/report/2023-report-nation

Mental Health Research Canada. (2024). *Understanding the mental health of Canadians through Covid 19 and beyond: poll 19 Pollara strategic insights*. https://www.mhrc.ca/findings-of-poll-19

Mersky, J. P., Topitzes, J., & Reynolds, A. J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: A cohort study of an urban, minority sample in the U.S. *Child Abuse & Neglect, 37*(11), 917-925. https://doi.org/10.1016/j.chiabu.2013.07.011

Mesa-Vieira, C., Haas, A. D., Buitrago-Garcia, D., Roa-Diaz, Z. M., Minder, B., Gamba, M., . . . Franco, O. H. (2022). Mental health of migrants with pre-migration exposure to

armed conflict: a systematic review and meta-analysis. *The Lancet Public Health, 7*(5), e469-e481. https://doi.org/10.1016/S2468-2667(22)00061-5

Murphy, R., Keogh, B., & Higgins, A. (2021). An embodied distress: African asylum seekers' experiences of mental health difficulties while awaiting an asylum outcome in Ireland. *Transcultural Psychiatry*, *58*(2), 239-253. https://doi.org/10.1177/1363461520966108

Nath, A., Choudhari, S. G., Dakhode, S. U., Rannaware, A., & Gaidhane, A. M. (2022). Substance abuse amongst adolescents: An issue of public health significance. *Cureus, 14*(11), e31193. https://doi.org/10.7759/cureus.31193

National Institute of Mental Health (NIMH). (2021). *Chronic illness and mental health: Recognising and treating depression.* https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health#part_6722.

National Institute of Mental Health (NIMH). (2023). *Perinatal Depression*. https://www.nimh.nih.gov/health/publications/perinatal-depression

Newlove-Delgado T, M. F., Williams T, Mandalia D, Dennes M, McManus S, Savic M, Treloar W, Croft K, Ford T. (2023). *Mental Health of Children and Young People in England, 2023- wave 4 follow up to the 2017 survey.* NHS England. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up

Power, E., Clarke, M., Kelleher, I., Coughlan, H., Lynch, F., Connor, D., Fitzpatrick, C., Harley, M. & Cannon, M. (2015). The association between economic inactivity and mental health among young people: a longitudinal study of young adults who are not in employment, education or training. *Irish Journal of Psychological Medicine*, *32*(1), 155-160. https://doi.org/10.1017/ipm.2014.85

Rodwell, L., Romaniuk, H., Nilsen, W., Carlin, J. B., Lee, K. J., & Patton, G. C. (2018). Adolescent mental health and behavioural predictors of being NEET: A prospective study of young adults not in employment, education, or training. *Psychological Medicine, 48*(5), 861-871. https://doi.org/10.1017/S0033291717002434

Sæther, S. M. M., Knapstad, M., Askeland, K. G., & Skogen, J. C. (2019). Alcohol consumption, life satisfaction and mental health among Norwegian college and university students. *Addictive Behaviors Reports, 10*, 100216. https://doi.org/10.1016/j.abrep.2019.100216

Schilling, E. A., Aseltine, R. H., & Gore, S. (2007). Adverse childhood experiences and mental health in young adults: a longitudinal survey. *BMC Public Health, 7*(1), 30. https://doi.org/10.1186/1471-2458-7-30

Silke, C., Brady, B., & Heary, C. (2024). *Adolescent Mental Health & Adversity: Profiles & Trends in the West of Ireland from 2018-2022*. Galway, Ireland: UNESCO Child & Family Research Centre.

Smyth, E., Murray, A., McNamara, E., O'Mahony, D., Nolan, A., Duggan, B., & Shaw, J. (2022). *Growing up in Ireland: Research needs for wave 5: Age 25.* https://www.esri.ie/publications/growing-up-in-ireland-research-needs-for-wave-5-age-25-cohort-98

Spillane, A., Matvienko-Sikar, K., Larkin, C., Corcoran, P., & Arensman, E. (2018). What are the physical and psychological health effects of suicide bereavement on family members? An observational and interview mixed-methods study in Ireland. *BMJ open,* 8(1), e019472. https://doi.org/10.1136/bmjopen-2017-019472

Tankersley, A. P., Grafsky, E. L., Dike, J., & Jones, R. T. (2021). Risk and resilience factors for mental health among transgender and gender nonconforming (TGNC) youth: A

systematic review. *Clin Child Fam Psychol Rev, 24*(2), 183-206. https://doi.org/10.1007/s10567-021-00344-6

Teo, R. H., Cheng, W. H., Cheng, L. J., Lau, Y., & Lau, S. T. (2023). Global prevalence of social isolation among community-dwelling older adults: A systematic review and meta-analysis. *Archives of Gerontology and Geriatrics, 107*, 104904. https://doi.org/10.1016/j.archger.2022.104904

Totsika, V., Liew, A., Absoud, M., Adnams, C., & Emerson, E. (2022). Mental health problems in children with intellectual disability. *Lancet Child Adolesc Health, 6*(6), 432-444. https://doi.org/10.1016/s2352-4642(22)00067-0

Veldman, K., Reijneveld, S. A., Hviid Andersen, J., Nøhr Winding, T., Labriola, M., Lund, T., & Bültmann, U. (2022). The timing and duration of depressive symptoms from adolescence to young adulthood and young adults' NEET status: the role of educational attainment. *Social Psychiatry and Psychiatric Epidemiology, 57*(1), 83-93. https://doi.org/10.1007/s00127-021-02142-5

Villani, J., Kuosmanen, T., McDonagh, M, Barry, M.M. (2023). *Traveller Mental Wellness Continuum: A qualitative peer research study of Travellers' views. Summary Report*. Health Promotion Research Centre, University of Galway.

Wallace, E. R., O'Neill, S., & Lagdon, S. (2024). Risk and protective factors for suicidality among lesbian, gay, bisexual, transgender, and queer (LGBTQ+) young people, from countries with a high global acceptance index (GAI), within the context of the socio-ecological model: A scoping review. *Journal of Adolescence.* https://doi.org/10.1002/jad.12308

Ward, M., Briggs, R., McGarrigle, C. A., De Looze, C., O'Halloran, A. M., & Kenny, R. A. (2023). The bi-directional association between loneliness and depression among older

adults from before to during the COVID-19 pandemic. *International Journal of Geriatric Psychiatry*, *38*(1), e5856 https://doi.org/10.1002/gps.5856.

White, S. J., Sin, J., Sweeney, A., Salisbury, T., Wahlich, C., Montesinos Guevara, C. M., . . . Iqbal, N. (2024). Global prevalence and mental health outcomes of intimate partner violence among women: a systematic review and meta-analysis. *Trauma, Violence, & Abuse, 25*(1), 494-511. https://doi.org/10.1177/15248380231155529

Wong, S.-C., Do, P. H., Eisner, M., Hughes, C., Valdebenito, S., & Murray, A. L. (2023). An umbrella review of the literature on perinatal domestic violence: prevalence, risk factors, possible outcomes and interventions. *Trauma, Violence, & Abuse, 24*(3), 1712-1726. https://doi.org/10.1177/15248380221080455

World Health Organization (WHO). (2012). *Risks to Mental Health: An overview of vulnerabilities and risk factors*. Background paper by WHO secretariat for the development of a comprehensive mental health action plan. https://www.who.int/publications/m/item/risks-to-mental-health

World Health Organization (WHO). (2021). *Mental Health of Adolescents*. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

World Health Organization (WHO). (2022). *World Mental Health Report: Transforming mental health for all.* Geneva: World Health Organization.

World Health Organization (WHO). (2023). *Mental Health of Older Adults*. https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

World Health Organization (WHO). (2024). *Mental Health*. https://www.who.int/health-topics/mental-health#tab=tab_1.

CHAPTER 2 – SCOPING REVIEW OF THE EVIDENCE ON COMMUNITY-BASED MENTAL HEALTH PROMOTION INTERVENTIONS FOR PRIORITY GROUPS

Introduction

Community-based mental health promotion initiatives, rooted in the principles of empowerment, community engagement and social inclusion, show promising evidence of effectiveness in empowering community members, building social support and connectedness, reducing inequities, and improving mental health and wellbeing for all, including those at highest risk of poor mental health (Barry et al., 2019; Kuosmanen et al., 2022: Rickwood & Thomas, 2109; World Health Organization (WHO), 2022). This scoping review sought to identify the most robust evidence for effective community-based mental health promotion programmes for the following priority groups as outlined in the previous chapter:

- People living with disabilities and their families
- People experiencing social isolation and loneliness
- People living in deprived and disadvantaged communities
- Carers of people living with chronic illness
- Migrants and refugees
- Ethnic populations, including Traveller and Roma communities
- People with experience of domestic violence
- Members of the LGTBQI+ community
- Young people not in education, employment, or training (NEET)

While evidence points to the effectiveness of community-based mental health promotion interventions in improving mental health and wellbeing, the quality of the existing evidence is mixed, and many extant reviews do not focus specifically on vulnerable population groups (Kuosmanen et al., 2022). Additionally, community interventions do not always lend themselves to traditional experimental evaluations such as randomised controlled trials (RCTs) and are, therefore, less likely to be included in traditional evidence reviews. This review, therefore, has an explicit focus on intervention effectiveness for the identified priority population groups and a broader scope extending beyond RCTs, in order to identify the most

robust studies that can inform best practice on developing and implementing community-based interventions for marginalised and vulnerable population groups.

This chapter includes an overview of the methodological approach employed in this review, including the rationale for a scoping review, a narrative summary of the main findings, a discussion and conclusion with key recommendations for community-based approaches to mental health promotion initiatives for priority groups in Ireland. The findings from this phase of the research, together with parallel consultations being conducted with national organisations that work with priority groups (in the next phase of this research, reported in Chapter 3), will help identify best-practice examples that can inform the development of community-based mental health promotion initiatives for priority groups that could be implemented and scaled-up in the Irish context.

Methods

Approach

Building on the existing evidence and considering its limitations, a scoping review approach was deemed the most appropriate for this study in order to explore the breadth and depth of the existing literature. The inclusion of a variety of evidence in scoping reviews such as primary research, reviews, grey literature, and case examples from key stakeholders gives greater depth to the review and allows for a more complete mapping of all the available evidence on community-based mental health promotion initiatives for the identified priority groups, as listed earlier.

The methods used in the identification of selected priority population groups, which form the focus of this scoping review, are detailed in a previous chapter. The specific priority groups identified as being at increased risk of mental health difficulties include:

- People living with disability and their families
- People experiencing social isolation and loneliness
- People living in deprived and disadvantaged communities
- Carers of people living with chronic illness
- Migrants and refugees
- Ethnic populations, including Traveller communities and & Roma communities
- People with experience of domestic violence

- Members of the LGTBQI+ community
- Young people NEET

Review Aim. The scoping review was guided by the research question:

> ***What effective mental health promotion interventions have been implemented in community settings for priority population groups?***

The overall aim of the scoping review was to explore the existing evidence on community-based mental health promotion interventions for the identified priority populations.
More specific objectives include:

- To identify the types and focus of mental health promotion interventions that have been found to be effective in promoting the mental health and wellbeing of priority population groups.
- To examine the process of implementation of effective mental health promotion interventions for priority groups, including the who, what, where when and how.
- To explore the potential of scaling up these interventions in the Irish context.

Study Selection. The scoping review followed the Preferred Reporting Items for Systematic reviews and Meta-Analysis extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). The search process was more broadly guided by the five main stages outlined in the Arksey & O'Malley framework (2005):

I. Identification of the research question
II. Identification of relevant studies
III. Selection of studies
IV. Extraction and charting of data
V. Collation, summary, and reporting of findings.

Sources and Search Strategy. A search of six electronic databases, PubMed, Scopus, PsycINFO, Embase, CINHAL and Cochrane, was conducted by two researchers to retrieve relevant peer-reviewed papers pertaining to community-based mental health promotion initiatives for the priority groups of interest. The initial search was carried out in PubMed,

refined, and then translated across the other five databases. Search limiters included English language text only and publications since 2014.

Search Terms. The search strategy was informed by the research question and was developed through discussions with the research team. Table 1 (in Appendix 2.1) outlines the general concepts and search terms used. Individual search terms were combined with the Boolean operator OR and concepts were combined with AND. Search lines looked for terms in both abstract and title.

Eligibility Criteria. Study selection criteria (see Table 2) were developed in line with the Population Concept Context (PCC) framework (Munn et al., 2018) that informed the research question. Studies were deemed eligible for inclusion if they:

- were published since 2014
- were published in English
- provided evidence of community-based mental health promotion initiatives
- had a focus on mental health promotion and the primary prevention of mental health
- included priority population groups as outlined in this scoping review

Articles were not included if:

- interventions did not have a focus on community-based approaches
- programme delivery was in clinical or therapeutic settings
- participants had complex mental health difficulties
- studies evaluated treatment programmes
- participants did not fall into the priority group categories as defined herein

Table 2 Study selection criteria

	Inclusion Criteria	Exclusion Criteria
Population	Members of selected priority groups	Members of priority groups not selected for inclusion in this review Participants with complex mental health difficulties

Concept	Any community-based initiative/interventions/programmes that aim to promote the mental health/prevent mental health disorders of members of selected priority groups (universal/selective/indicated)	Interventions not having a community-based approach Interventions not containing a mental health promotion/prevention component Treatment programmes
Context	Interventions/programmes delivered in community settings, including the digital communities	Interventions not delivered in community settings Interventions delivered in clinical/therapeutic settings

Screening Process. The initial search of the six electronic databases yielded a total of 33,624 peer-reviewed journal articles. These studies were exported to Rayyan software (www.rayyan.ie) where deduplication resulted in 19, 316 remaining articles. Due to the volume of articles and the limited resources, including a short project timeline, it was decided by the research team to include only review papers in the screening process. Using Rayyan, articles were screened for review papers only, to include systematic reviews and meta-analyses, scoping reviews, rapid reviews and narrative reviews. This left 2,737 reviews for screening.

Two reviewers (DG and EMG) screened the 2,737 reviews by title and abstract for relevance based on the 'a priori' inclusion and exclusion criteria outlined in Table 2. After title and abstract screening, some 149 reviews remained for full-text review. Eligible studies were then read in full, and eligibility was agreed between researchers (DG and EMG) and the research team. Selected studies were then exported to EndNote reference manager and grouped according to the population groups of interest they pertained to. A total of 33 review studies that met the eligibility criteria remained for data extraction. These reviews synthesised evidence on community-based approaches to promote the mental health of the following priority groups: people living with disabilities and their families (n= 2), people experiencing social isolation and loneliness (n= 8), people living in disadvantaged communities (n= 2), carers of people living with chronic illness (n= 4), refugees and migrants

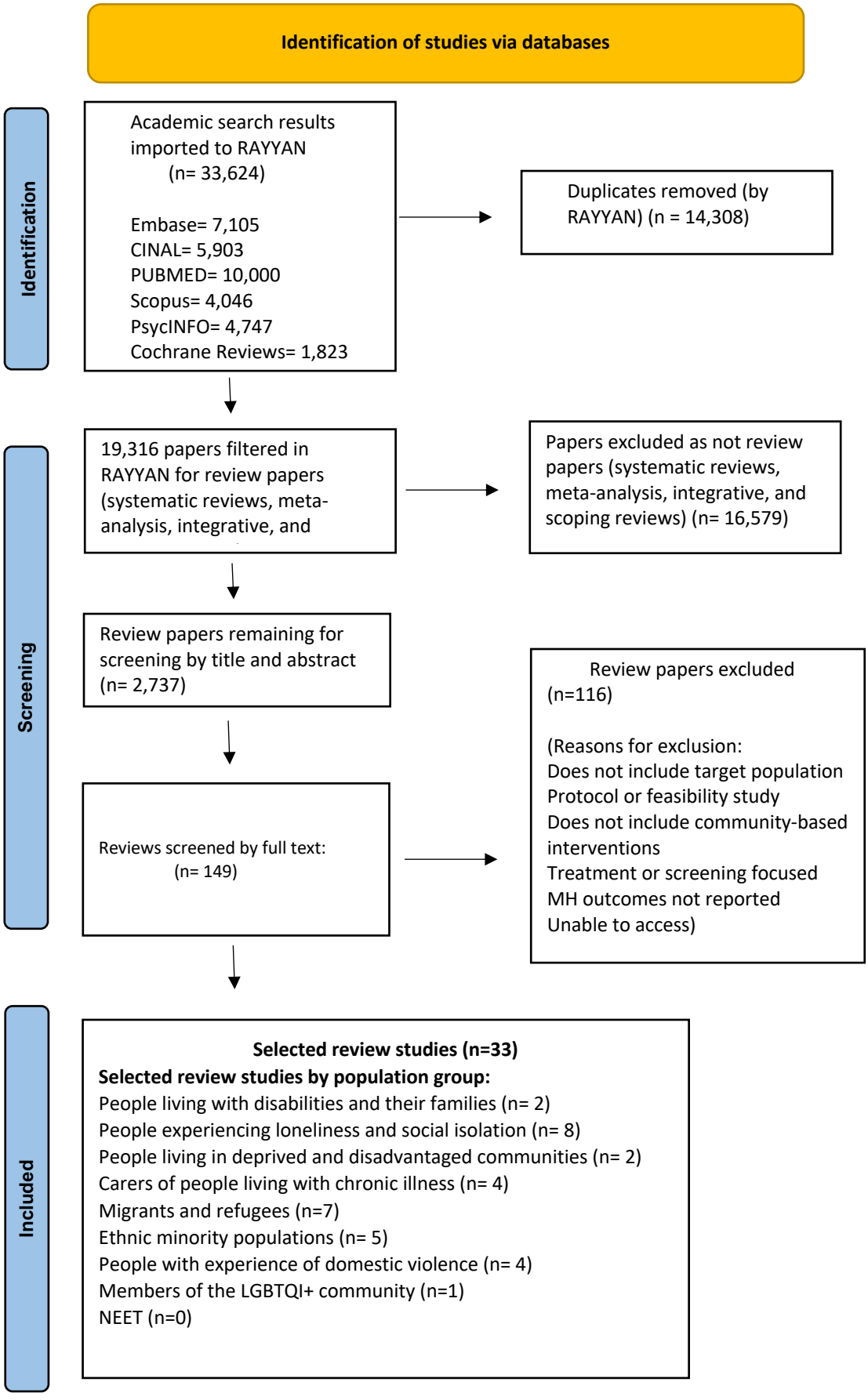
(n=7), ethnic minority groups (n= 5), people who experienced domestic violence (n= 4), and members of the LGBTQ+ community (n=1). No reviews were found that included NEET young people as participants. See Figure 2.1 for a PRISMA flowchart that summarises the search and screening process.

Data Extraction. Data were extracted from included papers using 'a priori' data extraction charts in Microsoft Excel and reflected the aims and objectives of the research. Data extracted included:

- study author, year, and country (if available)
- the overall aim of the review
- target audience (priority group and sample size)
- the total number of primary studies in the review and the number relevant to this research
- the type of intervention and aim
- primary outcomes (mental health, wellbeing, resilience, social inclusion, social support, community engagement, empowerment, community connectedness)
- secondary outcomes (health behaviours, knowledge, and physical health)
- implementation details (if provided) including; duration of programmes, type of community setting, content, mode of delivery, facilitators, barriers and facilitators to implementation

A narrative synthesis outlining the main findings from the selected studies was then written and considered programmes per population groups of interest according to their focus as delineated by the framework of the family of community-centred approaches for health and wellbeing (PHE, 2015a). Examples of best-practices in community-based mental health promotion for specific priority groups were highlighted and show-cased. Following consideration of the main findings, key recommendations are made for community-based initiatives that could be scaled-up in the Irish context for the selected priority groups.

Figure 2.1 *PRISMA flowchart summarising the search and screening process*



Results

The following section provides a narrative synthesis of the results for each of the population groups of interest. More detailed information can be found in the data extraction tables (Tables 3-10;), which can be found in Appendix 2.1. For the purposes of reporting, the community-based interventions relevant to each priority population were grouped according to their focus by applying the framework of the family of community-centred approaches for health and wellbeing developed by PHE in 2015. While in practice interventions can fall under multiple categories, this framework acts as a guide to structure the review findings, allowing for a more cohesive synthesis.

Interventions are considered under the following headings: (i) interventions which increase access and connection to community resources; (ii) interventions involving peers, befrienders and lay community volunteers; (iii) interventions based on collaborations and partnerships; (v) interventions based on strengthening communities and building social capital. Those interventions which do not clearly fit into any one of these categories are reported separately, e.g., digital-based interventions, multilevel interventions, arts.

People with disabilities and their families

Two (n=2) systematic reviews detailing interventions for people with disabilities and their families are included in this synthesis. Brand et al. (2023) sought to synthesise the key characteristics of befriending interventions for adults with Intellectual Disabilities (ID), and one (n=1) of the 11 included studies was deemed relevant to this research. Giummarra et al. (2022) considered the effectiveness of interventions that aimed to improve community participation for adults with Autism, ID, or psychosocial disabilities. This comprehensive systematic review synthesised the available evidence on the effectiveness of various types of community-based programme for this sub-group, such as animal companionship interventions, programmes to enhance community linkage, befriender programmes, peer-support groups, horticultural interventions, and outdoors and arts-based interventions. Of the 522 primary studies included, 17 met the inclusion criteria for this review. See Table 3; Appendix 2.1 for further details on the included studies.

Across the selected review studies, outcome measures included mental health and depressive symptoms, social functioning and wellbeing, social participation and connectedness. The

quality of included primary studies were found to vary with Ali et al. (2021), as referenced in the review by Brand et al. (2023), reporting a small sample size and non-statistically significant programme effects for the pilot study of a befriending intervention for adults with ID and depressive symptoms. The most robust evidence for the promotion of mental health and wellbeing among this subgroup was found for befriending interventions with non-disabled volunteers and outdoor recreation and leisure programmes (Giummarra et al., 2022)

1. Interventions which increase access and connection to community resources

There is a paucity of robust evidence relating to the effectiveness of interventions designed to increase access to community resources for this cohort. Ali et al. (2021) reference this as a secondary aim of the Befriending Programme for adults with ID, where participating adults were paired with volunteer befrienders weekly over six months. However, positive effects for social participation were reported for both intervention and controls groups and therefore, could not be attributed to the intervention; while additional positive outcomes reported for decreased depressive symptoms were not regarded as statistically significant. It is worth noting that this was a pilot study with a small sample size of just 16 participants. Similarly, while Community Linkage Programmes delivered by recreational therapists included in the systematic review by Giummarra et al. (2022) reported positive programme effects for increased social networks and reduced loneliness, the quality of studies included in this category of interventions was reported as varying from low to high by the review authors (see Table 3; Appendix 2.1).

The duration of interventions varied from nine weeks to six months and examples of programme activities included walking with peers and visiting community cafes (Ali et al. 2021). Giummarra et al. (2022) highlighted the importance of person-centred approaches to programme development, trained and empathetic facilitators, and the need to improve access to personalised supports in the community for people with disabilities and their families.

2. Interventions involving peers, befrienders and lay community volunteers

Interventions for adults with disabilities and their families that adopted a befriending or peer support approach showed promising trends for both participants and befrienders in a pilot study by Ali et al. (2021). Although the results were not statistically significant,

improvements in social networks and mood were found for participants, while increased knowledge, new experiences, and opportunities to "give back" were reported for befrienders.

Positive effects were reported for primary studies included in the systematic review by Giummarra et al. (2022). Types of interventions included befriender programmes including those which were peer-based, and community support groups. Positive programme outcomes included increases in perceptions of social support and social contact, and improved mental health.

Interventions were generally delivered weekly for 1-3 hours over durations of four weeks to 12 months. Overall, interventions with a focus on befriending and peer-based support were considered integral to the promotion of community participation for adults with disabilities. (see Table 3; Appendix 2.1).

3. Outdoors and arts-based interventions

Guimmarra et al. (2022) reported a wide range of positive outcomes for these types of community-based interventions, including a reduction in mental health symptoms and loneliness for adults with disabilities. The types of programmes reviewed included animal companionship interventions, music-based programmes, farm ecotherapy and horticultural interventions, and outdoor recreation and leisure programmes. In general, interventions were delivered weekly for durations of up to twelve weeks.

Of particular interest were the positive programme effects of the outdoor recreation and leisure programmes delivered weekly for 1-3 hours. Participants reported enhanced connectedness, improved relationships and wellbeing, and a reduction in loneliness and depressive symptoms, and the study was considered to be high quality. Giummarra et al. (2022) highlighted the importance of structured programmes in promoting programme acceptance and effectiveness.

CASE STUDY: ***Befriending intervention for people with ID and depressive symptoms***

This befriending intervention paired adults with mild or moderate ID with trained volunteer befrienders. Training was provided by community befriending schemes, which also included supervised interactions between participants and volunteers once per month. Each participant was matched to a volunteer based on shared interests and availability. The overall aim of the befriending relationship was to provide emotional support to participants and facilitate their access to community-based activities and resources. The pair met weekly for approximately one hour over a six-month period. Volunteers were reimbursed for travel and expenses.

Evaluation of the pilot programme by Ali et al. (2021) (n=16 participants; n=10 volunteers) showed positive trends for both people with ID and volunteers. The programme was accepted overall by both groups. For participants with ID, there was a decrease in depressive symptoms and an increase in engagement in community-based activities. Volunteers also expressed the benefits for them in increased knowledge, new experiences, and the opportunity to "give back to the community". Although the findings from this small pilot study were not found to be statistically significant, it demonstrates the potential of befriending interventions for people with ID and the need for a more robust study design to determine its efficacy for this population group.

People who experience loneliness and isolation

A total of eight reviews (n=8) that detailed initiatives targeting mental health promotion and prevention for older adults experiencing loneliness and isolation were included in this synthesis. Most were systematic reviews (n=6), with one adopting a mixed-methods approach and one scoping review. Study quality varied with many reviews reporting heterogeneity of studies and not providing details on individual studies.

Reviews considered a variety of interventions for this sub-group including; exergames with peers that combined digital gaming with physical activity, Groups 4 Health (see case study below), Social Prescribing services, exercise and arts-based programmes, systems-wide initiatives, information and communication technology (ICT) interventions, Men's Sheds,

and group cognitive behavioural therapy (CBT). The outcomes reported included mental health, loneliness, social anxiety, social isolation, wellbeing, and self-reported general health. Further details on the included studies may be found in Table 4; Appendix 2.1.

1. Interventions which increase access and connection to community resources

A review by Lee et al. (2021) explored the breadth of literature in the UK with a focus on community-based mental health prevention interventions for older adults. Overall, a total of 54 included studies detailed a range of initiatives categorised as connector, gateway, or direct interventions and additionally systems-wide approaches. Outcomes reported included social isolation and loneliness. While connector and gateway interventions were found to facilitate older adults in accessing services and staying more connected with their communities, Lee et al. (2021) highlighted the need for further research to ascertain the core components of effective mental health promotion and prevention interventions for this cohort. The crucial role of a systems-wide, inter-sectoral approach to address the wider determinants of older adults' mental health was highlighted.

The benefits of Social Prescribing services as a strategy to increase access and connection to community resources and alleviate loneliness for older adults was considered in a systematic review by Reinhardt et al. (2021). Three primary studies of interest (see Table 4; Appendix 2.1) reported a variety of positive outcomes including a decrease in loneliness, improved wellbeing, and an increased sense of social support. Evidence in this promising field is emerging and further research is needed on the impact of programmes among specific sub-groups and communities.

2. Interventions involving peers, befrienders and lay community volunteers

A systematic review by Li et al. (2018) synthesised the effectiveness of exergames, which involves both digital gaming and physical exercise. Across three community-based primary studies of relevance to this research, peer-based exergames were found to decrease loneliness. Additionally, a statistically significant increase in sociability after playing exergames was reported by Xu et al. (2016). This highlights the potential effectiveness of interventions that adopt both a peer-based and digital approach for this cohort.

CASE STUDY: ***Groups 4 Health (G4H) (Fischer & Hartle, 2023)***

The Groups 4 Health (G4H) intervention promotes social connectedness and improved social and emotional wellbeing for younger adults. The intervention was originally developed in Australia.

It consists of five modules that target the knowledge and skills required to manage social group membership. Modules include (i) schooling: aims to increase awareness of the importance of social group membership for health (ii) scoping: investigates current social functioning (iii) sourcing: identifies and strengthens existing valued social opportunities. (iv) scaffolding: uses the G4H group as a model for finding and establishing social group connections (v) sustaining: booster sessions held once monthly, to sustain progress made through intervention participation. The intervention is manualised and includes a programme workbook. For further information on the programme, visit: https://sign.centre.uq.edu.au/products-services/products/social-connection-for-health

The G4H intervention has been extensively evaluated in three phases:
(i) Testing proof of the concept (Haslam, Cruwys, Haslam, Dingle, & Chang, 2016)
(ii) A comparison of G4H with treatment as usual (RCT;n=120). (Haslam et al., 2019)
(iii) Comparing G4H with group CBT clinical trials (RCT;n= 174). (Cruwys et al., 2022).
Overall, studies have evidenced that G4H can reduce loneliness and improve mental health and wellbeing, reduce social anxiety and increases group belonging, and offers protection against loneliness and greater protection from relapse than CBT.

1. Interventions based on strengthening communities and building social capital

Strongest evidence for mental health promotion intervention approaches that are focussed on building social capital and strengthening communities come from a systematic review by Foettinger et al. (2022) on the effectiveness of Men's Sheds. This review included 52 studies from a range of high-income countries including Australia, UK, Ireland, New Zealand, Canada, and Denmark (see Table 4; Appendix 2.1). Although individual studies and characteristics were not reported, involvement in Men's Sheds was reported to increase

subjective wellbeing and decrease social isolation for participants, including those with mental health disorders. Hoang et al. (2022) also outline the potential benefits of the formation of social groups with an intergenerational focus on the loneliness and social isolation of older people.

2. Outdoors and arts-based interventions

Other interventions that show promise regarding the promotion of mental health and the reduction of loneliness and isolation among adults include exercise and music-based interventions, though the quality of evidence was mixed (Hoang et al. 2022). As shown in Table 4 (Appendix 2.1), examples of exercise programmes included dance, yoga, Tai Chi, and strength/balancing; while music programmes included the formation of a community-based choir.

3. Digital Interventions

Although evidence for the effectiveness of digital interventions is emerging, the impact of belonging to virtual communities and the potential for ICT interventions to address the loneliness and social isolation of older adults in the community is outlined in a scoping review of reviews by Gunnes et al. (2024). Sixteen of the 39 studies reported on various outcomes of interest, including decreases in social isolation and loneliness, though effects were considered short-term and not sustained in some cases. It is also worth noting that in a narrative review of remotely delivered interventions that targeted loneliness and psychological symptoms among older adults related to COVID-19 (Gorenko et al., 2024 in Gunnes et al., 2024), passive engagement in social networking sites was associated with participants experiencing higher levels of loneliness than those in direct communication via social networking sites (see Table 4; Appendix 2.1).

Evidence was also found for the effectiveness of exergames (outlined above) and other technological interventions detailed in Hoang et al. (2022), including computer training and video-conferencing with family/a facilitator. Gunnes et al. (2024) suggest considering gender specific components and means to facilitate the usability and accessibility of digital interventions for older adults.

People living in deprived and disadvantaged communities

Two reviews (n=2) detailing interventions that aimed to promote the mental health and wellbeing of people living in deprived and disadvantaged communities were included in this evidence synthesis. One was a narrative review by Harrison et al. (2023) that contained five primary studies of interest, while the second was a systematic review by Tracey et al. (2023) that included just one study of interest. Further study details may be found in Table 5; Appendix 2.1.

The focus of interventions included nature-based programmes, such as home/community gardening and sustainable building projects (Harrison et al. 2023), and community gardening for vulnerable populations (Tracey et al. 2023). Outcomes included mental health and wellbeing outcomes. The quality of evidence was regarded as moderate, and more robust research incorporating standardised outcome measures is needed, as well as further research on the specific components of effective programmes for people who live in deprived communities.

1. Interventions based on collaborations and partnerships

The review of community gardening for vulnerable populations, including refugees, Indigenous groups, and those from low socioeconomic backgrounds, by Tracey et al. (2023) included one community-based study of interest that reported on mental health outcomes. Jackson and Ronzi (2021) adopted a CBPR approach to evidence the impact of community gardening among socioeconomically deprived individuals and reported a range of positive effects including improved social connections and overall health. However, implementation details, such as programme components, were not specified.

2. Nature-based interventions

In a review of 18 studies by Harrison et al. (2023), five of which reported mental health/wellbeing outcomes, evidence was found for the positive impact of home-gardening interventions on participants' quality of life, which was sustained at a 12-months follow-up. Community-gardening programmes were found to increased participants' emotional connection with others; however, Gray et al. (2022) reported that 11 out of 23 participants of

a community gardening programme in social housing estates in Sydney reported being less satisfied with their health at post-test compared to pre-test. Although this result was statistically significant, it is worth noting that the average age of participants was an influencing factor; (M=64 years for those who reported being less satisfied with their health post-test compared with M=52 years for those who reported improved satisfaction with their health post-test). Additionally, Gray et al. (2022) suggest that an increased self-awareness of participants' health limitations through the gardening process may have contributed to this finding.

Finally, a study in Wales, UK by Davies et al. (2020) reported positive programme effects for participants of a brief outdoor Sustainable Building Project. This study, which included NEET young people as participants as well as asylum seekers and those unemployed, was implemented one day per week over eight weeks and focussed on the development of participants' construction and outdoor skills through their involvement in the not for profit social enterprise scheme, Down to Earth (http://www.downtoearthproject.org.uk/). Involvement in the programme had a positive impact on depression, anxiety, and resilience scores for participants whose baseline scores fell at/below the cut-off threshold pre-intervention. Of particular interest is the statistically significant increase in social connection post-intervention for young people NEET (n=93) who reported difficulty in the area at baseline.

Carers of people who experience chronic illness

A total of four systematic reviews (n=4) detailing 11 primary studies that promoted the mental health of caregivers of people living with chronic illness were included in this synthesis, one of which was a Cochrane systematic review (Liu et al. 2018). The participants of most of the studies were carers of people living with dementia/Alzheimer's disease, while the participants in one study were spousal carers of stroke survivors (Smith et al. 2012). Further study details may be found in Table 6; Appendix 2.1.

The vast majority of primary studies evaluated internet-based psycho-educational programmes with either a peer/professional psychosocial support component or a social networking component. Studies included in the Cochrane systematic review by Liu et al. (2018) pertained to in-person Mindfulness-based Stress Reduction (MBSR).

In general, outcome measures related to mental health (depressive symptoms, stress, distress, and anxiety) and perceived burden. Studies reported a range of positive programme effects including reduced perceived burden, depressive symptoms and anxiety for caregivers. Although the review by Liu at al. (2018) evaluated studies that employed RCT designs, the quality of evidence was considered poor with a high risk of bias. Other review authors highlighted the need for more robust research that evaluates programmes for carers of people with a wider range of chronic illnesses and incorporates longer follow-up periods in order to ascertain if outcomes are sustained.

1. Digital Interventions

Although evidence in the area of digital interventions for caregivers is emerging, analysis of the studies included in this synthesis point to the effectiveness of these types of interventions as an accessible and flexible means of supporting carers of people living with chronic disease and improving their mental health and wellbeing.

In general, interventions were found to decrease depressive symptoms, anxiety, stress, and increase quality of life scores. Torkamani et al. (2014) reported a decrease in perceived burden for participants of a six-month computer-based education and social networking programme, while Gustafson et al. (2019) reported that the multi-component D-CHESS intervention showed potential in aiding caregivers in managing their responsibilities and reducing stress (see case study below). However, it is worth noting that included studies evaluating digital interventions incorporated small sample sizes, making conclusions on efficacy and generalisability difficult to draw.

Modes of delivery included video modules, videoconferences, websites, and Computer and Telephone Integration System (CTIS), with some programmes incorporating a Social Networking Platform (Torkamani et al. 2014) or Facebook Community (Hattink et al. 2015). Where facilitators were needed, they were trained psychologists and in the case of the educational programme with professional psychosocial support intervention for caregivers of stroke survivors, facilitators were Cardiovascular Nurse Managers.

CASE STUDY: *D-CHESS*

The aim of this computer-based system is to improve the lives of caregivers of people with dementia, and in particular their ability to manage caregiving tasks and reduce caregiver stress.

This multi-component web-based intervention comprises interactive modules for problem-solving, communication tools, and resources for managing caregiving tasks and stress, such as educational resources and stress management tools. Access to online social support networks was also available to participants. In-home training on the D-CHESS system was provided and additional external sensors, such as GPS trackers and motion-activated sensors, to monitor the dementia patients. Technical support was also provided to participants.

Evaluation of the pilot programme by Gustafson et al. (2019) found that the system's comprehensive support structure showed the potential to aid caregivers in managing their responsibilities and reducing stress significantly. The need for adequate training, a user-friendly interface and sufficient technical support for these types of interventions was highlighted by authors.

2. Mindfulness-based Stress Reduction (MBSR) programmes

Regarding the mental health benefits of MBSR programmes for caregivers of people with dementia, although decreases in depressive symptoms and anxiety were reported, studies were considered to be of poor quality with a high risk of bias. Further research is needed to determine the benefits of MBSR interventions for this cohort.

In general, MBSR programmes were delivered in-person weekly over six to eight weeks and sometimes included participation in a social support group. Types of activities included body scans, hatha yoga, sitting meditation, groups education, and mindfulness practices (see Table 6; Appendix 2.1). Programmes were based on the original MBSR (Kabat-Zinn, 2013) and other cognitive theoretical frameworks (Oken, 2010).

Migrants and Refugees

Seven review studies are included, encompassing systematic reviews (n=5), a scoping review (n=1) and an integrative review (n=1), addressing interventions targeting mental health promotion and prevention for migrants and refugees. Participants included peri-natal women, families, young people, and older migrants, and the community-based approaches adopted included peer mentoring and befriending, the development of social support and social capital, family-based interventions, and co-production. Across the selected review studies, outcomes reported include mental health, wellbeing, quality of life and social capital, including bonding, bridging and linking, alongside outcomes regarding participants' ability to access/navigate community-based services and stigma. Further study details may be found in Table 7; Appendix 2.1.

1. Interventions which increase access and connection to community resources

A review by Bunn et al., (2022) identifies ten family-based mental health interventions for refugees, seven of which are categorized as community-based. This review concludes that family-based mental health interventions can reduce mental health problems, strengthen family functioning, and protect health and wellbeing. The review outlines how current delivery is by lay providers, peers and professionals. The review concludes that the evidence base for family-based mental health interventions with refugee communities is currently emerging in the literature and there is a need for clarification regarding effective intervention components, workforce development, training and support and cultural adaptations.

2. Interventions involving peers, befrienders and lay community volunteers

Gower et al. (2022) present evidence on peer interventions targeting various outcomes, including mental health, social connectedness, social capital and employment. Effective outcomes evidenced in peer support studies selected by Mahon et al., (2022) include the enablement of integration, building of community networks, increased feelings of empowerment, increased access to services, increased perceived emotional health, self-efficacy, resilience and hope. Additionally, Balaam et al. (2022) reports that peri-natal women who partake in befriending and peer support interventions feel less alone and experience reduced anxiety and depression. Adopting peer support interventions can yield

positive outcomes for both the recipient and the peer provider, with Balaam et al. (2021) reporting that both experienced an increase in confidence. This mutual beneficial effect is also reported by Gower et al. (2022). Reporting that family-based interventions led by peers and lay workers are feasible to deliver and potentially effective, Bunn et al. (2022) caution that this approach does require workforce development. Mahon et al. (2022) reports that an optimal training regime is yet unclear, while Gower et al. (2022) report that conclusive evidence for best practice requires ongoing research, trialling and evaluation of interventions.

3. Interventions based on collaborations and partnerships

The review by McGarity-Palmer et al. (2023) synthesises the literature on community participation in mental health interventions among Asian refugee communities. This review found that typically community participation was not present for the entire process of the intervention and was particularly absent at the beginning and end. While McGarity-Palmer et al. (2023) did not identify a relationship between improved psychosocial outcomes and level of community engagement, the authors suggest that community engagement approaches can positively impact the cultural appropriateness of interventions and their acceptability and uptake within the community, thus having potential to build community capacity. Supporting this, Mahon et al., (2022) cite evidence on the effectiveness of co-production and also emphasise its benefits in producing culturally appropriate interventions.

4. Interventions based on strengthening communities and building social capital

Reviews by Del Pino-Brunet et al. (2021) and Villalonga-Olives et al. (2022) evidence the beneficial effects of social capital interventions using strategies that focus on facilitating information sharing, relationship-building, increasing access to resources, increasing community participation and building social capital. Delivery of these interventions include the use of support groups, peer support and multilevel approaches to achieve outcomes.

The review by Del Pino-Brunet et al. (2021) includes 18 primary studies identifying interventions that promote social integration and prevention of radicalization of migrants, three of which meet the inclusion criteria for this current review (Thomas et al., 2016; Msengi et al., 2015; Bravo et al., 2014). The primary study by Thomas et al. (2016) reports on an intervention that pairs mentors known as “cultural navigators” with migrants (see case

study below). This intervention proved successful in establishing relations with long-term community residents. Similarly, the primary study by Msengi et al. (2015) outlines a peer pairing between female migrants and local female volunteers as "conversation partners" alongside focus group discussions. Outcomes reported include improved wellbeing for mothers and their families, with support groups reportedly helping to overcome language, culture, poverty and discrimination barriers. The primary study from Spain by Bravo et al. (2014) describes an intervention based on a once-weekly group session, which served as 'an altruistic exchange space' where the concerns of 12 migrant women from Morocco, Algeria, Gambia, Pakistan, and Russia respectively were shared. It was described as an empowering intervention for participating women, who reported the formation of positive relationships and broadened viewpoints (further details in Table 7; Appendix 2.1).

CASE STUDY: *The Cultural Navigator Programme*

The Community Navigator Program is based on the concept of building social capital and leverages the existing social networks of lay community volunteers to build social capacity among immigrant community members. This programme promotes the wellbeing and community integration of migrant participants by fostering partnerships between them and lay community members. Delivered in the local library, the intervention illustrates the benefits of collaborative working between a community and a public institution.

The intervention, which aims to build relationships and foster partnerships, is delivered over three months. Trained Cultural Navigators, for example students or retirees, are trained in aspects of cultural awareness and matched with individual migrants/migrant families. Intervention activities include; sharing personal stories, facilitating access to community resources (school, government agencies, social services), introducing migrant participants to community partners, and attendance together at social and educational events outside the library.

A qualitative evaluation by Thomas et al. (2016) reports programme benefits for migrant participants including increased self-efficacy to engage in local resources, increased trust among community members, increased sense of belonging, and decreased loneliness and boredom. Benefits were also observed for Cultural Navigators. The intervention was successful in creating bonded relationships between participants and navigators and bridging relationships between project partners and community stakeholders.

The review by Villalonga-Olives et al. (2022) is reportedly the first systematic review to investigate social capital interventions that promote the mental health of refugee populations. The review authors identified four community-level interventions, and two multilevel interventions (individual and group) (see Table 7 in Appendix 2.1). Of particular interest is a study by Logie et al. (2016), which involves migrants from the LGBTQ+ population. Social support group interventions addressing social isolation, community resilience and access to resources reported positive outcomes including, reduced isolation and improvements in social networking among LGBTQ+ migrants. While the review by Villalonga-Olives et al. (2022) reports positive mental health outcomes, the authors note that evidence in the literature is sparse, the use of validated outcome measures is lacking, and qualitative study designs dominate.

Ethnic minority populations

Overall, five review studies, including a systematic review (n=1), a systematic review and meta-analysis (n=1), scoping reviews (n=2) and a non-specified review (n=1) are included in this synthesis and provide evidence for mental health promotion and prevention interventions for ethnic minority populations. Two of the selected review studies have a specific sub-population focus on older ethnic groups experiencing loneliness (n= 1) and young ethnic people (n=1). One study focuses on delivery, specifically of culturally-adapted digital mental health interventions (n=1), while the remaining two studies take a geographical focus on interventions for ethnic groups in Europe (n=1) and the UK (n=1). Across the selected

1. Interventions which increase access and connection to community resources

Evidence of the effectiveness on mental health outcomes of interventions which facilitate free access to gyms, is presented in reviews by Baskin et al. (2021). A primary study presenting an Art-on-Referral (AoR) group intervention (van de Venter & Buller, 2014) is cited in the review by Apers et al. (2023), and this small-scale study suggests that AoR may be an effective intervention for management of emotions and protecting wellbeing for members of ethnic minority groups. Social participation interventions for older ethnic populations, identified in a review by Pool et al. (2017), include volunteering, group physical activities and group educational activities. While five out of a selected six studies were found to have

a positive effect on social participation, with a reduction in social isolation and loneliness, it should be noted that all studies in this review were USA based. Given the diversity in ethnicity between USA and Europe, evaluation in the European context is warranted.

2. *Interventions involving peers, befrienders and lay community volunteers*

Evidence of the effectiveness of the CONNECT parenting programme, which employed a culturally sensitive adaptation of the original programme (Osman et al., 2021), is cited in the review by Apers et al. (2023). The delivery approach includes peers of similar background acting as group leaders. The programme was delivered in the native language of ethnic participants and role plays were culturally adapted. This longitudinal cohort study reports significant improvements in parent mental health, which was maintained three years post-intervention. A qualitative systematic review by Sanchez et al. (2023) reports evidence on the significance of culturally tailored mentoring programmes, involving youth mentors promoting strong community partnerships to facilitate best mental health outcomes for indigenous youth. Finally, peer-to-peer support groups, reported by Baskin et al., (2021), demonstrate positive effects for depression and social functioning (see Table 8 in Appendix 2.1).

3. *Interventions based on collaborations and partnerships*

The review by Apers et al. (2023) identifies that fifteen of the selected primary studies adopt co-production strategies and involve members of the ethnic communities to enhance the intervention. Involvement ranged from consultative to complete participation. Apers et al. (2023) outline the benefits of co-production by highlighting a study by Malone et al. (2017). This study applied the 'Lived Life' methodology with members of the Irish Travelling community (n=150), evidencing the possibilities of co-ownership projects which address sensitive issues such as suicide (see case study below). Apers et al. (2023) outline three principles which may increase an intervention's success, including; having a sound theory-base, employing cultural adaptations (eight of such studies are included in his review), and using a participatory approach.

CASE STUDY*: Lived Lives: A Pavee Perspective*

Lived Lives: A Pavee Perspective is an example of a culturally-adapted approach to suicide prevention among the Irish Traveller community. The initiative, based in a community institution for Travellers, Pavee Point, can be regarded as a community-based intervention in which the Travelling Community acted as the target, resource, and agent for the intervention. The intervention was informed by original Lived Lives model (Jeffries, Clark, Wood, 2015), which employed an arts-science collaboration in a community-orientated approach to suicide prevention.

This suicide prevention initiative employed a co-production approach, including CBPR, to redesign the original Lived Lives exhibition to reflect the elevated suicide rates among Irish Travellers, in particular males. Researchers met with members of the Irish Travelling community over a twelve-month period in halting sites and at Pavee Point to explore their views around suicide in the community and measures that could be taken to reduce it. Responses were then written on cloth ribbons, later used as part of a one-week exhibition held at Pavee Point. Visitors to the exhibition, including Travellers and bereaved families, then picked the ribbon they most identified with and tied it to a hawthorn tree in front of Pavee Point. The hawthorn tree has particular significance for the Travelling community, with members believing that as the cloth rots so too do the illnesses of the person the cloth belongs to. Other activities included facilitated group discussions. Members of the general public including policy-makers, funders and students were also invited to attend. The initiative enhanced communication and engagement with members of the Travelling community on suicide, and reduced stigma in the wider community.

Qualitative data analysis (Malone et al., 2017) evidenced the intervention as powerful and moving for participants and reported that it succeeded in creating an opportunity to facilitate conversation around suicide. It also highlighted the devastating effects of suicide on bereaved family members. The establishment of mutual trust between researchers and members of the Travelling Community was found to be key to the engagement of community members and the acceptability of the intervention. Facilitators of trust-building included Travellers co-owning the project, giving community members the opportunity to express their thoughts and opinions in their own environment, and the use of Pavee Point as the location for the exhibition.

4. Digital Interventions

A meta-analysis by Ellis et al. (2022), identified a statistically significant positive effect for culturally adapted digital mental health interventions for racial and ethnic communities. However, half of the included studies in the review do not involve interaction with another individual. Additionally, a clear distinction is not made between mental health promotion and therapeutic approaches. Perhaps the most useful evidence this study provides is its findings on effectiveness of cultural adaptation on outcomes, and not its focus as a community-based health promotion study.

Digital formats included web-based, text-based and mobile application-based interventions. Intervention focus was wide ranging and variable. Three key adaptation strategies identified in the review include; language translation, modification of audio and visual content, and the inclusion of culturally salient messaging. These adaptations are considered by the authors to have significant influence on mental health outcomes for ethnic minority populations engaging in digitally-based mental health interventions (Ellis et al., 2022).

Overall, a paucity of strong evidence regarding community interventions addressing the mental health of ethnic minority groups was noted by Baskin et al. (2021). Only two of the seven selected studies in the Baskin et al. review were published after 2014, highlighting the paucity of recent studies. Apers et al. (2023) note that primary studies lack robustness with many being small in scale, while the review by Pool et al. (2017) highlights the need to consider the diversity of ethnicity before generalising outcomes.

Populations who experience domestic violence

Four review studies were included relating to people who experience domestic violence (see Table 9; Appendix 2.1). Synthesising the findings is challenging given that each of the four studies take a unique focus including; advocacy (Rivas et al., 2015), psychosocial interventions (Micklitz et al., 2024), community-based research approaches (Ragavan et al., 2018), and sources of wellbeing (Baeza et al., 2023). A wide range of outcomes are reported

including mental health, and other outcomes such as safety, legal, career and violence reduction. It is important to note that the level of delivery, being at the individual or community level, is not always easily identifiable as this is not always clearly defined in the primary studies. The mental health related outcomes reported in the selected studies include depression, quality of life (Micklitz et al., 2024 and Rivas et al., 2015), post-traumatic stress disorder (Ragavan et al., 2018), anxiety, psychological distress, suicidality, self-esteem, empowerment, social support and self-efficacy (Micklitz et al., 2024). The study by Ragavan et al., (2018) reports a lack of emphasis on mental health promotion and prevention interventions in the literature for survivors of domestic abuse, however, a recent review by Baeza et al. (2023) seeks to close this gap, with a synthesis of sources of wellbeing for Hispanic women following experiences of interpersonal violence. Over half of the selected studies in the review by Baeza et al., (2023) have been published since 2021, suggesting that a wellbeing approach to interventions with this population may be evolving. Study details are included in Table 9; Appendix 2.1.

Across the selected studies included in this current synthesis, modes of delivery reported include face-to-face individual and group sessions, phone, digital (Micklitz et al., 2024; Ragavan et al., 2018) and multi-modal delivery. Duration of interventions are variable with Micklitz et al. (2024) reporting intervention times varying from once-off delivery to 52 sessions over a 12-month period. Similarly, Rivas et al. (2015) emphasise heterogeneity between intervention studies, regarding both methodology and duration, and report interventions varying from 30 minutes to 80 hours. Overall, evidence of intervention effectiveness for mental health outcomes is lacking in the literature, with authors noting weak study designs and a paucity of quantitative outcomes. Miklitz et al. (2024) highlights the need for research to address gaps in the literature regarding interventions which are gender inclusive and sensitive to cultural diversity. Miklitz et al., (2024) conclude that the most promising approach to improve the safety, mental health, and psychosocial wellbeing of survivors is through the delivery of combined advocacy and psychology-based interventions delivered with high intensity and in an integrative manner.

1. Multi-level intervention

The need for multilevel interventions is evidenced in reviews by Micklitz et al. (2024) and Baeza et al. (2023). A referenced primary study by Cripe et al. (2015) highlights how

practical interventions targeting the wider determinants of mental health such as work (skills training), financial support and assistance with employment and housing, is recommended alongside individual professional counselling.

2. Interventions which increase access and connection to community resource

Advocacy interventions: evidence supporting advocacy interventions, as reported by Rivas et al. (2015), indicates that brief advocacy may provide short-term mental health benefits for depression and quality of life. However, Rivas et al. (2015) report that the evidence of effectiveness for intensive advocacy impacting a decrease in violence and promoting psychosocial wellbeing is weak. Overall, conclusions are that the impact of advocacy interventions is uncertain.

Community groups: Baeza et al. (2023) reference a study by Page et al. (2021) that provides qualitative evidence of the long-term benefits of participation in a nurse-led support group in the community, with participants becoming advocates for other survivors of domestic violence.

3. Interventions involving peers, befrienders and lay community volunteers

With a focus on community participation and peer leadership, Baeza et al. (2023) reports on a study by Serrata et al. (2016) which found positive outcomes for an empowerment focused intervention among Latina immigrant survivors of domestic violence. The intervention involved participation in a peer leadership programme (Lìders), based on peer health promotors in the community (a Promotora model of community leadership).

4. Interventions based on collaborations and partnerships

Ragavan et al. (2018) provides evidence for the application of programme co-production and CBPR with this population group. Included studies outline the important role of domestic violence survivors as community members who play an active role in needs assessments, and programme design and delivery. Ragavan et al. (2018) also identifies co-production practices, between survivors and service provider stakeholders, including shared decision-making, relationship building, programme changes based on survivors' feedback, and co-authorship

of programme outputs. While the greater emphasis of the review by Ragavan et al. (2018) is on evaluation of the implementation of CBRP, positive outcomes for depression and post-traumatic stress disorder are reported alongside improvements in social networking and social support.

5. Digital Interventions

The review by Micklitz et al. (2024) includes a pilot study of the six-week HELPP intervention, employing a mixed method study (n=32). The study by Constantino et al., (2015) provides empirical support for the feasibility and effectiveness of the online HELPP intervention, which has a multi-faceted focus on health, safety education, legal and resource information for survivors of interpersonal violence (IPV). Although small in scale, this pilot study presents statistically significant positive differences in pre-post scores for anxiety, depression and anger, social and personal support for course participants.

LGBTQI+ Populations

One review study presenting evidence on mental health interventions for members of the LGBTQI+ population is included in this synthesis (see Table 10; Appendix 2.1). The review by Paudel et al. (2024) addresses the role of digital interventions and identifies three primary studies, which measure mental health outcomes related to suicidal thoughts and behaviour among LGBTQI+ individuals.

1. Digital Interventions

Cited in the review by Paudel et al. (2024), a primary study by Pachankis et al. (2020) provides evidence for two self-guided online brief writing interventions, with positive effects indicated for depression and psychological distress. Pachankis et al. (2020) also identify the positive effects of self-affirmation on decreasing suicidal ideation and reducing drug use. Paudel et al. (2024) cite another primary study, an RCT by Han et al. (2023), which provides evidence of effectiveness for a digital multicomponent intervention composed of online psychoeducation, facilitated group discussions and digital brochures. This intervention proved effective in promoting participants' help-seeking intentions and in improving mental health literacy (Han et al., 2023). A third primary study (RCT) included in the review by

Kirchner et al. (2022), showed a small effect in decreasing suicidal ideation and increasing help-seeking through presentation of suicide prevention videos presented as part of the "It gets better project". Further study details can be found in Table 10; Appendix 2.1.

As the current synthesis is based on selected review studies only, primary studies have been omitted. However, given the dearth of mental health interventions tailored for LGBTQ+ populations (Coulter et al., 2019), with even less identifiable as community level interventions, one primary study identified during the iterative process of this research is highlighted herein as emerging evidence filling the literature gap. A single arm pilot trial reported by Facente et al., (2024) provides promising evidence for "Lets Connect" a primary prevention mental health intervention for LGBTQI+ people that the authors suggest can be delivered in a community setting and online. This study reports significantly effective outcomes for all three mental health domains of psychological distress, functioning and social isolation immediately post-intervention, with even greater beneficial effects observed six weeks post-intervention (please refer to case study below for further details).

Young people NEET

No relevant reviews were found for young people NEET. However, Davies et al. (2020), as cited in the review of nature-based interventions in socio-economically deprived areas by Harrison et al. (2023), reported an increase in wellbeing (not statistically significant) and social connection (statistically significant) for young people NEET (n=93) who participated in a brief outdoor sustainable construction project once per week over eight weeks. The intervention aimed to improve the mental health and social connection of hard-to-reach populations and focussed on the development of participants'' construction and outdoor skills.

CASE STUDY: Let's Connect intervention

Let's Connect is a primary prevention mental health intervention that was developed in the USA, specifically to target mental health outcomes for members of the LGBTQ+ community. The original intervention "Chai Chats" was developed by an Asian Women's Shelter to promote communication skills development for queer and trans women who experienced IPV. Adapted by Facente et al. (2024) to focus on the LGBTQI+ population more broadly, the intervention was originally designed to be delivered in an in-person community-based setting but was adopted for use on digital platforms during COVID-19.

Let's Connect has a standard curriculum comprised of eight two-hour online sessions over a six-week period. The focus of included modules is on the development of individuals' skills to support mental health and wellbeing and the development of supportive networks. The intervention is peer-led, with delivery by two LGBTQ+ facilitators.

Evaluation of the pilot of Let's Connect by Facente et al. (2024) reported statistically significant positive outcomes for psychological distress, social functioning and perceptions of social connectedness /loneliness ($p<0.01$). These effects were sustained and greater at follow-up.

For the local evaluation report please see: https://cultureishealth.org/wp-content/uploads/2024/05/SFCHC_Local-Evaluation-Report_FINAL_rev.pdf

Discussion

This review aimed to explore the existing evidence for community-based mental health promotion interventions for priority population groups. By synthesising the findings from international peer-reviewed reviews, this research sought to identify the types and focus of community-based mental health promotion interventions that have been found to be effective for the specified priority populations, while noting any additional information on the implementation and cultural adaptation processes.

A total of thirty-three (n=33) peer-reviewed review studies providing evidence for community-based mental health promotion interventions for the priority population groups of interest were identified in this scoping review of reviews: people living with disabilities (n=2), adults experiencing social isolation and loneliness (n=8), those living in deprived and disadvantaged communities (n=2), carers of people with chronic illness (n=4), migrants and refugees (n=7), ethnic minority populations (n=5), those with experience of domestic violence (n=4), members of the LGBTQI+ community (n=1), and young people not in education, employment or training (NEET) (n=0). Overall, the synthesis of the evidence highlights the variability of study quality and the paucity of strong evidence specific to the identified priority population groups, with no relevant reviews returned for NEET young people.

The following discussion presents a summary of the results with reference to the wider literature. As outlined earlier in this report, the framework of the family of community-centred approaches for health and wellbeing (PHE, 2015a), is used to guide the discussion. This framework provides a useful means of presenting the diverse range of community-based interventions evidenced in this review, while also providing an opportunity to highlight gaps and relative strengths in relation to interventions evidenced across the population groups. It should be noted that while intervention approaches are presented as individual entities for the purpose of discussion, in practice their interrelated and interconnected nature is observed across studies. The strengths and limitations of this review study are discussed, along with the implications of the findings for community-based mental health promotion practice with priority groups in the Irish context. Conclusions and key recommendations are outlined for the development of community-based mental health promotion for priority population groups in Ireland.

(1) Interventions which increase access and connection to community resources

Creating pathways to participation is a key approach to supporting community mental health and wellbeing (PHE, 2015a). Community-based mental health promotion interventions that increase community participation opportunities, as identified in this review, include group programmes, Social Prescribing services, and digital initiatives.

Community group interventions: Community group interventions addressing mental health and wellbeing outcomes, identified in this review, have a wide focus. Group intervention studies considered to have more robust evidence are cited here and reflect the existing diversity in focus across community-based mental health promotion approaches. These interventions include the following: arts-based activities for those living with IDs (Giumarra et al., 2022) and ethnic groups (van de Venter & Buller, 2014); parenting interventions for migrant families (Bunn, 2022); gardening and nature-based activities for those living in deprived communities (Harrison et al., 2023; Tracey et al., 2023); mindfulness groups for those living with autism (Giummarra et al., 2022), and carers of people with dementia (Liu, Sun, & Zhong, 2018); exercise and social engagement groups for those experiencing loneliness and social isolation (Yu et al., 2023); digital support groups for carers (Sherifali et al., 2018); community support groups for women who experience domestic violence (Page, Montalvo-Liendo, Nava, & Chilton, 2021); 'Groups 4 Health'(G4H) to strengthen social connectedness for those experiencing loneliness (Haslam et al., 2019 in Fischer & Hartle, 2023). Community groups listed above are found to be led by professionals, peers, and community lay members, both independently and in partnerships with a vast range of focus and purpose.

The heterogeneity across the group interventions listed in terms of their focus, delivery and recipient populations, alongside evidence generally regarded by authors as variable, renders drawing reliable or generalisable conclusions difficult. Notable exceptions do exist with promising evidence for culturally adapted parenting groups (Osman, Salari, Klingberg-Allvin, Schön, & Flacking, 2017), and digital based groups (Gunnes, Løe, & Kalseth, 2024). Additionally, the Groups for Health (G4H) intervention, previously highlighted as a case study, shows promise with positive evidence reported across three initial studies (Cruwys et al., 2022; Haslam et al., 2019; Haslam et al., 2016).

Social Prescribing: This review captures evidence regarding the use of social prescribing for those who experience loneliness (Reinhardt et al., 2021) and disadvantaged families (Razani et al., 2018, as cited in the selected review by Harrison et al., 2023). The "prescribed" activities described in these studies include nature-based park prescriptions (Razani et al., 2018), museum on prescription visits (Todd et al., 2017) and referral to wellbeing programmes. The current review, however, failed to capture evidence for the use of social prescribing beyond these two priority population groups. This can perhaps be explained by

the confirmed paucity of evidence in the literature regarding the use of social prescribing with specific population groups. As current social prescribing studies appear to have a more generic focus, it is possible, therefore, that the specific population search terms used in the search strategy for this study may not have facilitated the identification of these more generic studies, which may potentially include reports on the population groups of interest in this review.

In the wider literature, a review by Zhang et al. (2021) confirms the paucity of evidence regarding the effectiveness of social prescription use with migrant populations. Additionally, while Featherstone et al. (2022) argue that social prescribing has potential to be adapted to improve disparities in mental health and wellbeing for people with autism, they note a lack of measurement for its use with such populations. Pollard et al. (2023) emphasise the need for careful consideration of the methods and impacts of social prescribing implementation, and its efficacy for those living in disadvantaged circumstances. Finally, a systematic review by Pescheny et al. (2020) confirms that implementation of social prescribing is still evolving and while the authors acknowledge the positive outcomes being reported, they emphasise that the evidence base for social prescribing is lagging behind its practice.

Digital Interventions: Applying the concept of community to the digital space of social media, NICE (2016) state that social media use has two functions; to support an existing community-based approach, or, to function as a method of community engagement of itself. While the wider literature demonstrates an emergence of evidence to support the use of digital interventions to support mental health and wellbeing generally (Yeo et al., 2024), the current review cites evidence supporting potential benefits of digital intervention use with particular priority groups, including members of the LGBTQI+ populations (Facente et al., 2024; Paudel et al., 2024), ethnic populations (Ellis, Draheim, & Anderson, 2022), carers (Boyt et al., 2022; Ruggiano et al., 2018; Sherifali et al., 2018) and those who experience domestic violence (Constantino et al., 2015).

Selected reviews provide evidence for the mental health benefits of digital interventions for caregiver outcomes relating to depression, stress and anxiety (Sherifali et al., 2018), promoting help-seeking behaviours by members of the LGBTQI+ community (Paudel et al., 2024), and in enhancing social wellbeing and reducing loneliness (Li et al., 2018). Heterogeneity in intervention focus is found across studies and includes information

provision, education, and the promotion of social connection via Facebook communities (Sherifali et al., 2018) and online forums for example. Similarly, heterogeneity is identified across digital intervention delivery methods, which include mobile phones, online videos, online interactive activities (Paudel et al., 2024), specific apps and games (Li et al., 2018). The wider literature highlights further heterogeneity regarding in-person delivery, with use of peer delivery versus professional delivery (Romero-Mas et al., 2024).

The selected review study by Micklitz et al. (2024), which examines the efficacy of psychosocial interventions for survivors of IPV, cites a primary study by Constantino et al. (2015) that identifies positive intervention outcomes at individual, intrapersonal and community level following the online delivery of the HELPP (Health, Education on Safety, and Legal Support and Resources in IPV Participant Preferred) intervention. Mental health and social outcomes for IPV survivors include a decrease in anxiety, depression and anger and an increase in personal and social support, with more significant effects reported for online participants when compared to those who engaged in face-to-face delivery (Constantino et al., 2015). Evidence supporting the use of digital interventions to improve psychosocial outcomes for carers, is found in the selected reviews (Boyt et al., 2022; Ruggiano et al. 2018), however, the authors caution concerning the need for more rigorous evidence.

In the wider literature, Romero-Mas et al. (2024) acknowledge the existence of supportive communities within digital environments. The authors established that within virtual communities of carers for those living with Alzheimer's disease, peer-led online groups were valued by group members for the opportunity they prvide for social support and access to experiential knowledge. Gunnes et al. (2024) evoke caution, however, and highlight the established paradox of social media's potential to increase loneliness. The authors, therefore, emphasise the need to consider implementation factors and accessibility regarding the application of digital technology use with vulnerable populations, particularly with older populations. Not surprisingly, professional-led online groups are found to function more as a source of information gathering, while peer-led online groups are more sociable (Romero-Mas et al., 2024). A study by Goodsmith et al. (2022) outlines details of a community-partnered website development intervention, highlighting again the potential of mental health promotion through digital communities.

Overall, this review confirms gaps in the literature; robust evidence is missing and there is a paucity of large-scale studies to demonstrate the efficacy of digital health promotion interventions for priority populations, particularly through a community-approach lens. However, potential and opportunity for further development in digital mental health promotion initiatives is evident. This is observed in the pilot study by Facente et al. (2024), highlighted as a case study in the results section of this report. The authors report statistically significant outcomes for the Let's Connect intervention for the LGBTQ+ community. In the wider literature, Schueller et al. (2019), whose research focuses on the use of technology to address mental health needs among marginalised populations, agree and emphasise the potential of the digital space. Acknowledging the gap in the literature, the authors advocate for the ongoing need to translate potential into action and to build on the evidence base with an emphasis on measuring outcomes. Positive action is evident in the collaborative progress which continues at international and national levels (e.g. see details at: https://emhicglobal.com/news/emhic-member-news/navigating-the-future-hse-irelands-digital-mental-health-initiatives/).

(2) Peers, befrienders and lay community volunteers

An internationally growing trend to adopt peer support approaches to interventions within mental health services is evidenced in the wider literature, particularly regarding recovery-orientated mental health care (Shalaby & Agyapong, 2020). However, a gap in the literature exists regarding the involvement of peers in mental health promotion. This current review addresses this gap and adds to the emerging literature base as this section of the review synthesises mental health promotion interventions for priority population groups that include peers, volunteers and lay community members in mental health promotion interventions. Despite definitions of peers and befrienders being available in NICE (2016) guidelines, which defines the unique role of each, it has been noted that these terms are sometimes used interchangeably in the literature, challenging evidence synthesis.

Peer support and befriending interventions are delivered in a variety of formats and in a variety of combinations; providing support and/or mentoring, via face-to-face, phone or online delivery, and on a one-to-one/group basis. Gower et al. (2022) note that cultural and practical factors, such as transport and availability, can determine the method of peer and lay community member delivery.

This review provides evidence to support the role of peers, befrienders and lay community members in promoting the mental health and wellbeing of priority population groups in the community. Strongest evidence relates to migrant populations, carers, and those who experience loneliness, while further evidence relates to survivors of domestic violence and people with disabilities (Ali et al., 2021; Giummarra et al. (2022); Baeza et al., 2023; Nicolaidis et al., 2013; Ragavan et al., 2018; Serrata et al., 2016).

The current review identifies beneficial outcomes for both the recipient and the peer mentor in the adoption of a peer-approach to service delivery. Individual level outcomes reported include an increase in confidence, perceived emotional health, resilience and hope (Gower at al., 2022; Mahon, D., 2022). Women who experienced domestic abuse and became trained peer leaders in the Lídres programme, reported increased levels of self-empowerment (Serrata et al., 2016). At a community level, reported benefits include strengthening of community networks and building of social capital. Additional benefits for participants include increased access to community-based services, greater citizenship knowledge and improvement in English proficiency (Gower et al., 2022).

It is widely evidenced in the literature that the involvement of peers in programme development adds to the cultural relevancy, and subsequent acceptance and effectiveness of interventions (Apers et al., 2023). Greatest effect has been demonstrated when individuals are matched with peers with lived experience, with Gower et al. (2022) reporting better outcomes when recipients are matched with peers for language and background. Short-term positive outcomes to support the involvement of peers, particularly with migrants, are found in this evidence synthesis, however, a gap in evidence persists regarding long-term outcomes (Gower et al., 2022).

Specific implementation and best practice guidance on involving peers in programme delivery is lacking in the literature. Gower et al. (2022) provide some insight and report that peer programme delivery with refugee and migrant women varies in duration from 8 weeks to 6 months, while training hours for peers range from eight hours to 48 hours. There is a wide variation in the training made available to peers and this appears to be dependent on multiple factors including the intervention itself. As expected, it is generally found that more structured programmes provide more structured training, as in the case of the Self-Help plus intervention (Purgato et al., 2021; Tol et al., 2020). Mahon (2022) notes that when training

is provided, it includes peer training mentorship and cultural elements. Supervision and intervention support for peers varies from ad-hoc to more structured approaches, while an absence of support was found to lead to attrition (Gower et al., 2022). In keeping with the selected review by Gower et al. (2022), this review concludes that evidence for best practice regarding the use of peers in mental health promotion activities with migrant groups requires ongoing trial and evaluation.

(3) Interventions based on collaborations and partnership

Recent evidence recognises the influence of the relationship between service providers and end-users on delivery and outcomes and advocates for a co-production approach that is based on the principles of equality, diversity, accessibility, and reciprocity (Robert, 2022). This review also identifies evidence supporting the emergence of the complimentary approach of co-production and CBPR with priority populations, albeit from a sparse evidence base.

Co-design is considered to be an intentionally applied process that engages community members as active participants in order to understand experiences and improve health promotion action (Robert, 2022). In the case of priority populations, by directly involving community members in local health promotion action, they are empowered to enable positive changes for the betterment of themselves, their communities and the wider community. This is evidenced in the Lived Lives: A Pavee Perspective (Malone et al., 2017), which is highlighted as a case study in the results section of this review. Further findings within the selected studies of this review provide additional evidence to support co-production approaches, including co-design and CBPR, in promoting better mental health and wellbeing outcomes across priority population groups including migrants and refugees (McGarity-Palmer, Saw, & Keys, 2023) and survivors of domestic violence (Ragavan et al., 2018). A range of interventions adopting this approach are identified in the selected review by McGarity-Palmer et al., (2023), with primary studies applying CBPR in parenting interventions for migrants (Shaw, Ward, Pillai, Ali, & Karim, 2020) and co-design in community gardening interventions (Hartwig & Mason, 2016). By way of example in the wider literature, Goodsmith et al. (2022) apply a co-production approach to a website development intervention and credit the approach with improving accessibility and engagement of diverse under-resourced community members.

The NICE guidelines (2016) and PHE (PHE, 2015b) recommendations also endorse the use of co-production as an element of a community-engagement approach to health promotion. Qualitative evidence synthesised herein is largely positive and supportive of engagement in co-production practices and notes that it is found to produce more culturally acceptable interventions by facilitating language translation, culturally appropriate programme modifications, and the inclusion of culturally salient messaging. Regarding implementation, a recent systematic review by Fusco et al. (2023) synthesises the extant multidisciplinary knowledge on co-creation in health and offers an operational guide to facilitate developments on its implementation. Such guides may prove a useful resource as researchers strive to strengthen the evidence base for co-production approaches to mental health promotion intervention.

(4) Strengthening Communities

Approaches to community engagement that focus on strengthening communities and building social capital have shown to be effective in the promotion of community health and wellbeing (PHE, 2015a). This review evidences the effectiveness of family-based and community champions interventions for ethnic minorities, migrants and refugees, and initiatives such as Men's Sheds for men experiencing loneliness. Potential exists for these types of interventions to be adapted and implemented with other priority groups.

Men's Sheds Groups: The literature evidences the benefit of Men's Shed's groups as an effective health promotion intervention to support men's mental health and wellbeing in the wider community. This review includes one review study (Foettinger et al., 2022) that evidences the benefit of Men's Sheds with priority population group members and shows positive outcomes for those who experience social isolation. Overall, this current review lacks evidence to support Men's Shed use with other priority population groups of interest. Referencing the wider literature, the potential for Men's Sheds to act as a platform for inclusive community engagement for people with disabilities is found: https://mensshed.org/mens-sheds-bat-for-will-standing-shoulder-to-shoulder-to-promote-social-inclusion/ , however, evidence of effectiveness specific to people with disabilities who engage with Men's Shed groups is lacking. With the emergence of Women's Sheds in Ireland, research is also needed into the effectiveness of these types of interventions for older women experiencing loneliness and isolation.

Extant evidence points to the positive impacts of Men's Sheds in Ireland, with increases reported in subjective and mental wellbeing, sense of belonging, social wellbeing, and social functioning, and decreases in depression scores (Mc Grath et al. 2021; Mc Grath et al. 2022a). Mc Grath et al. (2022a) also reported that improvements in mental wellbeing were higher for those living alone or those who had lower mental wellbeing scores at baseline. The same study noted that almost 99.3% (n=421) of participants in a Shed for Life intervention in Ireland categorized themselves as "white" or "white Irish", highlighting a lack of ethnic and migrant diversity within Men's Sheds in Ireland at that time. However, currently the Ireland Men's Shed website details initiatives underway to engage with new communities in Ireland: https://menssheds.ie/reducing-inequalities-sdgs/ .

Strengthening the literature base on Men's Sheds in Ireland, a subsequent paper by McGrath et al. (2022b) acknowledges the need to further engage with what the authors describe as, 'hard to reach men'. This 'hard to reach' group potentially includes men who fall into the priority population group categories relevant to the current review. The study, which adopts a co-production and CBPR approach with 'hard to reach men', captures the process and determinants of effective implementation of a community-based Men's Shed health promotion intervention in an Irish context (McGrath et al., 2022b). The study has potential to act a useful guide in supporting efforts towards greater and more effective inclusion of priority population groups in Men's Sheds.

Social capital-based interventions targeting mental health outcomes, delivered via community engagement interventions, such as those that work with community champions, partnerships and collaborations, are predominantly evidenced among the migrant and refugee and ethnic minority priority population groups in this review (Apers et al., 2023; Del Pino-Brunet et al., 2021 & Villalonga-Olives et al., 2022). A qualitative primary study by Mantovani et al. (2017), cited in the selected review by Apers et al. (2023), outlines a community wellbeing champions intervention (CWBCs) evidencing benefits for ethnic minority participants, lay providers otherwise known as CWBC's, and the wider community. Participant benefits include the building and strengthening of their social networks as well as positive social and emotional outcomes. CWBC's reported benefits include individual empowerment and increased psychosocial and emotional health and wellbeing.

Del Pino-Brunet et al. (2021) report that migrants feel more secure and less isolated when engaged with community lay mentors who facilitate interventions. In the selected review by Bunnet al. (2022), evidence is found to support engaging lay community members to deliver family-based mental health promotion interventions to refugee families. The authors report this as a feasible intervention, which is potentially effective, but lacking a strong evidence base. In the wider literature, a scoping review by South et al. (2021) evidences the impactful results of community mobilisation interventions with lay community health champions. However, the authors note a paucity of studies evidencing champions in the role of protecting and promoting mental health specifically, despite it too being an approach supported by NICE (NICE, 2016).

Del Pino-Brunet et al. (2021) conclude that some of the most effective interventions with migrants are those that are delivered by local community members. An example of such an approach is illustrated by the Cultural Navigators intervention (Thomas et al., 2016), presented as a case study in the results section of this review. Villalonga-Olives and Kawachi (2017) conclude that despite the evidence being sparse, largely qualitative in design, and lacking validated instrumentation, social capital interventions are indicative of positive mental health outcomes for the refugee population group.

Determinants of Successful Implementation

The synthesis provided above illustrates the wide range of mental health promotion interventions available to priority population groups by presenting the key findings under four categories reflective of best practice for community-based intervention (PHE, 2015a). In doing so, insights were also captured into the determinants of successful implementation. A review by Riza et al. (2020) addresses this issue, and while the review is based on migrant and refugee populations, the guidance offered is arguably applicable to the wider priority population groups, as the authors emphasise collaborative work practices which foster partnerships to promote culturally relevant interventions in line with NICE best practice guidance (2016). Additionally, specific guidance on implementation with some priority populations was identified in the wider literature, notably for ethnic communities (Netto, et al., 2010) and those living with disabilities (Giummarra et al., 2022), which highlights the need to consider each individual's unique needs and preferences.

Uphoff et al. (2020) in a review of systematic reviews, report that the strength of the evidence is weak across migrant and refugee population subgroups and highlight that reviews specific to mental health promotion and prevention are generally missing from the literature. Additionally, Soltan et al. (2022) conclude that, to date, evidence is not of sufficient quantity or quality to make recommendations regarding the best interventions to implement for migrant children and adolescents. This current synthesis concurs with these conclusions, not only relating to migrants and refugees, but across the wider priority populations of focus in this review. Additionally, the findings of this current review illustrate considerable similarities to the findings of Lee et al. (2021), who investigated community-based mental health promotion interventions for older people. Lee et al. (2021) concluded that no strong conclusions could be drawn due to the lack of robust evidence. Similarly, the overarching finding of this current review is that a weak evidence base underlies mental health promotion interventions for priority intervention groups and there is an urgent need to address the gap in evaluation.

Strengths and Limitations of this Review

The iterative process of this study has served as both a positive and a negative. Limiting selected studies to review studies only, was successful in capturing the range of focus within community-based mental health promotion interventions for priority population groups available in the literature. However, it is important to note that the primary studies from these reviews may not include the most up to date evidence available and it is possible that some potentially relevant primary studies published more recently were excluded. The use of Rayyan software facilitated a coordinated screening process among researchers, however, its use in the iterative process of reducing the studies included to reviews only may have compromised the evidence base of this review, as the primary function of Rayyan software is not a filtering tool, but as a collaborative screening tool.

The breadth of the research question on which this study is based may have proved limiting, particularly regarding the population focus. With the existence of subgroups within priority population groups, the range of population search terms employed may not have captured all studies relevant to each population and subpopulation grouping. This may explain the limited findings within the population groups of those living with a disability and NEET young people. No review studies met the selection criteria within the NEET population

group, and evidence for those living with disability captured only the subgroups of IDs, psychosocial disabilities and those on the autism spectrum. The review did not capture other subgroups within the disability population, such as those living with physical, visual, and other sensory disabilities, those with acquired and neurodegenerative disabilities and the wider neurodiverse populations.

The literature base relating to this study was noted to lack uniformity in its definition and application of relevant key terms, namely "community-based" and "mental health promotion". A considerable number of studies did not distinguish between mental health promotion and treatment approaches, while the level of delivery, community or otherwise, is not always defined or clarified. Although, researchers adhered to the use of a priori definitions of key terms, considerable subjective assessment on behalf of the researchers was required, particularly during the study selection and data extraction phases.
While the omission of grey literature may be considered a limitation of this review, a more significant observation may be the overall gap in the strength of the evidence available in the peer-reviewed literature and the opportunities this presents to direct future research towards strengthening the evidence base. This review did identify and present implementation details, however, studies overall lacked specificity regarding intervention content and implementation. This gap again highlights a research opportunity regarding the need for implementation evaluation of current interventions, to strengthen and standardise implementation approaches going forward. While this review includes a search of the international literature, the purpose of this review being specific to intervention delivery in Ireland guided the research process and this, therefore, should be considered if generalising the findings outside the target context.

Implications for community-based mental health promotion for priority groups in Ireland

Adopting a Community Engagement Approach. This review provides evidence from a wide range of studies to support a community-engagement approach to mental health promotion intervention planning, delivery and evaluation with priority populations groups, to support their mental health and wellbeing and that of the wider community. While evidence relating to priority population groups specifically, is sparse, this review synthesises promising

and emerging evidence linking the application of community-based mental health promotion approach(es) with these population groups. Among migrants and refugees, ethnic minorities, and survivors of domestic violence, initiatives that increase access to community resources and employ peer-led models of delivery, for example arts-based programmes, nature-based interventions, and support groups, are considered most effective. Across these three priority groups, facilitating collaborations through co-production approaches leads to more culturally acceptable interventions. For those experiencing loneliness and isolation and people living in disadvantaged communities, the most promising evidence is found for interventions that use befriending approaches and those that increase access to community resources, such as Social Prescribing services. Social capital interventions and those that aim to strengthen communities show positive effects among migrants and refugees, ethnic minority populations and those experiencing loneliness and isolation. Evidence also exists for the potential effectiveness of digital interventions among caregivers, ethnic populations, survivors of domestic violence, and members of the LGBTQI+ community. In line with WHO (2020) guidance referenced in the introduction section of this report, the approach(es) to community engagement adopted with priority groups in Ireland and the level of external support provided should be tailored to reflect the local needs of each group and specific community engagement objectives. While not recommended specifically for priority population groups, NICE guidelines (2016) do recommend the use of a framework to facilitate decision-making on the best approaches to consider when planning community-based mental health interventions. This may prove a useful tool in future mental health promotion planning for priority population groups (https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches). The following specific approaches are also highlighted in the present review findings.

A Co-production Approach. A co-production approach to community-engagement that facilitate relationship-building, and fosters trust between priority groups, researchers, third sector organisations, and government is considered crucial to the development, implementation and the scaling-up of community-based mental health promotion interventions. Particularly in the case of migrants and refugees, and ethnic minorities including the Travelling community, evidence from this review shows that involving community members as equal partners in all aspects of mental health promotion action, from needs assessment, to programme planning, development, implementation and evaluation results in more culturally responsive interventions that are accepted by communities and their

members. This is particularly apparent in the case study "Lived lives: A Pavee Perspective" described in the results section of this report.

Cultural Appropriateness. Related to co-production, the need to consider the cultural appropriateness of interventions is identified as a significant influencing factor on intervention efficacy. This review is consistent with the wider literature in reporting that co-production is an effective strategy to facilitate cultural appropriateness. Engagement in co-production with community members, therefore, should be viewed, and utilised as a valuable resource to enhance intervention effectiveness. Apers et al. (2023) conclude that there are three main mechanisms essential to ensuring successful development and implementation of interventions for ethnic minority and migrant populations; to have a sound theoretical base, to systematically adapt interventions for cultural sensitivity, and to employ participatory approaches. These mechanisms, all of which are evidenced in this synthesis, could potentially be applied to all priority population group intervention planning. There is a need also for intervention planners to consider all potential intervention outcomes, including any negative programme impacts, as outlined in the review by Micklitz et al. (2024) where the possible adverse effects of psychosocial interventions for victims of domestic abuse were considered. Co-production could be an important means of mitigating against potential harmful programme effects.

Peer and Volunteer Approaches: This review endorses the role of peers, befrienders, and lay community workers in the delivery of effective interventions for priority population groups. This approach to working with communities was found to be particularly effective when employed with migrants and refugees, caregivers, those experiencing loneliness and isolation, survivors of domestic violence, and people with disabilities. In the case of migrants, programmes are found to be most effective, reporting mutual benefits for participants and peer facilitators, where participants are matched with peer leaders who are from the same background and speak the same language.

Implementation Factors. Regarding implementation, while there is a paucity of specific guidance regarding the implementation components of effective community-based mental health promotion interventions for priority groups, some key points emerged throughout the review process. As endorsed in this research and in the wider literature (PHE, 2015a; NICE, 2016), partnerships and collaborative work practices, together with peer-led models of

delivery results in more acceptable programmes and promote active participation by community members. Tailoring and culturally adapting evidence-based programmes with specific subgroups including language translation, programme modifications, and culturally salient messaging can ensure culturally appropriate interventions. Additionally, the review findings indicate that more structured programmes are better received and more effective.

Supportive Infrastructure. The importance of a supportive infrastructure for intervention efficacy is highlighted, including structured training and ongoing support for peer and lay community facilitators. It is necessary, therefore, for policies and practices to adopt a focus beyond the initial intervention development and delivery, and to prioritise the implementation of actions and supportive structures that will ensure effective and sustainable interventions outcomes in the long-term. There is a need to consider the accessibility of interventions to community members. The importance of identifying and addressing barriers to end-user participation was highlighted by Wilson et al. (2016) who investigated the participation of men with disabilities in Men's Sheds, and Baskin et al. (2021) who consider transport and language as structural barriers to active participation.

In the Irish context, infrastructure already exists for mental health promotion interventions that focus on increasing access to community resources, such as Social Prescribing Services, digital initiatives, and support groups, and those that aim to strengthen communities, such as Men's Sheds. This review reports emerging but promising evidence for the impact of Men's Sheds on the mental health and wellbeing of older men. With the existence of the Irish Men's Shed Association, a dedicated website (https://menssheds.ie/), and recently announced renewed funding of 250,000 euro (Department of Health (DOH), 2024), there is considerable potential for this initiative to be tailored to address the needs and preferences of other priority populations such as migrants and ethnic minorities, and those living with disabilities. While robust evidence for Social Prescribing services across priority populations is lagging behind its practice, the service is being rolled out at a national level in Ireland with over 40 different locations. Funded by the HSE, it is accessed by people with long-term conditions, those experiencing loneliness and isolation, and those who have complex social needs (HSE, 2024). Anecdotally, the service is well received in communities including deprived and disadvantaged areas and there is a clear opportunity to try to engage other priority population groups if the service is further resourced. Initiatives providing support to new mothers in migrant and refugee populations and ethnic communities can be effective if culturally-

adapted and peer-led. Consideration should be given to adapting the widely evaluated, evidence-based Community Mothers Programme (https://www.khf.ie/community-mothers-programme/)[2] for priority groups in Ireland, and in keeping with the principles of the programme, using volunteer lay community members as programme facilitators. Consideration should also be given to the use of digital platforms in the promotion of the mental health of priority groups in Ireland. While evidence to support their use is evolving in the literature, adopting co-design approaches to programme development can ensure culturally appropriate content and positive outcomes across a variety of subgroups beyond those evidenced in this review (caregivers, ethnic populations, survivors of domestic violence, and members of the LGBTQI+ community).

Strengthening the Evidence Base. Finally, akin to the findings by Reinhardt et al. (2021), who identified a gap between social prescribing design and social prescribing evidence, this review identifies a gap between existing community-based mental health promoting interventions for priority population groups and the strength of the supporting evidence. This review has synthesised a wide range of interventions, while also emphasising a lack of robust evidence. The findings, therefore, confirm the need to document community-based mental health promotion interventions and evaluate their impact for priority groups appropriately in order to strengthen the evidence base so that future action can build on this effectively.

Conclusion

This review aimed to synthesise the evidence for community-based mental health promotion interventions for pre-defined priority population groups; people living with disability and their families, people experiencing social isolation and loneliness, those living in deprived and disadvantaged communities, carers of people living with chronic illness, migrants and refugees, ethnic populations, including Traveller communities and & Roma communities, survivors of domestic violence, members of the LGTBQI+ community, and young people NEET. This review included a total of thirty-three (n=33) peer-reviewed studies with evidence from relevant primary studies found within these reviews cited directly. Overall, the study quality varied, with many having a weak study design, small sample sizes, and a lack of standardised outcome measurement. However, evidence in this field continues to emerge and

[2] recently updated as Community Families (https://www.communityfamilies.ie)

there is an opportunity to strengthen the existing evidence by ensuring that future practice is documented, and its impact is appropriately evaluated.

While the limitations of this scoping review are acknowledged, this review was successful in comprehensively mapping existing community-based mental health promotion interventions, while also evidencing the benefits of adopting community-engagement approaches with priority populations to ensure relevant, accessible, and effective programmes. Facilitating access to community resources and ensuring priority population members take an active role in their communities can promote a sense of belonging and improve their overall mental health and wellbeing; while collaborative and co-production work practices build trust and ensure culturally appropriate and sustainable programmes. In the Irish context, there is therefore, a need to co-produce community-based mental health interventions with members of specific priority population groups to ensure that interventions meet their particular needs, are designed appropriately and can be delivered in an effective and sustainable manner. There is also an opportunity to adapt and evaluate the delivery of already resourced mental health promotion initiatives considered effective for the general population for implementation among priority groups. Ensuring that programmes are accessible for all community members will require close partnership with communities to identify their specific needs and preferences and address the wider determinants of their mental health.

The results of this study contribute to the evidence base for community-based mental health promotion of priority population groups. Additionally, the identified literature gaps could serve as a springboard to guide future research in order to strengthen the evidence base. Most importantly, it is hoped that this synthesis of evidence will serve as a useful base to guide, support and facilitate the development of a suite of effective community-based mental health promotion interventions for priority populations in Ireland. Key recommendations are outlined below.

KEY RECOMMENDATIONS

- A community engagement approach to promoting the mental health and wellbeing of priority groups in Ireland should be adopted. The strongest evidence across the majority of population groups of interest is found for approaches that aim to increase participants' access to community resources, such as Social Prescribing services, support groups and digital initiatives, and those that aim to strengthen communities, such as Men's Sheds.
- In line with the principles of community engagement, adopting a co-production approach to mental health promotion initiatives with priority groups fosters relationship-building and trust. Ensuring that community members are actively involved from needs assessment and intervention planning to delivery and evaluation creates a sense ownership and ensures the relevance of programmes.
- There is a need to tailor mental health promotion interventions for specific subgroups to ensure their cultural appropriacy. Adopting co-production approaches, such as shared decision-making, co-design, and CBPR, can facilitate culturally acceptable programmes.
- Peers, befrienders, and lay community members could be trained and employed as programme facilitators. This approach to programme delivery yields beneficial outcomes for both facilitators and participants, particularly in the case of migrants and refugees, caregivers, those experiencing loneliness and isolation, survivors of domestic violence, and people living with disabilities.
- Although specific implementation components of effective mental health promotion interventions for priority groups are unclear, evidence suggests that programmes with a sound theoretical base and structured content, employing collaborative work practices, and culturally tailored are most effective.
- Supportive infrastructure is needed to implement and sustain programmes. This includes adequate mental health promotion training and ongoing support for peer facilitators.
- Programmes should be accessible and careful needs assessment and planning with communities is required to ensure that structural barriers to end-user engagement, such as transport and language, are identified and addressed.
- Robust evaluation of community-based mental health promotion practice is needed to strengthen the evidence base, including documenting the implementation process and outcomes of interventions, as well as ensuring that there are no adverse programme effects.
- In the Irish context, consideration should be given to adapting, resourcing, and scaling-up initiatives for priority groups that have existing infrastructure, such as Men's Sheds, Social Prescribing services, and peer-led programmes such as the Community Mothers Programme.

References

Ali, A., McKenzie, E., Hassiotis, A., Priebe, S., Lloyd-Evans, B., Jones, R., Panca, M., Omar, S., Finning, S., Moore, S., & King, M. (2021). A pilot randomized controlled trial of befriending by volunteers in people with intellectual disability and depressive symptoms. *Journal of Intellectual Disability Research*, *65*(11). doi: 10.1111/jir.12886

Apers, H., Van Praag, L., Nöstlinger, C., & Agyemang, C. (2023). Interventions to improve the mental health or mental well-being of migrants and ethnic minority groups in Europe: A scoping review. *Global Mental Health (Cambridge, England), 10*, e23. doi:10.1017/gmh.2023.15

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19-32. https://doi-org.nuigalway.idm.oclc.org/10.1080/1364557032000119616

Baez, M., Far, I. K., Ibarra, F., Ferron, M., Didino, D., & Casati, F. (2017). Effects of online group exercises for older adults on physical, psychological and social wellbeing: A randomized pilot trial. *PeerJ*, *5*, e3150. https://doi.org/10.7717/peerj.3150

Baeza, M. J., De Santis, J. P., Cianelli, R., Metheny, N., Villegas, N., & Iriarte, E. (2023). Sources of Well-Being for Hispanic Women Who Have Experienced Intimate Partner Violence: A Scoping Review. *Hispanic Health Care International, 22*(3), 178-189154041532312108 58. doi:10.1177/15404153231210858

Balaam, M.C., Kingdon, C., Haith-Cooper M. (2022). A systematic review of perinatal social support interventions for asylum-seeking and refugee women residing in Europe. *Journal of Immigrant and Minority Health, 24*(3), 741-758. doi:10.1007/s10903-021-01242-3

Barry, M. M., Clarke, A.M., Petersen, I., Jenkins, R. (2019). *Implementing Mental Health Promotion (2nd edition).* Cham, Switzerland: Springer Nature. https://www.springer.com/in/book/9783030234546

Baskin, C., Zijlstra, G., McGrath, M., Lee, C., Duncan, F. H., Oliver, E. J., . . . Gnani, S. (2021). Community-centred interventions for improving public mental health among adults from ethnic minority populations in the UK: A scoping review. *BMJ Open, 11*(4). DOI:10.1136/bmjopen-2020-041102

Block, A. M., Aizenman, L., Saad, A., Harrison, S., Sloan, A., Vecchio, S., & Wilson, V. (2018). Peer support groups: Evaluating a culturally grounded, strengths-based approach for work with refugees. *Advances in Social Work, 18*(3), 930-948. https://doi.org/10.18060/21634

Blom, M. M., Zarit, S. H., Groot Zwaaftink, R. B., Cuijpers, P., & Pot, A. M. (2015). Effectiveness of an Internet intervention for family caregivers of people with dementia: results of a randomized controlled trial. *PloS one*, *10*(2), e0116622. https://doi.org/10.1371/journal.pone.0116622

Boyt, N., Ho, A. K., Morris-Bankole, H., & Sin, J. (2022). Internet-facilitated interventions for informal caregivers of patients with neurodegenerative disorders: Systematic review and meta-analysis. *Digital Health*, *8*. https://doi.org/10.1177/20552076221129069

Brand, F., Scior, K., & Loewenberger, A. (2024). Psychological and social outcomes of befriending interventions for adults with intellectual disabilities: A systematic review. *Journal of Applied Research in Intellectual Disabilities*, *37*(1), e13168. https://doi.org/10.1111/jar.13168

Bravo, S.L., Caparrós, C.N. (2014). Café y palabras. Las voces de las mujeresque cruzan fronteras. Cuadernos de Trabajo Social. 28–2:225–34. https://doi.org/10.5209/rev_CUTS.2015.v28.n2.45523

Brown, K. W., Coogle, C. L., & Wegelin, J. (2016). A pilot randomized controlled trial of mindfulness-based stress reduction for caregivers of family members with dementia. *Aging & Mental Health*, *20*(11), 1157-1166. https://doi.org/10.1080/13607863.2015.1065790

Bunn, M, Z. N., Smith, CP, Khanna, D., Hanneke, R., Betancourt, T.S., Weine, S. (2022). Family-based mental health interventions for refugees across the migration continuum: A systematic review. *Mental Health 2*. doi:10.1016/j.ssmmh.2022.100153

Chalmin-Pui, L. S., Roe, J., Griffiths, A., Smyth, N., Heaton, T., Clayden, A., & Cameron, R. (2021). "It made me feel brighter in myself"-The health and well-being impacts of a residential front garden horticultural intervention. *Landscape and Urban planning*, *205*, 103958. https://doi-org.nuigalway.idm.oclc.org/10.1016/j.landurbplan.2020.103958

Constantino, R. E., Braxter, B., Ren, D., Burroughs, J. D., Doswell, W. M., Wu, L., . . . Greene, W. B. (2015). Comparing Online with Face-to-Face HELPP Intervention in Women Experiencing Intimate Partner Violence. *Issues in Mental Health Nursing, 36*(6), 430-438. https://doi-org.nuigalway.idm.oclc.org/10.3109/01612840.2014.991049

Coulter, R. W. S., Egan, J. E., Kinsky, S., Friedman, M. R., Eckstrand, K. L., Frankeberger, J., . . . Miller, E. (2019). Mental Health, Drug, and Violence Interventions for Sexual/Gender Minorities: A Systematic Review. *Pediatrics (Evanston), 144*(3), 1. https://doi-org.nuigalway.idm.oclc.org/10.1542/peds.2018-3367

Cripe, S. M., Espinoza, D., Rondon, M. B., Jimenez, M. L., Sanchez, E., Ojeda, N., . . . Williams, M. A. (2015). Preferences for intervention among Peruvian women in intimate partner violence relationships. *Hispanic Health Care International, 13*(1), 27-37. doi:10.1891/1540-4153.13.1.27

Cristancho-Lacroix, V., Wrobel, J., Cantegreil-Kallen, I., Dub, T., Rouquette, A., & Rigaud, A. S. (2015). A web-based psychoeducational program for informal caregivers of patients with Alzheimer's disease: A pilot randomized controlled trial. *Journal of Medical Internet Research*, *17*(5), e117. https://doi.org/10.2196/jmir.3717

Cruwys, T., Haslam, C., Rathbone, J. A., Williams, E., Haslam, S. A., & Walter, Z. C. (2022). Groups 4 Health versus cognitive-behavioural therapy for depression and loneliness in young people: randomised phase 3 non-inferiority trial with 12-month follow-up. *The British Journal of Psychiatry, 220*(3), 140-147. doi:10.1192/bjp.2021.128

Davies, J., McKenna, M., Bayley, J., Denner, K., & Young, H. (2020). Using engagement in sustainable construction to improve mental health and social connection in disadvantaged and hard to reach groups: a new green care approach. *Journal of Mental Health*, *29*(3), 350-357. https://doi-org.nuigalway.idm.oclc.org/10.1080/09638237.2020.1714001

Dayson C, & Bennett E. (2016). *Evaluation of Doncaster Social Prescribing Service: Understanding outcomes and impact.* Retrieved 1 June 2024 from: https://shura.shu.ac.uk/17298/1/eval-doncaster-social-prescribing-service.pdf

Del Pino-Brunet, N., Hombrados-Mendieta, I., Gómez-Jacinto, L., García-Cid, A., & Millán-Franco, M. (2021). Systematic review of integration and radicalization prevention programs for migrants in the US, Canada, and Europe. *Frontiers in Psychiatry, 12*, 606147. https://doi-org.nuigalway.idm.oclc.org/10.3389%2Ffpsyt.2021.606147

Department of Health (DOH) 2024. Press release: Minister Burke announces €250,000 in funding to continue to support the Irish Men's Sheds Association. Accessed 22 August 2024 at: https://www.gov.ie/en/press-release/2b7a7-minister-burke-announces-250000-in-funding-to-continue-to-support-the-irish-mens-sheds-association/

Ellis, D. M., Draheim, A. A., & Anderson, P. L. (2022). Culturally adapted digital mental health interventions for ethnic/racial minorities: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology, 90*(10), 717.

Facente, S. N., Davila, X., Kowell, N., Calma, N., Kwan, M. M., & Gupta, S. (2024). Let's Connect: Impact Evaluation of an Intervention to Reduce Mental Health Disparities Among People Who are LGBTQ+ *Community Mental Health Journal, 60*(4), 754-763. doi:10.1007/s10597-024-01231-4

Finkel, S., Czaja, S. J., Martinovich, Z., Harris, C., Pezzuto, D., & Schulz, R. (2007). E-care: a telecommunications technology intervention for family caregivers of dementia patients. *The American journal of Geriatric Psychiatry*, *15*(5), 443-448. https://doi.org/10.1097/JGP.0b013e3180437d87

Fischer, R., & Hartle, L. (2023). Effective interventions to reduce loneliness in big cities. *Current Opinion in Psychiatry*, *36*(3), 206-212. https://doi.org/10.1097/YCO.0000000000000844

Foettinger, L., Albrecht, B. M., Altgeld, T., Gansefort, D., Recke, C., Stalling, I., & Bammann, K. (2022). The role of community-based men's sheds in health promotion for older men: a mixed-methods systematic review. *American Journal of Men's Health*, *16*(2). https://doi.org/10.1177/15579883221084490

Fusco, F., Marsilio, M., & Guglielmetti, C. (2023). Co-creation in healthcare: framing the outcomes and their determinants. *Journal of Service Management, 34*(6), 1-26. doi:10.1108/JOSM-06-2021-0212

Gerber, M. M. (2015). Community gardening: A novel intervention for Bhutanese refugees living in the USA [Thesis]. University of North Texas. Available at: https://www.proquest.com/docview/1774019921?pq-origsite=gscholar&fromopenview=true&sourcetype=Dissertations%20&%20Theses

Gilmartin, D., Mercado-Garrido, E., Harte, P. & Barry, M.M. (2024). *Defining Priority Population Groups at Risk of Poor Mental Health Outcomes: A report to guide a scoping review of the evidence on community-based mental health promotion interventions for priority groups. Report prepared for the Health Service Executive, Ireland.* Health Promotion Research Centre, University of Galway

Giummarra, M., Randjelovic, I., O'Brien, L., & Gardner, B. (2022). Interventions for social and community participation for adults with intellectual disability, psychosocial disability or on the autism spectrum: An umbrella systematic review. *Frontiers in Rehabilitation Sciences*, *3*, 935473. https://doi-org.nuigalway.idm.oclc.org/10.3389%2Ffresc.2022.935473

Goodkind, J.R.; Hess, J.M.; Isakson, B.; LaNoue, M.; Githinji, A.; Roche, N.; Vadnais, K.; Parker, D.P. (2005). Reducing refugee mental health disparities: A community-based intervention to address postmigration stressors with African adults. Psychological Services. 2014, 11, 333–346

Gorenko JA, Moran C, Flynn M, Dobson K, Konnert C. Social isolation and psychological distress among older adults related to COVID-19: A narrative review of remotely-delivered interventions and recommendations. Journal of Applied Gerontology. 2021;40(1):3–13. https://doi-org.nuigalway.idm.oclc.org/10.1177/0733464820958550

Gower, S., Jeemi, Z., Forbes, D., Kebble, P., & Dantas, J.A.R. (2022). Peer Mentoring Programs for Culturally and Linguistically Diverse Refugee and Migrant Women: An Integrative Review. *International Journal of Environmental Research and Public Health, 19*(19). doi:10.3390/ijerph191912845

Gray, T., Tracey, D., Truong, S., & Ward, K. (2022). Community gardens as local learning environments in social housing contexts: Participant perceptions of enhanced wellbeing

and community connection. *Local Environment*, *27*(5), 570-585. https://doi-org.nuigalway.idm.oclc.org/10.1080/13549839.2022.2048255

Griffiths, P. C., Whitney, M. K., Kovaleva, M., & Hepburn, K. (2016). Development and implementation of tele-savvy for dementia caregivers: a department of veterans affairs clinical demonstration project. *The Gerontologist*, *56*(1), 145-154. https://doi-org.nuigalway.idm.oclc.org/10.1093/geront/gnv123

Gunnes, M., Løe, I. C., & Kalseth, J. (2024). Exploring the impact of information and communication technologies on loneliness and social isolation in community-dwelling older adults: a scoping review of reviews. *BMC Geriatrics*, *24*(1), 1-15. https://doi.org/10.1186/s12877-024-04837-1

Gustafson Jr, D. H., Gustafson Sr, D. H., Cody, O. J., Chih, M. Y., Johnston, D. C., & Asthana, S. (2019). Pilot test of a computer-based system to help family caregivers of dementia patients. *Journal of Alzheimer's Disease*, *70*(2), 541-552. https://doi.org/10.3233/JAD-190052

Han, M., Wang, Y., Zhang, Y., Wang, Y., Ou, J., Ren, D., . . . Chen, R. (2023). A multicomponent digital intervention to promote help-seeking for mental health problems and suicide in sexual and gender diverse young adults: A randomized controlled trial. *PLoS Med, 20*(3), e1004197. doi:10.1371/journal.pmed.1004197

Harrison, H., Burns, M., Darko, N., & Jones, C. (2023). Exploring the benefits of nature-based interventions in socio-economically deprived communities: a narrative review of the evidence to date. *Perspectives in Public Health*, *143*(3), 156-172. https://doi-org.nuigalway.idm.oclc.org/10.1177/17579139231170768

Haslam, C., Cruwys, T., Chang, M., Bentley, S., Haslam, S., Dingle, G., & Jetten, J. (2019). Groups 4 Health reduces loneliness and social anxiety in adults with psychological

distress: Findings from a Randomized Controlled Trial. *Journal of Consulting and Clinical Psychology, 87*(9), 787-801. doi:10.1037/ccp0000427

Haslam, C., Cruwys, T., Haslam, S. A., Dingle, G., & Chang, M. X.-L. (2016). Groups 4 Health: Evidence that a social-identity intervention that builds and strengthens social group membership improves mental health. *Journal of Affective Disorders, 194*, 188-195. https://doi-org.nuigalway.idm.oclc.org/10.1016/j.jad.2016.01.010

Hattink, B., Meiland, F., van der Roest, H., Kevern, P., Abiuso, F., Bengtsson, J., ... & Dröes, R. M. (2015). Web-based STAR E-learning course increases empathy and understanding in dementia caregivers: results from a randomized controlled trial in the Netherlands and the United Kingdom. *Journal of Medical Internet Research*, *17*(10), e241. https://doi.org/10.2196/jmir.4025

Health Service Executive (HSE) (2024). Social Prescribing. Accessed 22 August 2024 at: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/social-prescribing/

Hoang, P., King, J. A., Moore, S., Moore, K., Reich, K., Sidhu, H., Vern Tan, C., Whaley, C. & McMillan, J. (2022). Interventions associated with reduced loneliness and social isolation in older adults: a systematic review and meta-analysis. *JAMA Network Open*, *5*(10), e2236676-e2236676. https://doi.org/10.1001/jamanetworkopen.2022.36676

Jackson, C., & Ronzi, S. (2021). Residents' perceptions of a community-led intervention on health, well-being, and community inclusion through Photovoice. *Health Education & Behavior*, *48*(6), 783-794. https://doi-org.nuigalway.idm.oclc.org/10.1177/10901981211009738

Jeffries, J., Clark, H., Wood, D. (2015). Lived Lives: Materializing Stories of Young Irish Suicide. *The Handbook of Textiles.* UK: Bloomsbury Publishing

Jung Y, Li K, Janissa N, Gladys W, Lee K. (2009) *Games for a better life: Effects of playing Wii games on the well-being of seniors in a long-term care facility*. Proceedings of the Sixth Australasian Conference on Interactive Entertainment; Sydney, Australia https://doi.org/10.1145/1746050.1746055

It Gets Better Project (2010). Available at www.itgetsbetter.org

Kabat-Zinn J. (2013). *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness.* New York: Delacorte

Kahlbaugh PE, Sperandio AJ, Carlson AL, Hauselt J. (2011). Effects of Playing Wii on Well-Being in the Elderly: Physical Activity, Loneliness, and Mood. *Activities, Adaptation & Aging, 35*(4)*,* 331-344. https://doi-org.nuigalway.idm.oclc.org/10.1080/01924788.2011.625218

Kimberlee, R., Ward, R., Jones, M., & Powell, J. (2014). *Measuring the economic impact of the Wellspring Healthy Living Centre's Social Prescribing Wellbeing Programme for low level mental health issues encountered by GP services. Project Report.* Available at: https://networks.sustainablehealthcare.org.uk/sites/default/files/resources/2014_kimberlee_0.pdf

Kirchner, S., Till, B., Plöderl, M., & Niederkrotenthaler, T. (2022). Effects of "It Gets Better" Suicide Prevention Videos on Youth Identifying as Lesbian, Gay, Bisexual, Transgender, Queer, or Other Sexual or Gender Minorities: A Randomized Controlled Trial. *LGBT Health, 9*(6), 436-446. doi:10.1089/lgbt.2021.0383

Korn, A., Bolton, S. M., Spencer, B., Alarcon, J. A., Andrews, L., & Voss, J. G. (2018). Physical and mental health impacts of household gardens in an urban slum in Lima, Peru. *International Journal of Environmental Research and Public Health*, *15*(8), 1751. https://doi.org/10.3390/ijerph15081751

Kuosmanen, T., Keppler, T., Dowling, K., Barry, M. M. (2022). *Evidence Synthesis of Impact of Mental Health Promotion: A systematic rapid evidence assessment of the effectiveness of mental health promotion interventions across the lifecourse.* Health Promotion Research Centre, National University of Ireland Galway. Available at: https://assets.gov.ie/245531/6dbfa423-7455-4ea5-b666-758f3972cadd.pdf

Larsen, R. T., Korfitsen, C. B., Keller, C., Christensen, J., Andersen, H. B., Juhl, C., & Langberg, H. (2021). The MIPAM trial–motivational interviewing and physical activity monitoring to enhance the daily level of physical activity among older adults–a randomized controlled trial. *European Review of Aging and Physical Activity*, *18*(1), 12. https://doi.org/10.1186/s11556-021-00269-7

Lee, C., Kuhn, I., McGrath, M., Remes, O., Cowan, A., Duncan, F., ... & Lafortune, L. (2022). A systematic scoping review of community-based interventions for the prevention of mental ill-health and the promotion of mental health in older adults in the UK. *Health & Social Care in the Community*, *30*(1), 27-57. https://doi-org.nuigalway.idm.oclc.org/10.1111/hsc.13413

Li, J., Xu, X., Pham, T.P., Theng, Y.L., Katajapuu, N., Luimula, M. (2017). Exergames designed for older adults: A pilot evaluation on psychosocial well-being. *Games Health Journal, 6*(6), 371–378. https://doi.org/10.1089/g4h.2017.0072

Li, J., Erdt, M., Chen, L., Cao, Y., Lee, S. Q., & Theng, Y. L. (2018). The social effects of exergames on older adults: Systematic review and metric analysis. *Journal of Medical Internet Research*, *20*(6), e10486. https://doi.org/10.2196/10486

Liu, Z., Sun, Y. Y., & Zhong, B. L. (2018). Mindfulness-based stress reduction for family carers of people with dementia. *Cochrane Database of Systematic Reviews*, (8), CD012791. https://doi.org/10.1002/14651858.CD012791.pub2

Mahon, D. (2022). A systematic scoping review of interventions delivered by peers to support the resettlement of refugees and asylum seekers. *Mental Health & Social Inclusion, 26*(3), 206-229. doi:10.1108/MHSI-12-2021-0085

Malone, K., McGuinness, S., Cleary, E., Jefferies, J., Owens, C., & Kelleher, C. (2017). Lived Lives: A Pavee Perspective. An arts-science community intervention around suicide in an indigenous ethnic minority [version 1; peer review: 3 approved]. *Wellcome Open Research, 2*(27). https://doi.org/10.12688%2Fwellcomeopenres.11330.1

Mantovani, N., Pizzolati, M., & Gillard, S. (2017). Engaging communities to improve mental health in African and African Caribbean groups: a qualitative study evaluating the role of community well-being champions. *Health and Soialc Care in the Community, 25*(1), 167-176. https://doi-org.nuigalway.idm.oclc.org/10.1111/hsc.12288

Michael, L., Marchelewska, E., Omidi, N. & Stewart, I. in collaboration with project participants and facilitators. (2024). Wellbeing and Integration program for women. Evaluation Report. Cairde. Available at: https://cairde.ie/wp-content/uploads/2024/03/Pathways-to-Wellbeing-Empowering-Migrant-and-Refugee-Women-Mental-Health-and-Integration-2024.pdf

McGarity-Palmer, R., Saw, A., & Keys, C. B. (2023). Community engagement in psychosocial interventions with refugees from Asia: A systematic review. *Asian American Journal of Psychology, 14*(2), 117.

McGrath, A., Murphy, N., Egan, T., & Richardson, N. (2022a). Sheds for life: health and wellbeing outcomes of a tailored community-based health promotion initiative for men's sheds in Ireland. *BMC Public Health, 22*(1), 1590. doi:10.1186/s12889-022-13964-6

McGrath, A., Richardson, N., & Murphy, N. (2022b). Strategies for effective implementation and scale-up of a multi-level co-designed men's health initiative “Sheds for Life” in Irish Men's Sheds. *Frontiers in Health Services, 2*. doi:10.3389/frhs.2022.940031

McGrath, A., Murphy. N, & Richardson, N. (2021). *Sheds for Life Impact Report: The Impact of Implementation Phase one on the health and wellbeing outcomes of participants.* Irish Men’s Sheds Association (www.menssheds.ie) & Irish Research Council. Available at: https://menssheds.ie/wp-content/uploads/2021/06/Sheds-for-Life-impact-report-june-21.pdf

Micklitz, H. M., Glass, C. M., Bengel, J., & Sander, L. B. (2024). Efficacy of Psychosocial Interventions for Survivors of Intimate Partner Violence: A Systematic Review and Meta-Analysis. *Trauma Violence Abuse, 25*(2), 1000-1017. https://doi-org.nuigalway.idm.oclc.org/10.1177/15248380231169481

Msengi,C.M., Arthur-Okor, H., Killion, L., Schoer, J. (2015). Educating Immigrant Women Through Social Support. SAGE Open. 2015:1–8. https://doi.org/10.1177/2158244015611935

Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology, 18*(1), 143-143. https://doi-org.nuigalway.idm.oclc.org/10.1186%2Fs12874-018-0611-x

Netto, G., Bhopal, R., Lederle, N., Khatoon, J., & Jackson, A. (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International, 25*(2), 248-257. doi:10.1093/heapro/daq012

National Institute for Health and Care Excellence (NICE) (2016). *Community engagement: improving health and wellbeing and reducing health inequalities, in NICE guideline*

NG 44. National Institute for Health and Care Excellence: London. Available at: https://www.nice.org.uk/guidance/ng44

Nicolaidis, C., Wahab, S., Trimble, J., Mejia, A., Mitchell, S. R., Raymaker, D., . . . Waters, A. S. (2013). The Interconnections Project: Development and evaluation of a community-based depression program for African American violence survivors. *Journal of General Internal Medicine, 28*(4), 530-538. doi:10.1007/s11606-012-2270-7

Oken, B. S., Fonareva, I., Haas, M., Wahbeh, H., Lane, J. B., Zajdel, D., & Amen, A. (2010). Pilot controlled trial of mindfulness meditation and education for dementia caregivers. *The Journal of Alternative and Complementary Medicine*, *16*(10), 1031-1038. https://doi.org/10.1089/acm.2009.0733

O'Mara-Eves, A., Brunton, G., McDaid, D., Oliver, S., Kavanagh, J., Jamal, F., …Thomas, J. (2013). Community engagement to reduce inequalities in health: A systematic review, meta-analysis and economic analysis. *Public Health Research*, 1(4), 1-526. https://doi.org/10.3310/phr01040

Olshansky, E., & Zender, R. (2016). The use of community-based participatory research to understand and work with vulnerable populations. In *Caring for the Vulnerable* (pp. 243-252). Burlington, MA: Jones and Bartlett Learning. Available at: https://www.researchgate.net/publication/275649804_The_use_of_community-based_participatory_research_to_understand_and_work_with_vulnerable_populations

Osman, F., Salari, R., Klingberg-Allvin, M., Schön, U.-K., & Flacking, R. (2017). Effects of a culturally tailored parenting support programme in Somali-born parents' mental health and sense of competence in parenting: a randomised controlled trial. *BMJ Open, 7*(12), e017600. doi:10.1136/bmjopen-2017-017600

Osman, F., Vixner, L., Flacking, R., Klingberg-Allvin, M., Schön, U.-K., & Salari, R. (2021). Impact of a culturally tailored parenting programme on the mental health of Somali

parents and children living in Sweden: a longitudinal cohort study. *BMJ Open, 11*(8), e045067. doi:10.1136/bmjopen-2020-045067

Pachankis, J. E., Williams, S. L., Behari, K., Job, S., McConocha, E. M., & Chaudoir, S. R. (2020). Brief online interventions for LGBTQ young adult mental and behavioral health: A randomized controlled trial in a high-stigma, low-resource context. *Journal of Consulting and Clinical Psychology, 88*(5), 429-444. doi:10.1037/ccp0000497

Paloma, V., Morena, I., & López-Torres, C. (2020). Promoting posttraumatic growth among the refugee population in Spain: A community-based pilot intervention. *Health & Social Care in the Community*, *28*(1), 127–136. https://doi-org.nuigalway.idm.oclc.org/10.1111/hsc.12847

Page, R. L., Montalvo-Liendo, N., Nava, A., & Chilton, J. (2021). 'Now My Eyes are Open': Latina women's experiences in long-term support groups for intimate partner violence survivors. *International Journal of Mental Health Nursing, 30*(3), 715-723. https://doi.org/10.1111/inm.12840

Paudel, K., Gautam, K., Bhandari, P., Shah, S., Wickersham, J. A., Acharya, B., . . . Shrestha, A. (2024). Digital health interventions for suicide prevention among LGBTQ: A narrative review. *Health Prospect, 23*(1), 1-10. https://doi.org/10.3126%2Fhprospect.v23i1.62795

Pescheny, J. V., Randhawa, G., & Pappas, Y. (2020). The impact of social prescribing services on service users: A systematic review of the evidence. *European Journal of Public Health, 30*(4), 664-673. https://doi.org/10.1093/eurpub/ckz078

Pollard, T., Gibson, K., Griffith, B., Jeffries, J., & Moffatt, S. (2023). Implementation and impact of a social prescribing intervention: an ethnographic exploration. *British Journal of General Practice, 73*(735), e789-e797. https://doi.org/10.3399/BJGP.2022.0638

Pool, M. S., Agyemang, C. O., & Smalbrugge, M. (2017). Interventions to improve social determinants of health among elderly ethnic minority groups: a review. *Eur J Public Health, 27*(6), 1048-1054. https://doi.org/10.1093/eurpub/ckx178

Public Health England (PHE) (2015a). *A Guide to Community-centred Approaches for Health and Wellbeing*. London: Public Health England. Available at: https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches

Public Health England (PHE) (2015b). *Community-centred Public Health: Taking a Whole System Approach.* London: Public Health England. Available at: https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach

Purgato, M., Carswell, K., Tedeschi, F., Acarturk, C., Anttila, M., Au, T., . . . Barbui, C. (2021). Effectiveness of self-help plus in preventing mental disorders in refugees and asylum seekers in Western Europe: A multinational randomized controlled trial. *Psychotherapy and Psychosomatics, 90*(6), 403-414. doi:10.1159/000517504

Ragavan, M., Thomas, K., Medzhitova, Y., Brewer, N., Goodman, L., & Bair-Merritt, M. (2018). A Systematic Review of Community-Based Research Interventions for Domestic Violence Survivors. *Psychology of Violence, 9*, 1-17. https://psycnet.apa.org/doi/10.1037/vio0000183

Razani, N., Morshed, S., Kohn, M. A., Wells, N. M., Thompson, D., Alqassari, M., Agodi, A. & Rutherford, G. W. (2018). Effect of park prescriptions with and without group visits to parks on stress reduction in low-income parents: SHINE randomized trial. *PloS one*, *13*(2), e0192921. https://doi.org/10.1371/journal.pone.0192921

Reinhardt, G., Vidovic, D., Hammerton, C., & Reinhardt, G. Y. (2021). Understanding loneliness: a systematic review of the impact of social prescribing initiatives on

loneliness. *Perspectives in Public Health, 141*(4), 204-213. https://doi.org/10.1177/1757913920967040

Rickwood, D.J. and Thomas, K.A. (2019). *Mental wellbeing interventions: An evidence check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for VicHealth,* Melbourne, Australia. Available at: https://www.saxinstitute.org.au/evidence-check/mental-wellbeing-interventions/

Rivas, C., Ramsay, J., Sadowski, L., Davidson, L. L., Dunne, D., Eldridge, S., . . . Feder, G. (2015). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database of Systematic Reviews* (12). https://doi.org/10.4073/csr.2016.2

Riza, E., Kalkman, S., Coritsidis, A., Koubardas, S., Vassiliu, S., Lazarou, D., . . . Linos, A. (2020). Community-Based Healthcare for Migrants and Refugees: A scoping literature review of best practices. *Healthcare (Basel, Switzerland), 8*(2): 115. https://doi.org/10.3390/healthcare8020115

Robert, G. (2022). *Co-Producing and Co-Designing*. Cambridge University Press.

Romero-Mas, M., Cox, A. M., Ramon-Aribau, A., & Gómez-Zúñiga, B. (2024). Knowledge sharing in virtual communities of practice of family caregivers of people with Alzheimer's. *BMC Geriatrics, 24*(1), 577. doi:10.1186/s12877-024-05045-7

Ruggiano, N., Brown, E. L., Li, J., & Scaccianoce, M. (2018). Rural dementia caregivers and technology: What is the evidence? *Research in Gerontological Nursing*, *11*(4), 216-224. https://doi.org/10.3928/19404921-20180628-04

Sanchez, J., Maiden, J., Barton, E., Walters, L., Quinn, D., Jones, N., . . . Lim, D. (2023). Factors that sustain indigenous youth mentoring programs: A qualitative systematic review. *BMC Public Health, 23*(1), 429. https://doi.org/10.1186/s12889-023-15253-2

Schueller, S. M., Hunter, J. F., Figueroa, C., & Aguilera, A. (2019). Use of Digital Mental Health for Marginalized and Underserved Populations. *Current Treatment Options in Psychiatry, 6*(3), 243-255. https://doi.org/10.1007/s40501-019-00181-z

Serrata, J. V., Hernandez-Martinez, M., & Macias, R. L. (2016). Self-Empowerment of Immigrant Latina Survivors of Domestic Violence: A Promotora Model of Community Leadership. *Hispanic Health Care International, 14*(1), 37-46. https://doi.org/10.1177/1540415316629681

Shalaby, R. A. H., & Agyapong, V. I. O. (2020). Peer support in mental health: Literature review. *JMIR Ment Health, 7*(6), e15572. https://doi.org/10.2196/15572

Sherifali, D., Ali, M. U., Ploeg, J., Markle-Reid, M., Valaitis, R., Bartholomew, A., Fitzpatrick-Lewis, D. & McAiney, C. (2018). Impact of internet-based interventions on caregiver mental health: Systematic review and meta-analysis. *Journal of Medical Internet Research*, *20*(7), e10668. https://doi.org/10.2196/10668

Small, E., Kim, Y.K., Praetorius, R.T., Mitschke, D.B. (2016). Mental health treatment for resettled refugees: A comparison of three approaches. Social Work in Mental Health 2016, 14, 342–359. https://doi-org.nuigalway.idm.oclc.org/10.1080/15332985.2015.1080205

Smith, G. C., Egbert, N., Dellman-Jenkins, M., Nanna, K., & Palmieri, P. A. (2012). Reducing depression in stroke survivors and their informal caregivers: A randomized clinical trial of a web-based intervention. *Rehabilitation Psychology*, *57*(3), 196-206. https://psycnet.apa.org/doi/10.1037/a0029587

Soltan, F., Cristofalo, D., Marshall, D., Purgato, M., Taddese, H., Vanderbloemen, L., . . . Uphoff, E. (2022). Community-based interventions for improving mental health in refugee children and adolescents in high-income countries. *Cochrane Database Systematic Reviews, 5*, CD013657. doi: 10.1002/14651858.CD013657.pub2

South, J., Bagnall, A., & Jones, R. (2021). Community champions: A rapid scoping review of community champion approaches for the pandemic response and recovery. *Public Health England*. Available at: https://www.gov.uk/government/publications/community-champion-approaches-rapid-scoping-review-of-evidence#:~:text=Overall%2C%20findings%20show%20that%3A,meet%20local%20needs%20and%20assets

Thomas, R. L., Chiarelli-Helminiak, C. M., Ferraj, B., & Barrette, K. (2016). Building relationships and facilitating immigrant community integration: An evaluation of a Cultural Navigator Program. *Evaluation and Program Planning, 55*, 77-84. doi:10.1016/j.evalprogplan.2015.11.003

Todd, C., Camic, P. M., Lockyer, B., Thomson, L. J., & Chatterjee, H. J. (2017). Museum-based programs for socially isolated older adults: Understanding what works. *Health Place, 48,* 47–55. https://doi.org/10.1016/j.healthplace.2017.08.005

Tol, W. A., Leku, M. R., Lakin, D. P., Carswell, K., Augustinavicius, J., Adaku, A., . . . Garcia-Moreno, C. (2020). Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: a cluster randomised trial. *The Lancet Global Health, 8*(2), e254-e263

Torkamani, M., McDonald, L., Aguayo, I. S., Kanios, C., Katsanou, M. N., Madeley, L., ... & ALADDIN Collaborative Group. (2014). A randomized controlled pilot study to evaluate a technology platform for the assisted living of people with dementia and their carers. *Journal of Alzheimer's Disease*, *41*(2), 515-523. https://doi.org/10.3233/JAD-132156

Tracey, D., Gray, T., Manohar, N., Kingsley, J., Bailey, A., & Pettitt, P. (2023). Identifying key benefits and characteristics of community gardening for vulnerable populations: A

systematic review. *Health & Social Care in the Community*, *2023*(1), 5570089. https://doi.org/10.1155/2023/5570089

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., . . . Straus, S. E. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine* (169), 467-473. https://doi.org/10.7326/M18-0850

Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum-seeking children: A systematic review. *PLoS ONE, 9*(5): e97977. https://doi.org/10.1371/journal.pone.0089359

Uphoff, E., Robertson, L., Cabieses, B., Villalón, F., Purgato, M., Churchill, R., & Barbui, C. (2020). An overview of systematic reviews on mental health promotion, prevention, and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons. *Cochrane Database of Systematic Reviews* (9). doi:10.1002/14651858.CD013458.pub2

van de Venter, E., & Buller, A. (2014). Arts on referral interventions: a mixed-methods study investigating factors associated with differential changes in mental well-being. *Journal of Public Health, 37*(1), 143-150. https://doi.org/10.1093/pubmed/fdu028

Villalonga-Olives, E., Wind, T. R., Armand, A. O., Yirefu, M., Smith, R., & Aldrich, D. P. (2022). Social-capital-based mental health interventions for refugees: A systematic review. *Social Science & Medicine, 301*, 114787. https://doi.org/10.1016/j.socscimed.2022.114787

Whitebird, R. R., Kreitzer, M., Crain, A. L., Lewis, B. A., Hanson, L. R., & Enstad, C. J. (2013). Mindfulness-based stress reduction for family caregivers: a randomized controlled trial. *The Gerontologist*, *53*(4), 676-686. https://doi.org/10.1093/geront/gns126

Wilson, N. J., Cordier, R., Parsons, R., Vaz, S., & Buchanan, A. (2016). Men with disabilities – A cross sectional survey of health promotion, social inclusion and participation at community Men's Sheds. *Disability and Health Journal, 9*(1), 118-126. https://doi.org/10.1016/j.dhjo.2015.08.013

World Health Organisation (WHO) (1986). *Ottawa Charter for Health Promotion*. Geneva, Switzerland: World Health Organization. Accessible at: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

World Health Organisation (WHO) (2020). *Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the People*. Geneva, Switzerland: World Health Organization. Accessible at: https://www.who.int/publications/i/item/9789240010529

World Health Organization (WHO) (2022). *World Mental Health Report: Transforming Mental Health for All.* Geneva: World Health Organization. Accessible at: https://www.who.int/teams/mental-health-and-substance-use/world-mental-health-r

Xu X, Li J, Pham TP, Salmon CT, Theng Y. (2016). Improving Psychosocial Well-Being of Older Adults Through Exergaming: The Moderation Effects of Intergenerational Communication and Age Cohorts. *Games Health Journal, 5*(6), 389-397. https://doi.org/10.1089/g4h.2016.0060

Yu, D. S. F., Li, P. W. C., Lin, R. S. Y., Kee, F., Chiu, A., & Wu, W. (2023). Effects of non-pharmacological interventions on loneliness among community-dwelling older adults: A systematic review, network meta-analysis, and meta-regression. *International Journal of Nursing Studies*, *144*, 104524. https://doi.org/10.1016/j.ijnurstu.2023.104524

Zhang, C. X., Wurie, F., Browne, A., Haworth, S., Burns, R., Aldridge, R., . . . Campos-Matos, I. (2021). Social prescribing for migrants in the United Kingdom: A systematic

review and call for evidence. *Journal of Migration and Health, 4*, 100067. https://doi.org/10.1016/j.jmh.2021.100067

CHAPTER 3 – STAKEHOLDER CONSULTATIONS ON COMMUNITY-BASED MENTAL HEALTH PROMOTION INTERVENTIONS FOR PRIORITY GROUPS IN IRELAND

Introduction

This phase of the project aimed to gain an understanding of existing community-based mental health promotion practice for priority populations in Ireland. To this end, national organisations that have implemented evidence-based mental health promotion initiatives for the selected priority groups were consulted to ascertain what interventions work best for which priority groups and under which conditions. The consultations aimed to outline best-practice case examples of community-based mental health initiatives for priority groups in Ireland along with an understanding of challenges and opportunities for effective implementation.

This chapter will outline existing criteria for community-centred mental health promotion best practice and will then present the methods and findings of the stakeholder consultation process. The chapter will conclude with a discussion and conclusions of the consultation findings which, along with the findings from Chapter 2, will inform the set of key recommendations presented in Chapter 4.

Best Practice for Community-centred Approaches

Aligning with a community-centred approach to health promotion practice (as outlined in the Introduction to this report), and based on a review of evidence and practice, PHE (2015) developed a framework of four evidence-based, community-centred approaches for promoting health and wellbeing, underpinned by equity, social connectedness and voice and control. This framework was used as an overarching frame to present the findings from the scoping review of the of the international evidence on community-based mental health promotion interventions for priority groups as presented in Chapter 2. These four strands of the PHE 'family of community-centred approaches' include:

- Facilitating access to community resources (pathways to participation, community hubs, and community-based commissioning)
- Volunteer and peer roles (bridging, peer interventions, volunteer health roles)

- Collaborations/partnerships (community-based participatory research (CBPR), co-production projects)
- Strengthening communities (community development, asset-based approaches, social networking).

In a call to action on their website, the PHE outlined a set of overarching recommendations in implementing a community-centred approach:

- Develop a whole-system approach across sectors
- Map and mobilise local assets
- Ensure genuine co-design and co-delivery – with, not to, communities
- Commission across the four strands of the family of approaches
- Measure community outcomes
- Integrate community-centred, asset-based approaches as part of place-based commissioning and strategic planning.

Figure 3.1, on the following page, presents a summary of the guidance document offered on PHE's website at https://www.gov.uk/government/publications/health-matters-health-and-wellbeing-community-centred-approaches/health-matters-community-centred-approaches-for-health-and-wellbeing.

Stakeholder Consultations

Overview & Methods

This phase of the study involved a series of consultations with stakeholders in statutory roles and in the community and voluntary sector. Stakeholders included coordinators of community-based mental health promotion supports in various locations in Ireland with a focus on the priority groups identified above. Through the stakeholder consultations, researchers aimed to identify community-based mental health promotion initiatives for the pre-defined priority groups in Ireland and, specifically, which interventions work best and under which conditions, with insights into the feasibility of, and support needed for, scaling-up selected interventions in the Irish context.

Figure 3.1. Adaptation of PHE Recommendations in implementing a community-centred approach offered on PHE's website at https://www.gov.uk/government/publications/health-matters-health-and-wellbeing-community-centred-approaches/health-matters-community-centred-approaches-for-health-and-wellbeing.

Study Design. Through one-hour online consultations, researchers aimed to gain insight into the real-world experience of implementing community-centred mental health promotion interventions for priority groups identified in the first phase of this study. The discussions were guided by a semi-structured framework of questions (Appendix 3.1) to gain insights on (i) the work done in the community to support and enhance the mental health and wellbeing of priority groups, (ii) what is working well, and (iii) challenges and opportunities.

Sample. All participants were recruited by senior HSE decision-makers with a focus on mental health and wellbeing. Participants were employed by the HSE and various community organisations across the country receiving funding from the HSE and/or the Department of Health, in addition to grants, fundraising efforts and/or corporate sponsors.

Ethical Considerations. Participants were provided with a Participant Information Sheet (Appendix 3.2) and submitted a signed consent form (Appendix 3.3) prior to voluntary participation in the consultation.

Data Synthesis. Each of the consultations were recorded and transcribed. The findings are offered as a descriptive narrative of insights pertaining to each priority group.

Results are presented in the next section of the report. A discussion follows where the findings are interpreted using PHE's family of approaches as a framework. The report concludes with final recommendations based on the findings from the consultations and in alignment with the findings of the scoping review from the second phase of the study.

Results

Nine one-hour online consultations were hosted by one researcher and conducted from July until September. Participants (n=13) included stakeholders involved in supporting the mental health and wellbeing of priority groups in Ireland. Participants were staff within the HSE (n=2) and the community and voluntary sector ("CVS"; n=11) (see Table 1). The aim of the consultations was to identify best-practice examples of community-based mental health promotion initiatives for priority groups in Ireland.

Table 1: Stakeholder Consultation Participant Profiles		
Priority Group	CVS-based	HSE-based
Ethnic minority populations, migrants and refugees	6	0
People with disabilities and their families	1	0
People who experience loneliness and isolation	1	0
People living in deprived and disadvantaged communities	1	1
Family Carers	1	0
Populations who experience domestic violence	0	1
LGBTQI+ Populations	1	0

This section will offer the findings from the consultations. Findings are grouped according to each priority group and will present first the needs of each group and their level of engagement, as identified by participants, followed by details of the existing community-based mental health promotion supports currently offered, and any enablers and challenges encountered by implementors. Case Studies are presented throughout this section that provide a practice example of effective community-based mental health promotion interventions currently delivered in Ireland.

It is important, from the outset, to understand the high degree of **intersectionality** when addressing the needs of priority groups. This was expressed by all participants. While in research it is helpful to group vulnerable communities so as to ensure primary cultural considerations, this is not the way these communities are experienced phenomenologically. Ethnic minority communities, for example, will also present as carers, living with disabilities, experiencing loneliness, living in deprived communities, experiencing domestic violence, have personal gender orientations, and are experiencing their own stage within the life cycle. This adds levels of complexity that are difficult to navigate in systematic research, which by its nature tends to proceed compartmentally, but is a quality that should be kept to the forefront while interpreting the findings of this report.

Ethnic Minority Populations, Migrants & Refugees

Understanding their Needs & Level of Engagement

These consultations included participant(s) who:

- are representative(s) from Pavee Point Traveller and Roma Centre, a national non-governmental organisation comprised of Travellers, Roma and members of the majority population committed to improving the quality of life, living circumstances, status and participation of Travellers and Roma by working in partnership at national, regional, local and international levels.
- are representative(s) from Cairde, a community health development organisation dedicated to reducing health inequalities among minority ethnic communities in Ireland.
- work as a subgroup of a community-led local development company (LDC) committed to the support and empowerment of Roma communities and individuals.

Participant(s) from Pavee Point report that the needs of their communities centre around the social determinants of physical and mental health such as accommodation and living conditions; education; employment and equality in employment opportunities; racism and discrimination (and the fear of such); access to services and lack of services and referrals; and fear or mistrust within services. Participant(s) noted that the prevalence of suicide is worrying and the factors contributing to this, and broader mental wellbeing concerns, are complex and interdependent.

Participant(s) from Cairde concurred. They added that the needs of minority ethnic communities, migrants and refugees are also interlinked to immigration status, the length of staying in Ireland, mental health stigma, racism and discrimination among others. For example, many Roma experience housing and employment inequality as well as language and cultural barriers, among others. Additionally, accessing Irish social welfare is extremely difficult due to the Habitual Residence Condition (HRC), whereas the needs of people seeking protection include accommodation conditions, experiences of trauma, and living in uncertainty.

Additionally, minority ethnic communities, migrants, and refugees generally have poorer social support and limited family presence. Cairde participant(s) noted research indicating that refugees who developed strong formal supports (with organizations, administrative supports) and informal supports (friends, family, and a welcoming community) experienced better mental health and wellbeing, and integration. Moreover, participant(s) stated that minority ethnic communities, migrants, and refugees can experience cultural disorientation, which can lead to difficulties with self-esteem, a sense of belonging, and personal or career progression. Cairde identified the need to build migrants' knowledge, skills, and support systems, enabling them not only to manage stress and cope with adversity but also to enhance their positive mental health, fulfil their potential in a new country, and contribute to society.

Participant(s) from the LDC stated that ethnic minority populations have a family-oriented culture and will often experience stress, such as grief, across their community and these challenging experiences can sometimes manifest as a divide within the community, leading to fragmentation of connectedness. One participant from this smaller LDC has expressed witnessing significant gender disparities in their community, where the opinions of women are not always valued. While stress is highly experienced due to social adversity, conversations about stress and mental wellbeing are not well received. Thus, in this smaller LDC, the ethnic minority community is extremely difficult to engage. It is **difficult to open conversations** about supporting mental wellbeing, participant(s) stated, due to the sensitivities of the community who may believe these conversations are rooted in stigma; that they are targeted as a group, with the prejudice that they need help with their mental health. This points to a need to offer contextualised supports particularly to smaller organisations who are responding to the unique needs of their community.

For larger organisations such as Cairde and Pavee Point, who have dedicated time, energy and resources to advocacy, mediation and community development, **engagement** with ethnic minority communities, migrants and refugees is high, and their groups are not as difficult to reach. Participant(s) from Pavee Point stated that the key to engagement, then, is not reaching these communities per se, but tailoring the messages appropriately and creating the proper conditions (a safe space; common, relatable language and images) that meet service-users where they are to open these conversations. To support efforts to address this issue, participant(s) from Pavee Point suggested that: 1. services and health service providers should be more engaged with Traveller organisations to be more intercultural and accessible

in order to assuage the feelings of fear and mistrust, and 2. more emphasis should be placed on keeping people healthy, on promotion and early intervention, so that the need for services is lightened.

Participant(s) from Cairde stated that when service users encounter difficulties, they access support through well-established drop-in centers or Infolines. For example, members of the Roma community facing financial hardship find it challenging to devote time to educational initiatives that are not remunerated. Other barriers to participation include a lack of childcare options and transportation. For non-English-speaking communities, language can be a significant barrier; therefore, Cairde emphasises peer-delivered interventions, the use of interpreters, translated resources and other creative solutions to overcome this challenge.

Existing Community-based Mental Health Promotion Supports

1. Interventions which increase access & connection to community resources

Cairde works to improve minority ethnic communities' access to health services by utilising a community development and human rights approach. This is achieved through Health Information and Advocacy Centres and special-purpose projects like the **National Roma Infoline** (annual report available here), the **Ukrainian Project**, and the **Be Aware. Be Well Migrant Mental Health Initiative**. Some of Cairde's service users require mental health support to connect with services or while on waitlists for clinical services, while others simply seek someone to talk to.

Cairde has also developed **HealthConnect**, a multilingual website that provides information on health services in Ireland, including mental health. It allows users to immediately connect with relevant services in their area of residence. Several HSE departments work with Cairde to co-produce specific content. The website is promoted through migrant community channels and relevant health service providers. Additionally, in 2015, Cairde coproduced the **Mental Health Guide & Directory for Ethnic Minorities** in eight languages, distributing 8,000 copies to both community members and service providers (this guide is part of the 'Pathways to Wellbeing' initiative described in the next section and in Case Study 2).

The smaller LDC initiatives focus on disseminating health information and providing personal support in navigating the Irish welfare system. Participant(s) stated that there is very little outreach other than social media announcements as members of the community reach out to the organisation in times of need.

With a focus on advocacy and community development, Pavee Point is not a service provider, thus signposting plays a big part in connecting their communities to local resources. Participant(s) from Pavee Point noted that their communities receive most of their health information from Traveller **Primary Healthcare Projects** and organisations who provide appropriate messaging and create appropriate conditions for effective communication and to encourage engagement. Participant(s) mentioned their work in knowledge translation where resources are redesigned to be accessible in terms of literacy as well as culturally representative in terms of the message and the language and images used in communicating the message. Other initiatives that work at predominantly awareness raising and policy-making levels include the Gender Equality and Violence Against Women Programmes. Finally, Pavee Point's men's health work adopts a social prescribing approach to engagement in important conversations about mental wellbeing.

2. Interventions involving peers, befrienders & lay community volunteers

Participant(s) from Cairde highlighted that the **'Peer' element** is central to their work, bridging language, cultural, and information gaps while fostering community engagement. To address mental health needs, Cairde has trained and co-produced a **peer-based model for Mental Health Advocacy & Support Volunteers for Ethnic Minorities**. The model's key practices (Amplifiers, Listeners, Connectors, and Modellers) are rooted in shared lived experience, holistic wellbeing, and a community-responsive approach. Volunteers from various communities now deliver these services, supported by mentoring and a code of practice, with Cairde's ongoing efforts to secure funding, streamline the role, and ensure continuous development. (report available here).

Participant(s) from Cairde mentioned the various skills-building classes tailored to the unique needs of its groups, resulting in improved mental wellbeing for participants. These classes are **peer-(co)delivered** both online and in person, with venues selected based on their effectiveness in community building, particularly in areas with high ethnic minority, migrant, or refugee populations. For instance, the Cairde/Acet run **Ukrainian Project** provides

activities such as a Women's Club, which offers peer-to-peer support. Workshops and webinars, touch topics like "How to Overcome the Pain of War" led by a Ukrainian psychologist. While the **Roma Education Programme** focuses on developing skills needed for integration into Irish society, including language and literacy classes, along with practical supports. Evaluations indicate that this program helps break the isolation experienced by homeless single parents, positively impacting their mental health. Additionally, as per Cairde's mission, the organisation encourages and supports ethnic minority communities' involvement in service planning and delivery to ensure **peer representation** in upstream decision-making.

Most of the work by Pavee Point is Traveller-led in terms of identifying collective concerns and solutions, disseminating accessible and culturally appropriate information, and delivering services and supports. Thus, peer- and volunteer- or community champion-led approaches are central to the work of Pavee Point.

3. Interventions based on collaborations & partnership

Participant(s) noted that Cairde is a project partner in the **DCU-led Cultural Humility in Mental Health Services Study (CHUMS)**, implementing Community-Based Participatory Research (CBPR) to co-produce an optimised model of cultural humility in mental health care that is context-responsive, implementable, and measurable. Cairde's volunteers serve as advisory committee members and peer researchers. Also, through Cairde, Roma communities participated in **Proiecto Romano**, a participatory research project that highlights the socio-economic situation of Roma in Balbriggan (report available here). Additional CBPR initiative include the **Flemington Community Research Project**, which was a community assessment with minority ethnic communities (report available here). Participants emphasised a preference for co-production and the need for more funding and training for this type of research. Cairde is also involved in co-producing mental health promotion campaigns and initiatives such **as HELLO, How Are You? and Thrive Balbriggan.** Finally, recognising seldom representation for ethnic minorities in mental health engagement structures, Cairde partnered with HSE Mental Health Engagement, Peer Advocacy in Mental Health, and CHUMS to enhance these opportunities through capacity-building programs and focus groups. The aim is to gather recommendations for service improvement and to establish a **national mental health engagement forum for migrants and refugees**.

Pavee Point itself is comprised of Travellers and Roma, who thus play a key part in decision making. Participant(s) mentioned the **Pavee Point Primary Health Care (PHC) for Travellers Project** as a form of outreach by Traveller women who bring health information to their community and then report back the experience of health and health services which informs Pavee Point's work to facilitate collective solutions (see Case Study 1). There are currently 29 projects in operation in Ireland. **Regional Traveller Health Units** may have their own mental health initiatives that work on advocacy, policy and research, along with work in partnership with the Traveller PHC projects to identify key areas of concerns and developing collective responses. This regional and local work, participant(s) mentioned, leads to collaboration and partnership. The development of Young Pavee's **Mind Your Nuck website** is an example of this partnership approach. The initiative was a response to concerns raised by the Travelling community and involved the co-creation of a website that aims to provide a culturally appropriate understanding of mental wellbeing accessible to young Travellers and their families (the website can be accessed here). The website considers literacy levels, offering icons that provide culturally appropriate audio explanations for effective engagement. This was used as a case study in the HSE's Stronger Together plan (HSE, 2022).

The smaller LDC has had a different experience of participatory research. The community is invited to take part in research and consultations, but uptake of these invitations has been poor. This could be for any number of reasons, including a feeling that doing so will be of no benefit to the community where tangible results are not seen in the short term. The participant(s) noted that levels of participation appear to be higher where there is more input from community leaders as seen in other larger projects around the country.

4. Interventions to strengthen social networks

To facilitate community-based mental health promotion and improve access to services for ethnic minorities, migrants, and refugees, Cairde has been developing a community resource pack **Pathways to Wellbeing**. This pack aims to include a guide, workshop, training programme, and train-the-trainer programme.

Case Study 2 (following) details the Pathways to Wellbeing training programme delivered in a community setting in Cairde Balbriggan. While informed by the evidence base and **culturally adapted**, it is delivered by experts in mental health fields, such as psychology, and

CASE STUDY 1

PRIMARY HEALTH CARE FOR TRAVELLERS PROJECT

Pavee Point Traveller and Roma Centre

AIM

The Pavee Point Primary Health Care for Travellers Project (PHCTP) was the first time Travellers went out into the Traveller Community with the aim to identify the needs of Travellers and improve their health and wellbeing. The Project began as a pilot initiative in October 1994. Since then the project has been replicated and approximately 27 Traveller Primary Health Care Projects are in operation around the country.

APPROACH

The project is peer led initiative allowing primary health care to be developed based on the Traveller community's own values and perceptions to achieve positive outcomes with long-term effects. The project ensures that Travellers are central to their own care and delivery of health and personal interventions resulting in increased engagement and user satisfaction.

BRIEF SUMMARY

The model is delivered by Community Health Workers (CHW's) and Community Development Workers (all members of the Traveller community) and a Project Coordinator, who work with Traveller families in their community in a two-pronged approach: working to raise awareness on a variety of health issues within the community and working with service providers to highlight the barriers to equal health outcomes that may exist for Travellers. Trained CHW's conduct baseline surveys to identify and articulate Traveller's needs. Results are fed back to the community and they prioritise their needs and suggest changes to the health services which would facilitate their access and utilisation. The results are also fed back to the health service providers. Examples of actions taken as a result of this process have included:

- Culturally appropriate health education materials (incl. videos)
- Well-woman clinics specifically targeted to Traveller women
- Pilot initiatives for Traveller men
- A co-designed model of education on mental health
- Enhanced research and advocacy efforts.

McCabe & Keyes, 2005

EVALUATION

Key Outcomes:

- Consultation between service providers & the Travelling community, greater information collection & sharing & improved access to services
- Establishing PHC service delivery by Travellers to Travellers
- Successful model of employment for Travellers in health care provision
- Community participation has enhanced confidence & empowerment in Travellers, particularly in terms of participating in the health system & policy development
- Numerous awards: WHO, European Union & the National Adult Literacy Association.

McCabe & Keyes, 2005

KEY ASPECTS OF SUCCESS

- Peer-led and based on collaboration and partnership, while working to integrate Travellers' experience within mainstream health service
- Peers are trained: skills development, capacity building and empowerment
- Sufficient planning, funding & resources.

ADVICE FOR FUTURE INITIATIVES

- Meaningful participation as part of a genuine community development approach underpinned by principles of community work is crucial.
- Power sharing is key.
- Significant lead-in & planning time is important for success.
- The ability to lobby nationally was considered a crucial factor in the mainstreaming process.
- Terms and conditions of employment of Local CHW's, career path options & personal & professional development must be delineated.

CASE STUDY 2

PATHWAYS TO WELLBEING: EMPOWERING MIGRANT WOMEN'S MENTAL HEALTH

Michael, L., Marchelewska, E., Omidi, N. & Stewart, I. in collaboration with project participants & facilitators. (2024). Wellbeing and Integration program for women. Evaluation Report. **Cairde**.

AIM

Enhance the mental health & wellbeing of migrant women living in the Balbriggan area in Ireland.

APPROACH

This innovative intervention stands out for its holistic approach to mental health and wellbeing, utilizing culturally adapted, evidence-informed interventions rooted in Positive Psychology, Lifestyle Medicine, stress and trauma healing practices, and health habit formation models. This strategic blend specifically addresses the unique challenges of ethnic minority and migrant communities, offering information and creating a supportive environment for sustainable behavioural change, with benefits that extend beyond the individual level.

BRIEF SUMMARY

The program targeted 15 migrant women from diverse ethnic backgrounds, seeking to enhance their mental health & wellbeing. Its structure included a triad of psychoeducation by health & mental health professionals, individual support from Cairde, & a research component by an external evaluator.

- Consolidating knowledge
- Encouraging the regular practice
- Forming alliances and seeking support from peers
- Raising self-awareness.

EVALUATION

Data gathering tools:

- Pre-post intervention focus groups
- Weekly reflection surveys
- Mental Health Continuum Short Form (MHC-SF).

Improvements:

- Positive Increases on the MHC-SF Measure (happiness, sense of direction, societal trust, relationship warmth, personal growth). A mitigating factor seemed to be consistency in engagement and reflection.
- Continued engagement throughout the program.
- Adoption of a range of wellbeing practices.
- Capacity of participants to narrate the relationship between program content and changed behaviours or outcomes.
- A more recent evaluation is available currently as an unpublished draft by Michael & Ogutu (2024)

KEY ASPECTS TO SUCCESS

- Culturally relevant mental health initiative
- Held at a venue that is valued by participants (well-established hub for migrant support & signposting)
- Targeted recruitment
- Specific efforts to maintain good attendance
- Funding by the HSE.

ADVICE FOR FUTURE INITIATIVES

- Maintain key strengths of the content (holistic approach, encourage reflection & practice, challenge mental health stigma)
- Prioritise cultural adaptations (safe environments, diversity among tutors, community engagement)
- Greater focus on migrant-specific issues
- Continuous group support
- Adapt to diverse contexts
- Comprehensive training for facilitators to ensure culturally sensitive & supportive delivery.

aims to enhance the mental health and wellbeing of migrant women. Subsequently, Cairde piloted a version of the programme adapted to the needs of women in a direct provision centre, some of whom have limited English proficiency. Although the evaluation report is still in publication, the need for such interventions and the success of the approach have been demonstrated by oversubscription, with 24 participants enrolled and 80 others from the same centre on the waitlist. The evaluation reports include guidance for the programme's broader rollout and recommendations for further adaptations based on community needs.

Participant(s) suggested that a key aspect of strengthening these communities is a holistic, strengths-based approach that **builds on what is already working** within the community. In this approach, advocacy and addressing the social determinants of health are crucial, alongside counselling and peer-led supports (the latter is discussed in the following section). This is why the *Pathways to Wellbeing*, *Mental Health Advocacy & Support*, and *Mental Health Engagement* triad are key components of Cairde's **Be Aware, Be Well: Migrant Mental Health Initiative**. The completion and full rollout of this initiative, however, will depend on the availability of necessary resources.

The current supports offered by the smaller LDC include social media posts about vaccine awareness and healthy lifestyles, classes of practical value including English classes, and events to bring the community together such as trips to the Dublin Zoo or a community celebration on a special day such as International Roma Day. The events are usually attended mostly by women and children.

Participant(s) from Pavee Point reported the central core of their ethos is a community development approach; "nothing for the community without the community" is a guiding principle. Participant(s) reported a multitude of initiatives to bring their community together and promote mental health. These include structured and planned culturally celebrative gatherings within their Heritage and Art & Culture Programmes, such as flower and craft making. Other supports mentioned by participant(s) include women's fitness groups that connect peers in a familiar social environment. These initiatives, participant(s) mentioned, are not labelled as mental health promotion formally, however they certainly impact on the mental and social wellbeing of community members.

Additionally, there are initiatives such as Pavee Mothers under their Maternal Health Programme, as well as programmes for Roma, Traveller Men's Health, Mental Health, Drug and Alcohol and Education that work not only to strengthen social networks and raise awareness, but also to: 1. ensure accessible and culturally respectful services, communication, information and resources; 2. ensure an intersectoral approach to creating equal opportunities; and 3. ensure inclusive policy making. A similar approach is taken in Cairde Balbriggan centre working with local migrant groups and organising sewing, cooking, yoga, self-advocacy and other classes.

While the Men's Sheds were not consulted as part of this project, researchers felt it important to include a case study of an adaptation of the Men's Shed approach to ethnic minority communities, refugees or migrants (see Case Study 3 on the following page).

Enablers

A significant enabler of success reported by participant(s) from Pavee Point, is their familiarity with their groups and family-ties and their intimate knowledge of dynamic contexts; they don't 'access' their communities, they *are* their communities. This is a crucial piece to successfully implementing community-based mental health promotion and helps buffer cynicism; proving that efforts are not tokenistic, but from the heart of the community. These sentiments were echoed by participants from Cairde. Participant(s) from Pavee Point attribute this sense of connectedness and trust in large part to their commitment to the values and principles of community work, as set out by the *All Ireland Standards for Community Work* (Community Work Ireland, 2016). These principles serve a community development approach underpinned by meaningful "participation, empowerment and collective decision making in a structured and co-ordinated way" (p. 5). Participant(s) highlight that meaningful participation goes beyond bringing individuals to the table. Rather, meaningful participation takes the form of an empowered collective mandate, where the individual represents the collective solutions of individuals, families and communities that will in turn have collective outcomes. This is a crucial piece of the co-production approach used by Pavee Point. Rather than bringing Travellers into a co-production project (as if from the outside), Travellers are at the heart of directing activities at all times.

Participant(s) from Cairde felt that the key to success involves three pillars: trust, community involvement and stability of funding. More primary to implementation of a programme, one

CASE STUDY 3

NEW COMMUNITY MEN'S SHED

Irish Men's Shed Association

AIM

To bring people of different communities and nationalities together to form a new community and integrate into Irish society.

APPROACH

Strengthening socially isolated communities through assets-based, capacity building approach.

BRIEF SUMMARY

This is a Men's Shed for Refugees (members drawn from the Direct Provision Centres, Viking House, Birchwood House, Portree House & Ocean View in Waterford & Tramore) Operating from our workshop in Coffee House Lane which is adjacent to the Viking House Refugee Hostel.

To prevent the intergenerational cycle of poverty & social isolation, this Men's Shed engages refugees to build friendships through sharing skills woodwork, gardening & furniture repair in an informal, English language environment. After 30 hours participation in these activities an understanding of members' abilities & challenges is gained & members are provided with appropriate work-based training such as forklift operation, barista training, hairdressing, painting & decorating, driving lessons & horticulture.

The programme provides an avenue for regular engagement. A Friendship Cafe is hosted once per week with up to 30 guests. Three different levels of English conversation classes are offered through the Fàilte Isteach programme. A CV writing service is provided along with funding for driving lessons with the support of Vincent De Paul. Several members have found full time employment with the support of the shed.

EVALUATION

- Strongest evidence is for people experiencing social isolation and loneliness.
- Evidence for increases in subjective & mental wellbeing, sense of belonging, social wellbeing, & social functioning, & decreases in depression scores.

Foettinger et al., 2022
McGrath et al., 2021, 2022, 2022a

KEY ASPECTS TO SUCCESS

- Programme delivery in familiar venue that is accessible.
- Combines strengthening community & asset-based approaches with personal skills building & empowerment.
- Strong foundational evidence base from which to build culturally representative adapted programmes in collaboration with priority groups.
- Existing infrastructure within the Irish context.
- Clarity of evidence provides justification for funding commitments.

ADVICE FOR FUTURE INITIATIVES

- Recent studies adopt a co-production, CBPR-based approach for 'hard to reach men' in Ireland, which could inform future efforts to increase programme diversity for appropriate implementation with priority groups.

participant stated, is an additional crucial "invisible layer." This crucial layer involves **building relationships and trust** and keeping members engaged. This was corroborated with the participant(s) from the smaller LDC who felt a sense of frustration at their lack of capacity to focus energy on building trust and relationships and the challenges to community engagement without these targeted pre-intervention efforts.

Challenges

Participant(s) from Pavee Point acknowledge that funding commitments by the HSE have enabled much of the success of these projects. Participant(s) from Cairde mentioned, similarly, that they receive grant aid funding from the HSE and the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) and additional project-specific funding which is key to success. Participant(s) stated that these grants do not cover mental health promotion per se, so organisations prioritise the focus of the funding according to their discretion. For example, participant(s) from Pavee Point noted that there is no dedicated funding stream for Traveller mental health infrastructure. With no sustainable funding dedicated to mental health and wellbeing, participant(s) across these organisations find it challenging to keep this work consistent and strong. Participant(s) from Cairde also highlighted the need for dedicated sustainable funding for dedicated groups like migrants, refugees and Travellers, and added that when availing of project-specific funding, intervention characteristics, such as the project focus, timeline, venue and evaluation, are dictated along with other stipulations attached to the grant. This type of approach is **not sustainable** and does not allow for **post-programme supports**.

According to participant(s) from Cairde, **upskilling and career development** for staff in community organisations is another challenge, as this is not included in most funding streams. Participant(s) from the smaller local community organisation in particular felt frustrated at the desire, but lack of sufficient capacity and skills, to do more in their community. They felt they were given funding and posts but a **lack of guidance** and direction and felt isolated without a method of consistent counsel from those with experience in evidence-based mental health promotion. The LDC's various strands of funding help to support community link working or signposting services along with the administrative costs of hosting events and holding weekly classes but there is no extra budget for upskilling staff, co-production with the community or other much needed pro-active activities to generate engagement.

Pavee Point participant(s) expressed concerns about sufficient resourcing by the State and investment in Traveller mental health, especially considering the higher rates of mental wellbeing discrepancies experienced by their communities. Participant(s) reported the challenges of working within budget restraints with the backdrop of a recruitment and retention crisis due to increasing costs of living and insufficient capacity for suitable compensation. Participant(s) shared the need for **core funding that is more stable** as it is essential for successful supports. Funding for permanent posts, for example, offers a level of liberty with regards to action and creative problem co-solving. The **freedom to be creative** and focus resources in a way that responds to ever-changing needs and contexts was mentioned by participant(s) from Cairde as a key enabler of community-based implementation, and particularly when working in partnership with service-users.

Participant(s) from Cairde stated that peer-led and peer-designed projects (i.e., building the project together for empowerment and ownership) requires a significant amount of upskilling and training. Peers, of course, need to be compensated for this, thus **sufficient funding and realistic time expectations are crucial for peer-led approaches to be feasible**. This skills-building is a significant challenge. Participant(s) from Cairde felt that the complexity of co-production and co-delivery is underestimated both in terms of feasibility and economics. For this reason, most programmes are delivered by staff or 'outsider' experts with qualifications, even though it is recognised that for greatest success, the initiatives should be delivered by peers. Participant(s) mentioned instances where a Cairde service-user has turned their journey with the organisation into a career, thus peer-led initiatives have the potential to positively influence both the participants and the facilitators. Finally, participant(s) from the smaller LDC highlighted the importance of buy-in from the community as a whole, including male community leaders, as this will impact on the success of any health driven projects.

Participant(s) from Cairde mentioned that a stronger focus on **addressing mainstream attitudes** would be a helpful complement to community-based mental health promotion efforts for priority groups. This would help mitigate the sense of discomfort and exclusion they feel engaging in life in Ireland. Mainstream approaches (i.e., public health approaches for the 'average Irish citizen') are difficult for people who feel excluded or uncomfortable socially; participant(s) caution that this is a deterrent to engagement straight from the outset. Thus, including a bigger mainstream piece would be more effective than focusing solely on equipping the minority to integrate into the majority. Participant(s) from Pavee Point echo

this sentiment, stating the importance of ensuring Travellers and Roma are "mainstreamed" within any service delivery and development (working in partnership so that they are "included by design rather than excluded by accident"). Participant(s) from Cairde mentioned that partnership work with health services, and significant advocacy measures help in this regard. On the other hand, there are additional community-centred efforts that may benefit the smaller LDC who experience tremendous difficulty engaging the male leaders of their ethnic minority community. Participant(s) from the LDC stated that planned efforts to meet this challenge include enlisting the help of other successful peer leaders in similar but more well-established national organisations to **piggy-back** on their efforts to encourage male engagement and leadership.

Regards implementation and evaluation, participant(s) from Pavee Point mentioned the need for **comprehensive indicators** that more accurately capture community-based efforts and that there is a crucial need for **disaggregated data** at primary care and acute levels and at the level of promotion, prevention and early intervention. Participant(s) highlight that this is essential to the development of targeted responses, evidence-based policy making and to capture the added value for investment. Without disaggregated data, efforts are occurring "in a vacuum." Existing evaluation, particularly in programme-specific projects, focuses on a narrow set of indicators for each programme but the true impacts of efforts are much more contextual. Pavee Point participant(s) echo these concerns, stating that much has been done in Ireland in the way of policy development, however the challenges lie in implementation and policy action. Particularly challenging but a crucial element in promoting the mental wellbeing of priority groups in Ireland, participant(s) note, is stimulating a **whole-of-government response** to implementation so as to address the social determinants of health that are a significant obstruction to the success of community-based approaches. Finally, participant(s) from Pavee Point acknowledge that genuine, meaningful community development takes a significant amount of time (generational timescales), thus budget and resource commitments should reflect the nature of these **long-term** pursuits.

People with Disabilities & their Families

Understanding their Needs & Level of Engagement

Findings from the discussion with Inclusion Ireland, an advocacy organisation working for full inclusion of people with intellectual disabilities while connecting them to networks of supports**,** revealed that people with disabilities should have the right to advocacy and supports to build their capacity to become self-advocates and to be involved in the planning of their lives. They are in need of empowerment to know and access their rights and fundamental freedoms as equal citizens, such as personalised budgets and accommodation, housing, social care, employment, education and further training, and appropriate communication that enables them to recognise where help is needed with proper assistance in seeking it.

In general, participant(s) mentioned that people with intellectual disabilities lack accessible information and lack a level of autonomy in terms of their living circumstances which can exacerbate mental health issues. Participant(s) highlighted the need to address systemic issues which are barriers that can intensify, or indeed cause, the difficulties and inequalities experienced by people with intellectual disabilities, such as incorrect labelling, institutional approaches to residence and communication barriers. Rather than a service provision model, participant(s) suggest empowerment approaches where people with intellectual disabilities can be enabled to play a part in directing their own lives and their own supports. In a service provision model, life choices are dictated by the structure of the services, which are oftentimes flawed and not co-produced; thus, rather than having autonomy, the life (and quality of life) of people with intellectual disabilities can be entirely mediated, dictated and limited to conform to the structure of the services.

Participant(s) stated that **engagement challenges** arise due to access barriers including lack of accessible and understandable information. Tailored communication, participant(s) say, should not only focus on written materials but should include multiple versions including audio/visual in order to reach people with intellectual disabilities. It is not enough to simply create accessible information (e.g easy to read documents), people also need support to access the information and understand it. Without well-developed, accessible communication, people with intellectual disabilities are essentially “locked out of the

information." One participant gave the analogy that lack of tailored, accessible information equates to not having wheelchair-accessible public services. Finally, participant(s) shared that the schedules and resources of their family members can also impact on engagement. Many people live at home with elderly parents who may not have the resources to support their loved one to access community services.

Existing Community-based Mental Health Promotion Supports

1. Interventions which increase access & connection to community resources

As a civil society organisation, Inclusion Ireland has a focus on policy work and advocacy on a national basis. A proportion of their offering focuses on giving high quality information and signposting people to services and supports. They have a phone line that people with intellectual disabilities and their family members can call with support requirements and are then matched to networks and services in their locality where available. Inclusion Ireland state that there are challenges in linking people with intellectual disabilities to appropriate community mental health supports as there are significant barriers in accessibility or suitability. **Appropriately signposted services and toolkits** include access to health and social care, self advocacy, assisted decision-making and future planning, housing, employment and income, education, voting and linking to Disabled Persons Organisations and support groups.

2. Interventions involving peers, befrienders & lay community volunteers

According to participant(s), Inclusion Ireland works **alongside fellow 'self advocates'** in communities such as Sligo, the Midlands and Cork. This work aims to link people with intellectual disabilities learning how to become self advocates. They provide support and training to self advocates. Importantly, they also provide support to staff working within services who wish to develop their skills in advocacy and have developed a number of toolkits and guides to support this work. The self advocate training for people with intellectual disabilities takes a strength-based capacity building approach and includes building personal skills such as self-development, understanding their own rights, self-reflection and identifying how to say yes or no, or to make a complaint. Facilitators are typically community development workers who are trained through Inclusion Ireland. Participant(s) stated that **peer work takes on a more general form** in that disability service

providers may have advocacy forums or groups that service users can join. Inclusion Ireland state that independent advocacy is critical to disabled people; it is important that people have representative advocacy opportunities to ensure their rights are upheld as well as the opportunity to join external advocacy forums or DPOs.

3. Interventions based on collaborations & partnership

There is currently in Ireland an alliance of five **Disabled Persons' Organisations (DPOs)** who work alongside disabled people to ensure equal partnership and effective implementation of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) treaty. DPOs adopt a co-creation approach and are self-representative organisations (governed, led and directed by disabled people who make up the majority in decision-making) and are the vehicle through which disabled persons are enabled to participate in their own lives, civil society and policy development. Participant(s) stated that DPOs have seen success in other countries such as New Zealand who have local DPOs responding directly to the needs of the community. DPOs, participant(s) note, are in beginning stages in Ireland and local representation is in development.

4. Interventions to strengthen social networks

In an effort to support families to connect and get access to good quality information, Inclusion Ireland developed the **Connect Family Network** to connect people with intellectual disabilities and their families to others who share their concerns. The network, participant(s) state, links a number of local and national support groups that provide services, supports and trainings, while also enabling people with intellectual disabilities and their family members to participate in policy development. This initiative is funded through the Government of Ireland through Pobal.

Enablers & Challenges

According to participant(s) a key challenge to promoting the mental health and wellbeing of people with intellectual disabilities is the lack of accessible information and communication. Systemically, there is a need for a more sensitive **understanding of what 'accessible' communication is**; it is not merely providing existing information in easy language, it needs to be seen as a right, as per the UNCRPD. These are more **fundamental challenges** to face prior to even planning community-based mental health promotion interventions. Additionally, participant(s) stated that pre-intervention work includes upstream activities to

enable people with intellectual disabilities to direct their own services. Participant(s) suggested that key supports to address these fundamental challenges would be upskilling health professionals and service providers to provide appropriate communication and adopt a continuum of support from community-based preventative initiatives to specialised interventions. Thus, **building the capacity** of General Practitioners, Public Health Nurses and community services to adapt their services and communication is key, and community-based training and education at a local level is a promising consideration.

Finally, participant(s) mentioned the significant upstream challenges such as **lack of resources and the time to provide the proper supports**. This is particularly true with regards to improving peer-led approaches and disability service providers as these existing approaches are oftentimes ad hoc versus a more sustainable and effective formal system of appropriate support. In summary, there is limited suitable community mental health based supports available and accessible to people with intellectual disabilities. To address these challenges at a systemic level the following is recommended:

- Ensuring that services and supports are codesigned and led by disabled people - moving away from more institutionalised practices and towards community-based supports.
- A focus on independent advocacy and resourcing this properly (including representative advocacy, collective advocacy through advocacy orgs and DPOs).
- Many people with intellectual disabilities need to develop their capacity to self advocate and to self-manage their health and this takes resourcing.
- Families also need support to understand what services and supports are available to their loved one.
- Developing understanding across community services of inclusive and accessible communication as a key enabler of accessing health supports. Without accessible information no service will be suitable or appropriate. This will take an upskilling of health and social care staff and resourced properly.

People Experiencing Loneliness & Isolation

Understanding their Needs & Level of Engagement

Findings from the discussion with ALONE, a national organisation that enables older people to age at home as well as providing befriending services, advocacy and support, revealed that the needs of older people in Ireland centre around loneliness and social exclusion (geographically and psychologically); physical health-related issues, such as chronic illness, mobility, personal care and daily functioning; and financial and housing support.

Participant(s) felt that older people are not difficult to engage, however, a general lack of awareness of the full range of supports available to older people may be considered a barrier to engagement. The supports offered to older people cover a wide range across an integrated care model, and this is difficult to share with older people in a way that will prompt action. Finally, participant(s) stated that in community organisations that adopt a volunteer-based model, engagement can depend on the success of volunteer matching.

Existing Community-based Mental Health Promotion Supports

1. Interventions which increase access & connection to community resources

In terms of accessing community supports, participant(s) stated that ALONE provides older people with aid in linking to alternative housing, and legal, financial and other supports. **Social Prescribing services** are used to link older people with non-medical local events and activities, and more specialised support for emotional and mental wellbeing. There is also an existing **National Support & Referral Line** for older people.

2. Interventions involving peers, befrienders & lay community volunteers

Participant(s) mentioned ALONE's existing volunteer-supported **befriending and companionship service** which includes visitation and telephone supports. Additionally, **ALONE BConnect** offers technology that enhances care and support through smart home technology (BHome), a health-monitoring app (BWell), and an app for befriending volunteers (BFriend). This information can feed into the BConnect platform and can be shared with family, support agencies and health professionals.

3. Interventions based on collaborations & partnership

Participant(s) shared their more **upstream approach to community building**. ALONE's ongoing work to build the capacity of community networks is part of the Enhanced Community Care (ECC) Programme. There is an existing Community Impact Network which aims to build partnerships with statutory, community and voluntary services to enhance services and integrated care for older people. The programme is a national network focused on building the collective leadership and capacity of organisations to meet the needs of older people in Ireland. ALONE strives to strengthen their National Network of Community Service Hubs. Through this Service Model, ALONE provides assistance with support coordination and management, case management and integrated care pathways for and with older people. Here, older people are involved in determining their care while being supported emotionally, socially and practically by ALONE Service Coordinators and Volunteers.

All of ALONE's initiatives are **created with input from older people** in the form of focus groups and guided by information provided by older people. Needs assessments and quarterly reports include collaboration with older people in terms of identifying and fulfilling their needs and capturing feedback about satisfaction with the services provided. (access latest report here). Initiatives are facilitated through a large body of volunteers. Core staff are mostly involved in volunteer support, training and coordination, fundraising, and research to understand the impacts of their support efforts. Core staff and volunteer undergo comprehensive training and upskilling.

4. Interventions to strengthen social networks

Initiatives for older people offered by ALONE were described as focusing mostly on offering help on a personal level, rather than community based. These initiatives focus on ageing well at home with supports that include technology solutions, support volunteers who engage in fulfilling practical needs, physical health and mobility supports, safeguarding supports, and safety or security supports. In terms of advocacy, older people are represented through national campaigns to **encourage supportive environments** at the individual, local and political levels (access latest report on their services here).

Enablers & Challenges

ALONE is well-recognised as a major provider of supports for older people and, as such they have a mostly **stable funding stream** from the HSE. Other avenues for funding include

Enhanced Community Care Programme (through Sláintecare funding), Integrated Care Model funding, research funding (e.g., the HSE, Trinity College, Maynooth University and the Health Research Board) and private and campaign-based fundraising. According to participant(s), due to their national status, well-established reputation and mostly stable funding streams, sustainability is not considered a concern. A dedication to **research of a high standard** adds to sustainability of continued service provision (e.g., the Halo report, Integrated Care Model, ECC Programme etc.).

In terms of challenges, participant(s) mentioned that some of ALONE's initiatives are supported by volunteers, such as telephone or in person befriending support. This can become challenging as **the number of volunteers and their ability to commit** may cause difficulties in terms of coordinating services and ensuring that services remain stable and reliable. The success of these types of interventions is partially dependent upon appropriate volunteer matching, which makes this particularly challenging.

Participant(s) mentioned that ALONE acutely understands that Ireland is an ageing population. Thus, commitment must be prioritised so that supports are set in place presently to avoid a crisis in the future. This was viewed as a challenge, i.e. to find the appropriate level of commitment for these types of **pro-active pursuits** as current budgeting strategies tend to focus on immediate demands.

Participant(s) suggested that current ad hoc approaches be remedied and worry that the action plan to combat loneliness and social isolation is not yet completed, funded or committed to. Additionally, it was felt that there is currently a lack of sufficient funding for Irish research to develop and investigate specific, tailormade solutions to loneliness and social isolation. In general, participant(s) reported that there is consistent **under-resourcing and under-staffing** of mental health promotion supports for older people.

Another challenge mentioned by participant(s) is a lack of national priority-setting, including; 1. to reduce stigma and increase awareness and education around mental wellbeing for older people, 2. to capture the level of untreated mental illness among older people, and 3. to assess the barriers older people experience in relation to mental health. Participant(s) believe a list of actions should be developed in collaboration with experts and stakeholders working with older people, as part of a specialist group. They also noted that in Sharing the Vision, there

are **specialist groups** for youth mental health transitions, acute bed capacity, women's mental health, primary care, and digital mental health, however, none exists to drive the actions for older people. Participant(s) were of the opinion that existing commitments by Government should be revisited to ensure they are being fulfilled and feel that there may be a need for **stronger communication** and updates on programmes that were started or piloted without further implementation and post-programme supports.

People Living in Deprived & Disadvantaged Communities

Understanding their Needs & Level of Engagement

These consultations included participant(s) who:

- work as part of the Family Resource Centre National Forum (FRCNF), which serves as the national representative and peer support body for 121 Family Resource Centres (FRC) across Ireland who aim to support, empower, and represent communities through community development and family support approaches.
- work as part of the Sláintecare Healthy Communities Programme (SHCP), a programme to promote and protect the health and wellbeing of disadvantaged communities (identified based on the 2016 Pobal HP Deprivation Index) in partnership with the HSE, local authorities and community groups.

In terms of the needs of members of deprived and disadvantaged communities, participant(s) from FRCNF mentioned a focus on protecting the wellbeing of children, youth and families (mothers in particular) of low socio-economic status. Due to their strategic location in disadvantaged areas, they are able to respond to local contexts and needs, which vary across the country. Participant(s) from SHCP mentioned that supports focus on promoting healthy coping mechanisms. Existing coping mechanisms can take on the form of smoking, drugs, alcohol and other unhealthy dietary and lifestyle behaviours. Additionally, these participant(s) mentioned that people in disadvantaged communities are socially isolated and carry emotional sensitivity due to internal and external stigma with regards to their social circumstances.

Successfully engaging this community, according to participant(s) from SHCP requires navigation around several logistical concerns. Timing is important and offering several varying time slots at different times in the day offers success along with offering online as well as in-person services as many members of disadvantaged communities seem to prefer face-to-face supports. These participant(s) cited geographical and access challenges among the top barriers to engagement. Rural areas such as Donegal are difficult to access and are typically Gaeltacht regions that require translation and delivery by Irish-speaking facilitators. Thus, participant(s) advise paying particular attention to convenient venues such as a school or other local gathering area. There is, therefore, a significant **context-specific** element to engaging these populations which gives further validation to an initial consultation and **relationship-building phase**.

As with ethnic minority communities, participant(s) from SHCP noted that these initiatives are susceptible to generating **sensitivities** as service-users may feel they are being judged as lacking these skills simply because of their social status. This is particularly true of parenting interventions where participants can feel they are being targeted as bad parents and less likely to engage. Thus, participant(s) from SHCP recommend strategies for communication, promotion and partnership with other organisations that are designed with consideration of these potential sensitivities. Contrastingly, participant(s) from FRCNF reported no such challenges to engagement. In fact, the levels of engagement currently have been overwhelming to FRC's who are **underfunded and lack sufficient infrastructure** to support engagement and need.

Existing Community-based Mental Health Promotion Supports

1. Interventions which increase access & connection to community resources

Social Prescribing services are described as being utilised to link community members to available supports in the community. Participant(s) from SHCP referred to the fact that these services are often accessed by people who are awaiting clinical referrals due to mental health difficulties, but social prescribing services aim to help these struggling community members to engage in activities in the community. These participant(s) report that 60% of people who engage in Social Prescribing services do so due to social isolation. A considerable proportion of those who access Social Prescribing services are retired or unemployed. Accessing the service can be challenging for community members that are employed. It was noted that

challenges to social prescribing are extensive waiting lists due to lack of available services and a lack of understanding of the social prescribing approach by practitioners. Thus, there is the challenge of inappropriate prescribing where people in need of clinical help are sent to link workers. These participant(s) cautioned that social prescribers can feel overwhelmed as they are not able to provide clinical support as it is outside the scope of their role.

Participant(s) from NFCNF referred to a pilot programme in County Kerry implemented in collaboration with Creative Ireland. The programme, called **Creativity, You and Me**, adopted a social prescribing approach to bring people together through the medium of art (see Case Study 4 on the following page). Additionally, FRC's have national relationships with other community-based supports for other priority groups (such Traveller organisations, migrants and refugees, LGBT groups). Local Domestic Violence organisations will sometimes use the space of FRC's not only as a use of community assets and for recruitment opportunities, but as FRC's also offer a level of privacy and safety for participants availing of these services. The FRC itself, thereby acts as a physical means of link working.

2. Interventions involving peers, befrienders & lay community volunteers

FRCNF are at the forefront of working with priority groups, as all FRC's, participant(s) note, are managed by a board of grassroots **volunteer directors** who come from and live in their communities. FRC's are therefore engaged at every level, "managed by the community, for the community and with the community". Participant(s) report that staff in each FRC, including a community development/family support worker in each location, and **deliver groups as community members** themselves. FRCNF also reportedly received funding recently to recruit qualified Ukranian support workers based in FRC's who can respond to the needs of their communities and deliver group supports. Employment follows procurement procedures in line with grant funding requirements. Staff reportedly come from community development or social support backgrounds or are trained by partnership organisations (e.g., Sports Partnership etc.). Participant(s) report that **staff up-skilling** is prioritised in FRC's and this is typically delivered in-house. These include basic skills training (e.g., Suicide Prevention Training, ASSIST, Mental Health First Aid etc.) or specialised training such (e.g., mindfulness training and facilitation training for various evidence-based programmes determined by the local need) and is supported by FRCNF core funding. Participant(s) also reported that some programme facilitators will be hired as external experts, however the majority of programmes are **delivered by staff, peers or volunteers**.

CASE STUDY 4

YOU, ME, CREATIVITY

Creative Ireland Kerry Social Prescribing Pilot Project, delivered in partnership with the National Forum of Family Resource Centre's Mental Health Project, Kerry County Council Arts Office, and Cork Kerry Community Healthcare. Report by Marina Ní Dhubháin PhD, December 2023

AIM

The You, Me, Creativity pilot programme was designed to expand the scope and content of activities which are available to social prescribing service users, by greatly extending the range of arts and creativity-based offerings over the course of the programme.

APPROACH

Social prescribing is understood as a structured, non-clinical, client-centred, tailoured, holistic intervention which connects people to activities, groups, and services within their own community, in order to address the emotional and social determinants. The You, Me, Creativity pilot programme was designed to expand the scope and content of activities available to service users, by greatly extending the range of arts and creativity-based offerings. In many cultures, arts and creativity have been utilised as a means of self-expression, connection and healing. These offerings gave participants the freedom to express themselves creatively, and to interact with arts and culture in a social environment.

BRIEF SUMMARY

In those isolated, often extremely rural, areas of County Kerry where social prescribing services are offered, significant barriers to arts participation continue to be a cause of concern. During the You, Me, Creativity pilot programme, the local arts and creativity assets of each community were deliberately integrated into the existing community care networks. This planned intervention ensured that an increased number of people, many of them vulnerable and suffering from multiple forms of disadvantage, had an opportunity to enjoy the health and wellbeing benefits of having improved ease of access to arts events and to creative participation. The pilot was delivered in four social prescribing centres in County Kerry.

EVALUATION

Data gathering tools:

- Group progress meetings, one-to-one interviews with Link Workers & service users, site visits, analysis of programme documentation.

Key Learnings:

- Over 500 participants during the 3-month delivery timeline.
- Multi-disciplinary pooling of experience & resources contributes significantly to their work, achievements & to the intervention value.
- Mapping policy, strategic & operational considerations (nationally & locally) for additional partnership would increase value benefits.
- Time & resources were a challenge & a sustainable model is needed.
- Customised training, skills development & awareness-raising measures within the public agencies involved is needed.
- Local findings can feed nuanced & reflective learning back to policy makers
- Comprehensive evaluation is key to ensure appropriate training & intervention components: process-led, impact & output indicators, ongoing monitoring, evaluation & review data.

KEY ASPECTS TO SUCCESS

- Community assets-based approach
- Building upon existing infrastructure and targeting to local priority groups
- Designed to align with strategic vision of HSE Healthy Ireland Implementation Plan (2023 – 2027) & Creative Ireland plan
- Opportunity to celebrate art and culture
- Collaborative project implemented in partnership with Family Resource Centres
- Documentation and evaluation to strengthen the evidence base.

ADVICE FOR FUTURE INITIATIVES

- A key consideration is to improve access and reduce barriers to participation, thus transportation services were offered and locations were strategically chosen.
- Professional commitment, time and engagement of Link Workers is crucial to success.
- The FRC's and Link Workers had an existing level of trust with the community and especially the most vulnerable individuals.
- The collaborative, cross-sectoral approach allowed for shared organisational resources, including guidance and advice.

CASE STUDY 5

COMMUNITY MOTHERS PROGRAMME IN NEWBRIDGE

Newbridge Family Resource Centre

AIM

To support parents and families through parental confidence and empowerment, maternal mental and physical health, parent-child attachment, social connectedness, information provision, linking to services and advocacy.

APPROACH

An early intervention and prevention programme providing structured peer support to families through home visits.

BRIEF SUMMARY

Trained volunteers from the local community visited local families monthly to share structured information, knowledge and support on a peer to peer basis. Visits are 1.5 hrs up to three times per week according to the need. The programme involved a manual with cartoon-like scenarios to talk through with parents about how to care for themselves as parents (specifically mothers) and how to promote the health and development of their baby. Topics included:

- Maternal diet, sleep and overall health
- Childhood vaccinations
- Infant diet and health
- Infant stimulation and development

Majority of programmes also provide a range of community supports and targeted groups (such as breastfeeding and weaning supports, infant massage, parent and toddler group) and engage in sign posting to community resources.

EVALUATION

One of Ireland's first prevention and early interventions with three Randomised Controlled Trials demonstrating demonstrated positive trends in the following areas:

- Higher level of uptake of immunisation
- Diet consisting of 'more appropriate' foods as reported by parents
- Parents reported increased levels of reading to their child
- Parents reported that they engaged in higher level of 'stimulation', nursery rhymes/games (excluding motor games), with their child
- Parents were more likely to feel positive when asked to rate their feelings since their child was born.

Johnson, Howell, Molloy, 1993

Outcomes were sustained at 7-yr followup & in some cases extended to subsequent children.

Johnson, et al., 2000

KEY ASPECTS TO SUCCESS

- Peer-led approach to family supports.
- Peers are trained and supported by a Public Health Nurse.
- Structured programme with flexibility to respond to local needs/context.
- Strong interagency working and advocacy piece.
- Funding principally by the HSE & Tusla, the Child and Family Agency. Note: funding streams are vulnerable, which is a significant challenge to successful implementation.

ADVICE FOR FUTURE INITIATIVES

- There was also an evaluation of the Programme's extension to the Traveller community replicating the promising results in relation to diet, maternal wellbeing and child stimulation, but not uptake of immunisations.

  Fitzpatrick, Molloy, & Johnson, 1997

- Changes within the early intervention and family support sector in terms of structure & funding streams have impacted on future viability.

Participant(s) mentioned a **telephone and befriending service** manned by both staff and community volunteers.

Participant(s) from SHCP find it **challenging to recruit peers** or volunteers. Participant(s) noted the benefit of champions in the community, however the difficulty in engaging community members is something that should be researched in order to successfully implement peer-led supports.

3. Interventions based on collaborations & partnership

Participant(s) from FRCNF report that they deliver evidence-based programmes that were originally co-produces (such as **Parents Plus, Start from the Heart, MindOut and Putting the Pieces Together**), and these programmes are oftentimes delivered by trained staff who are members of their communities. FRC's, however, have not engaged in a coproduction piece to develop a national evidence-informed programme alongside their community members. The closest interventions based on collaborations and partnership are **Community Mothers programmes** who employ mothers within the community as facilitators (see Case Study 5 on the previous page).

Participant(s) from SHCP report that currently initiatives are chosen to target the needs of the community. These programmes are evidence based and designed to encourage and help communities to choose healthier lifestyle behaviours. HSE staff under Sláintecare Healthy Communities work alongside organisations from the community and voluntary sector. Participant(s) state that these initiatives are not co-designed by service-users but are delivered by organisations that represent and advocate for disadvantaged communities. This approach **adds a level of partnership** as these community organisations and Family Resource Centres are well-known and trusted in their communities and are representatives of their collective interests. Participant(s) state that core staff in contracted community organisations are trained as facilitators and also employ facilitators on a sessional basis.

4. Interventions to strengthen social networks

Participant(s) from the FRCNF reported that each FRC responds to the unique needs and contexts of their local community. Thus, while programmes will differ across communities, all approaches are underpinned by a community development, human rights-based

perspective. Indeed, it was noted that the term 'mental health promotion' is not part of the vernacular; 'community development' or 'prevention and early intervention' are the terms used for efforts promote mental wellbeing by way of strengthening communities. Participant(s) referred to that programmes are empowerment- and family-oriented, with supports that aim to connect communities (e.g., support groups for parents and families such as Start from the Heart, children, youth, adult women and men etc.) while simultaneously offering opportunities to build personal skills (e.g., programmes that include mindfulness, yoga, woodworking, flower arranging, knitting etc.). Many programmes reported by participant(s) are implemented in partnership with other established initiatives including Healthy Ireland, Creative Ireland and local Sports Partnerships, who use FRC's both as a physical **community asset and as a means to access** local community members. Additionally, some are multi-agency programmes such as family wellness programmes implemented in collaboration with Children and Young People's Services Committees (CYPSC's).

Many SHCP initiatives were described as being group-based programmes and workshops based on building personal skills, such as We Can Quit, Healthy Food Made Easy and universal parenting programmes. These carry the added benefit of **bringing people from the community together**. Additionally, these initiatives are delivered by HSE staff or staff from community partners with intimate knowledge of and experience working with disadvantaged communities and are thus able to adapt their delivery style accordingly. Universal parenting programmes appear to participant(s) to be particularly promising. There are more tailored or targeted programmes, such as an informal initiative for Traveller women. These initiatives are per the discretion of decision-makers or champions in the locality. Participant(s) also mentioned a less formal strategy for targeted approaches as the recruitment of much smaller homogenous groups, so that issues are addressed as they arise from programme participants in an almost one-to-one manner. These informal initiatives were reported to be successful as programme participants are usually friends and feel a certain sense of comfort in participating.

Enablers

Participant(s) from FRCNF attribute much of the success of FRC's to their **physical presence within their communities**; their doors are metaphorically and physically open to community members in need. By virtue of the venue offering most of the supports available in the community, attendance in one programme serves as a recruitment channel for

participants in another. This has the added benefit of community members availing of supports on many different levels, and families availing of supports intergenerationally (e.g., a participant in a parenting initiative will also participate in personal skills building programmes, their older children can engage in youth supports and their own parents can engage in active aging groups all within the same centre). Participant(s) also mentioned their **core staff and sustainable funding** as a significant support to their work.

The programmes delivered under the aegis of Sláintecare Healthy Communities reportedly begin with a significant **relationship-building phase** and a focus on embedding new services within communities. According to participant(s), this phase increases engagement with service-users, and especially with the people that are in most need of these services. Sláintecare is funded through the Department of Health through coordinator and administrative posts within the HSE. It was stated that these posts also include pre-implementation relationship-building and engagement with community delivery partners. Their work is supported through grant aid agreements with the local community health organisations that are doing the groundwork.

Challenges

FRCNF reportedly receives 18.2 million in funding, through TUSLA (The Child and Family Agency), for their work throughout the country. Participant(s) caution that FRC's are "grossly **underfunded" and overburdened** with the responsibility to "save the day" and solve all the community's difficulties. Indeed, participant(s) highlight that community-based mental health promotion has been placed predominantly on the shoulders of FRC's and their work on the ground and in the heart of communities is overlooked, especially considering the extremely high levels of engagement and service provision recently. The cost-of-living crisis makes it **challenging to retain staff** on current wage scales (with little or no increases in pay to account for the changing economic climate), pension and maternity offerings, and terms and conditions of employment. This all within the backdrop of surging demand for supports across communities and a changing landscape where community **needs are becoming more complex**. Participant(s) note, importantly, that the academic understanding of priority groups may need revisiting. Many community members, especially youth or young adults, who would not traditionally be considered a vulnerable group, are presenting with the need for mental health and wellbeing supports due to this **changing, post-pandemic landscape**. People who had protective factors in place, but these were removed during the years of the

pandemic, are now presenting with the long-term mental impacts from, for example, social exclusion or inability to avail of promotion, prevention and early intervention supports. This is contributing to an unmanageable demand that appears to be escalating. Participant(s) also report that it is administratively challenging and time consuming to successfully engage community members in the most need and call them to action (e.g., socially isolated people who are hesitant to engage and need more encouragement).

Participant(s) from SHCP mentioned that training of community partners is complex and Sláintecare teams may need **more national support** not only to ensure more effective programme delivery, but recruitment is also complex and time-consuming. Currently, a Making Every Contact Count (MECC)-type of approach is used where facilitators invite participants to other initiatives. It was noted that there is a high level of ethnic minorities in Sláintecare catchment areas, but currently there are no targeted supports for them under the SHCP, and it is acknowledged that more should likely be done to **engage these sub-populations in a more tailored manner**.

Family Carers

Understanding their Needs & Level of Engagement

This discussion included participant(s) with Family Carers Ireland, *the* national charity supporting the 500,000+ family and young carers across the country who care for loved ones such as children or adults with additional needs, physical or intellectual disabilities, frail older people, those with palliative care needs or those living with chronic illnesses, mental health challenges or addiction. The key objective of **Family Carers Ireland** is to benefit the community by supporting and promoting the health, wellbeing and quality of life of family carers and those for whom they care. The organisation offers a number of supports and services that are developed based on feedback from formal and informal engagement with family carers

Existing Community-based Mental Health Promotion Supports

1. Interventions which increase access & connection to community resources

Participant(s) noted that one of the roles of the **Support Managers** is to signpost carers and link them to their local community resources. Participant(s) also mentioned a **National Freephone Careline** for carers to access for support. Since cared-for persons are supported by a very broad range of community organisations, participant(s) noted their work to partner with other community organisations and Family Resource Centres to link carers to supports for themselves.

2. Interventions involving peers, befrienders & lay community volunteers

Participant(s) highlighted the fact that carers are well-placed to support one-another and referenced Family Carers Ireland's role in enabling this beneficial support network. Participant(s) mentioned their existing **online and in-person peer support groups** that are facilitated by Family Carers Ireland staff (support managers in the community). Participant(s) also mentioned their current work in developing a model to train carers to become peer support facilitators, with Family Carers Ireland providing facilitator support and guidance where necessary.

Participant(s) mentioned the **Family Carers Ireland Forum** that aims to build an online community that is centred around peer support. Taking into account privacy considerations, the forum serves as an anonymous online place where carers with shared experiences can support one another. Various self-directed e-Learning courses are also available. While these are individual-level wellbeing supports, participant(s) note that these supports are developed based on issues carers have themselves identified and are developed with a level of input from carers themselves. Finally, participant(s) noted that Family Carers Ireland does not have a strong volunteer cohort currently, thus most of their supports are staff-led, noting future plans to explore volunteer-based models.

3. Interventions based on collaborations & partnership

The implementation of the evidence-based **Parents Plus programme for children with additional needs** was cited as an example, which is co-delivered by a member of Family Carers Ireland staff and a carer. Participant(s) reported on their process of interviewing participants prior to the start of the programme so as to match carer facilitators with

participants with similar experiences and similar needs, noting the success of this model. Programme participants often form a support group after delivery of the Programme.

An example of a programme previously implemented is **Mental Health and Family Caring: Supporting the Supporters**, developed in collaboration with Mental Health Ireland. This five-week online programme aimed to support the carers of people with mental health challenges. The programme was co-produced with family carers, supporters, people with lived experience of mental health challenges and service providers and is co-delivered by staff from Mental Health Ireland, Family Carers Ireland, family carers, people with lived experience of mental health challenges and a number of other community partners and wellbeing specialists.

Participant(s) also referred to the Communications and Policy branch of the organisation who drive an **advocacy** piece in the wider political arena. These staff have close relationships with carers, who are able to speak directly to their needs and concerns which are in turn highlighted by Family Carers Ireland in the policy sphere, enabling the carer voice to be heard. Participant(s) highlighted that carers sit within the **governance structure** of Family Carers Ireland and serve on various decision-making committees and boards.
The Family Carers Ireland's **Patient and Public Involvement (PPI) Panel** is a network of family carers who advise and work with researchers carrying out research that involve family carers. This collaborative effort is currently focused on research, and participant(s) note future plans to use the model to guide the development of carer supports, initiatives, training programmes and other resources.

4. Interventions to strengthen social networks

Efforts to enhance caregiver wellbeing, reduce social isolation and promote social connection include **online and in-person monthly groups** that centre around personal skills development (such as creative writing groups, book clubs, cookery, Yoga, mindfulness, and walking groups), as well as workshops and courses that are focused on information provision to enhance carer wellbeing. Participant(s) also reported on their work with the HSE in adapting the evidence-informed **Minding Your Wellbeing programme.** A pilot programme is currently under development for delivery to carers specifically.

Enablers & Challenges

Participant noted that in order for family carers to engage in co-production it is necessary for them to have the **time and energy to engage**. While there are carers who are in sustainable caring roles who can engage in co-production, there are many carers who may find it challenging to engage at that level. **Funding** was also noted as a challenge. While co-production and volunteer- and peer-based approaches are optimal, it is necessary to compensate these roles. Participant(s) suggest that **dedicated budgets and posts** for co-production efforts would help to support this work sustainably. While noting the value of support forums such as The Wheel, participant(s) suggest that national-level **guidelines for community-based best practice** would be helpful for community organisations to ensure their work aligns with the evidence base in a consistent manner across communities in Ireland. Finally, participant(s) noted perhaps a **lack of Irish research that contextualises** the international evidence on effective community-based approaches.

Populations Experiencing Domestic Violence

Understanding their Needs & Level of Engagement

This consultation included participant(s) within the HSE's National Social Inclusion Office (NSIO). Which supports equal access to Health Services for people from vulnerable groups including but not limited to people experiencing homelessness, people who use drugs and/or alcohol, victims or survivors of domestic, sexual and gender-based violence (DSGBV), the LGBTI+ community, Traveller and Roma communities, migrants and other ethnic minorities. Participant(s) mentioned a recent report, titled RECOGNISE, RESPOND, REFER: A review of the approaches used by frontline HSE staff to ask about domestic, sexual and gender-based violence (HSE NSIO, 2023). The report was commissioned by the HSE's National Inclusion Office and aimed to offer a review of current approaches used by frontline HSE staff to ask about DSGBV. In addition to the challenges and enablers identified by HSE staff in relation to asking about DSGBV, the report included a qualitative analysis of consultations with people with lived experience and summarised the barriers to disclosing DSGBV and seeking support. These included internal factors (such as self-blame and fear for their safety or of not being believed) along with external or structural factors (such as dismissive responses, ineffective referral pathways and lack of visibility of services). This report informed the

development of the HSE National DSGBV Training Programme, an four-module e-learning course comprised of four modules focused DSGBV awareness as well as how to Recognise, Respond and Refer victims or survivors of DSGBV.

Existing Community-based Mental Health Promotion Supports

1. Interventions which increase access & connection to community resources

Participant(s) reported the HSE DSGBV Training Programme, which focuses on raising awareness of DSGBV among healthcare staff as well as enabling HSE staff and staff from funded services. The programme is being developed in collaboration with DSGBV experts within the HSE, as well in consultation with specialist services. HSE experts include but are not limited to staff from Sexual Assault Treatment Unit (SATU), National Women's and Infants Health Programme (NWHIP), the Emergency Medicine Programme, the Sexual Health and Crisis Pregnancy Programme and the Office of the Nursing and Midwifery Services Director (ONMSD). As stated above, this programme also incorporates the views of frontline staff and people with lived experience collected as part of the Recognise, Respond Refer report (HSE NSIO, 2023). This report identifies key needs of people who experience DSGBV in terms of seeking support:

- Safety, confidentiality and trust when disclosing DSGBV to HSE staff.
- Staff competency including ability to recognise the signs of DSGBV, staff approach to the conversation, experience, training and staff understanding of DSGBV

Thus, it was noted that current efforts are on developing training that addresses these considerations, enabling **appropriate and streamlined referral pathways** to enable people who experience DSGBV to access appropriate support from specialist services and community resources safely. This work aligns with the HSE responsibilities under the Third National Strategy on DSGBV in relation to training of healthcare staff.

Additional topic-focused learning and resources have been developed as part of the **HSE DSGBV National Training Programme**, such as Female Genital Mutilation (FGM) training for Social Inclusion and a webinar focused on Working Sensitively with migrants who have experience trauma including sexual violence.

Participant(s) also reported that DSGBV information is currently available on the NSIO microsite/page on the HSE website (available here). This includes information about services available for victims and survivors of DSGBV, including contact for the 24h confidential **freephone helpline**, managed by The Rape Crisis Centre, as well as information about the six HSE Sexual Assault Treatment Units available in the country.

Future projects are also planned to develop **resources targeted to service-users** that will incorporate information about community resources. These include the development of a dedicated HSE DSGBV website to ensure an easily navigable experience for HSE staff and service-users while ensuring the information is suitable. This website is being developed in collaboration with HSE digital and communications departments to ensure a streamlined user experience of website, both in terms of website navigability and to ensure the content is relevant and relatable. These consultations were said to include both HSE staff and people with lived experience.

2. Interventions involving peers, befrienders & lay community volunteers

Participant(s) reported that NSIO works in partnership with organisations in the Community and Voluntary Sector who may offer peer- and volunteer-led supports or groups. NSIO is currently planning to develop DSGBV video resources in collaboration with SAOL's DAVINA Project (Domestic Abuse Violence Is Never Acceptable). **DAVINA Peers** are women who have a lived experience of addiction and domestic violence, who not only inform the direction of the project, but develop materials that can be used by professionals to work with women who experience dual issues of addiction and domestic violence. The DAVINA Peers are currently developing a 12-week psycho-educational programme, **co-facilitated by Peers**, that will help women understand the different forms abuse can take and empower them to seek help should they need it (see website here).

3. Interventions based on collaborations & partnership

As mentioned above, partnerships have been developed between NSIO and people with lived experience of DSGBV. Previously cited examples (training for HSE staff, websites and other resources) include the **views of people with lived experience**.

On a broader level, participant(s) mentioned **Criss Cross, a European pilot initiative** which is a collaboration between five countries in Spain, Italy, Portugal, and Luxembourg. This European collaboration project included consultation with people with lived experience to inform best practice and the development of the Training Intervention Program and Toolkit which aims to increase the capacity of professionals working with young people in the prevention of gender-based violence in leisure spaces. The project, participant(s) note, captures the intersectionalities of sexual violence, inter-partner violence, LGBTQI+-related discrimination, and drug and alcohol use experiences for young people in leisure places and night life. Locally, in Dublin, **focus groups were conducted with target groups** including young people of all genders and professional stakeholders to inform local efforts, which also included awareness raising, information stand and support for bystander interventions at events and leisure spaces.

4. Interventions to strengthen social networks

The Saol Project offers a **staff-coordinated, volunteer-led brunch service** each weekend where women and their children can enjoy food, activities and a safe space to relax and socialise. Participant(s) in the consultation with stakeholders representing people from disadvantaged communities mentioned that local DSGBV organisations will sometimes use **the space of FRC's** not only as a use of community assets, but as it also offers a level of privacy and safety for participants availing of these services.

Enablers & Challenges

Participant(s), who are staff of the HSE's NSIO, mentioned that **partnership working with the CVS** is crucial for success and to ensure supports and initiatives are empowerment-focused, safe and appropriate for people experiencing DSGBV. While there are many future plans, as noted throughout this section, participant(s) remain optimistic that the current level of resources, funding and support will enable these future efforts.

LGBTQI+ Populations

Understanding their Needs & Level of Engagement

Participant(s) in this consultation included representative(s) from LGBT Ireland, a national organisation with a localised approach to providing support, training, and advocacy aiming to improve the lives of LGBTQI+ people across Ireland. It was reported that while much work has been done in recent years to address LGBTQI+ stigma, there remains a great deal of hate and hostility both online and offline, as well as prejudice and misunderstanding in the mainstream. Participant(s) stated that LGBTQI+ communities need supports that address both internal and external factors such as lack of acceptance, identity confusion, shame, stigma and exclusion. Furthermore, LGBTQI+ communities still experience discrimination in the form of legal gaps where reform is needed to ensure equity and opportunities. Participant(s) reported that LGBTQI+ communities can also feel disenfranchised when engaging with services that do not appropriately address or accurately reflect their concerns and experience a lack of gender-affirming care. There is a large degree of intersectionality, which adds an additional layer of complexity to appropriate support services, particularly with the increasing rates of families seeking international protection.

It was reported that LGBTQI+ communities are not difficult to engage as the national Helpline is a well-established support system. Participant(s) stated that a challenge to engagement, especially locally, is that there are no funds to promote the service or to build brand awareness for community organisations that target LGBTQI+ populations.

Existing Community-based Mental Health Promotion Supports

1. Interventions which increase access & connection to community resources

LGBT Ireland offers a **volunteer-based helpline** for emotional support and signposting to LGBTQI+ competent services such as psychotherapy. Participant(s) state that many of these volunteers are also LGBTQI+ peers. It was reported that the helpline has a direct link with the Samaritans community organisation, which is a well-established national service. According to participant(s), LGBT Ireland does not engage officially with Social Prescribing services, but their own signposting efforts aim to link service-users with community supports available within their own organisation or others in the locality.

2. Interventions involving peers, befrienders & lay community volunteers

According to participant(s), **peer-support services** focus on sub-populations within the LGBTQI+ community such as those with refugee status or seeking international protection and accommodation. Participant(s) reported that formerly, the MyMind programme would

provide these peer-led services, however, due to funding challenges, the programme no longer supports these services specifically. Other initiatives that target LGBTQI+ refugees are run by staff within LGBT Ireland with integration skills training.

Other peer-support services were reported as volunteer based. Volunteers come with experience and will undergo facilitations skills training which is funded by the National Office of Suicide Prevention (NOSP). Examples of these services given by participant(s) include the monthly in-person **Married Women Peer Support Group** which includes women in heterosexual marriages or relationships who are now coming out. There is also the **First Out for Gay/Bi Men Peer Support Group** which offers a safe space for men who are gay, bisexual or questioning and want to talk about coming out. Rather than evidence-based programmes, these meetings offer an opportunity for people who are experiencing similar life challenges to offer informal support to one another. LGBT Ireland also have a **Telefriending** support service that serves as a form of peer support for older persons in LGBTQI+ communities.

3. Interventions based on collaborations & partnership

MyMind is a NOSP-funded initiative that is described as a unique movement for community-based mental health services that works towards giving every person in Ireland equal access to mental health support early, affordably, directly, and without stigma or delay. Participant(s) note that this programme is more focused on secondary and tertiary mental health supports; however, the programme offers a sense of solidarity and commitment that carries benefits to the mental wellbeing of LGBTQI+ populations. Anecdotally, it was mentioned by participant(s) that oftentimes potential mental health difficulties are alleviated once the individual engages with general support services. The simple act of feeling supported or the simple act of opening a conversation that allows the individual to understand that their anxieties may in part be due to unnecessary internal stigma can prevent the need for clinical mental health supports.

LGBT Ireland also builds a network called the **Irish Allied Group** which partners with Irish enterprises. Through the group, various career days are held and other employment-based supports such as the **Rainbow Internships programme**.

4. Interventions to strengthen social networks

While the aim of strengthening LGBTQI+ communities psychosocially underpins all supports, LGBT Ireland takes a soft approach rather than a hard evidence-based practice approach. Participant(s) state that they meet the needs of their groups as best they can with early intervention supports which are typically not specific interventions, but rather **opportunities to connect and strengthen bonds** with people with shared lived experience and challenges. They offer in-person, online and hybrid social events for community members to get together.

Enablers & Challenges

Participant(s) report that helpline cases are becoming more complex and there is a **paucity of available services**, and particularly services that are LGBTQI+ appropriate. There is also reportedly no available funding for upskilling of community organisation staff.

The training programmes for volunteers and peer support workers was reported as effective and includes active listening, which has underestimated value in supporting the mental wellbeing of LGBTQI+ communities. Additionally, it was reported that staff have translation skills and integration workers typically have five languages, thus can act as a lead peer for sub-populations who do not speak English.

The current biggest gaps expressed by participant(s) include **training for service providers** and **additional funding** for psychological community-based services. Participant(s) suggest that considering the significant amount of priority groups, culturally competent training for service-providers should be embedded into the education curriculum rather than ad hoc or optional professional development trainings. A further suggestion is to emphasise the lowering of service wait lists and this is believed by participant(s) to be a reasonable goal; many LGBTQI+ service-users only need the guidance to work through their stigma internally and a stronger commitment to this type of early intervention, participant(s) suggest, could significantly lessen the need for tertiary and secondary mental health services.

Finally, participant(s) believe strong research is a helpful driver of change and political motivation. Thus, **more funding for research** that establishes the importance of gender-affirming care and moving from a pathogenic model of health would be a strong enabler of supporting the mental wellbeing of LGBTQI+ populations.

Discussion

This report aimed to identify best-practice examples of community-based mental health promotion initiatives for priority groups in Ireland. Nine online consultations were conducted with a total of 13 participants. Eleven participants were stakeholders from organisations in the community and voluntary sector and two were based in the HSE. Priority groups represented by community organisations included ethnic minority populations, migrants and refugees (n=6), people with disabilities and their families (n=1), people who experience loneliness and isolation (n=1), people living in deprived and disadvantaged communities (n=1), family carers (n=1), and LGBTQI+ populations (n=1). HSE staff represented populations who experience domestic violence (n=1) and people living in deprived and disadvantaged communities (n=1). The findings of the consultations are discussed in terms of their implications for supporting best practice implementation of community-based mental health promotion for priority groups in Ireland.

Intersectionality

It is important to note the high degree of intersectionality; a finding from the consultations that is consistent with findings from the scoping review. Ethnic minority communities, for example, will also present as carers, living with disabilities, experiencing loneliness, living in deprived communities, experiencing domestic violence, have personal gender orientations, and are experiencing their own stage within the life cycle. This intersectionality adds a layer of complexity from both research and practice perspectives. All participants noted that tailoring approaches and supports to a defined priority group is not entirely feasible in practice as priority groups are not homogenous and their concerns lie at the nexus of multiple interdependent factors. From the outset, this highlights the crucial role of meaningful participation in identifying concerns and solutions as well as co-design and co-delivery of evidence-based interventions.

Terminology

It is also important to note that the terminology used in mental health promotion research and policy does not seem to be consistent with the terminology used in community practice in Ireland. Findings from the consultations revealed that the term ‘community development’ seems to be synonymous with, and the preferred term in practice for, ‘community-based

mental health promotion.' Many of this study's participants from the community and voluntary sector, who are implementing community-based mental health promotion, are guided by the *All Ireland Standards for Community Work* published by Community Work Ireland in 2016 under the All Ireland Endorsement Body for Community Work Education and Training. The Standards define community development as "A developmental activity comprised of both a task and a process. The task is social change to achieve equality, social justice and human rights, and the process is the application of principles of participation, empowerment and collective decision making in a structured and co-ordinated way" (p. 4). Thus, per Figure 3.2, the core values of a community development approach are:

1. Collectivity
2. Community Empowerment
3. Social Justice and Sustainable Development
4. Human Rights, Equality and Anti-discrimination
5. Participation

These values reflect the values of community-based mental health promotion. Community engagement, which is at the core of promoting population health and wellbeing, is described as both a process and an outcome where the impetus is to reduce health inequities, encourage sustainable global development, and foster partnership between communities, the community and voluntary sector, and government (PHE, 2015a; 2015b; WHO, 2020). Furthermore, the goal of community-centred approaches is to build trust, empowerment, self-advocacy and capacity so that communities are; 1. informed and mobilised (community-oriented), 2. consulted and involved (community-based), 3. decision-makers in priority setting (community-managed), or 4. self-governed (community-owned), according to local contexts (WHO, 2022) depending on their unique context. PHE's framework of community-centred approaches, which was used as a framework in the current study and the preceding scoping review, also aligns with a community development approach (PHE, 2015a).

Figure 3.2. The Five Core Community Development Values (from Community Work Ireland, 2016; p. 2)

Their whole system approach is particularly reflective of the *All Ireland Standards for Community Work* (Community Work Ireland, 2016). It is underpinned by values such as trust, power and relationships, that aims to involve, strengthen, sustain and scale community efforts, with the underlying principles of shifting mindsets, leadership and radical change, collective bravery, co-production and complex systems-thinking (PHE, 2020). Thus, while terminology differs between 'community development' and 'community-based mental health promotion' approaches, the task, underlying principles, and process are aligned. There is scope to formally link community development with community-based mental health promotion at a policy level.

Discussion Framework

The following discussion presents a summary of the findings of the consultations with reference to the scoping review in Chapter 2. For continuity, Public Health England's (2015)

framework of the family of community-centred approaches for health and wellbeing will be used to guide this discussion. The strengths and limitations of this consultation study are presented along with implications of the findings for community-based mental health promotion practice with priority groups in the Irish context. Conclusions and key recommendations are outlined to support implementation of community-based mental health promotion for priority population groups in Ireland.

Interventions to Increase Access to Community Resources

Approaches that increase access to community resources include not only approaches to connect community members to community resources and supports but also to encourage and facilitate social participation (PHE, 2015). All participants in the consultations mentioned **signposting services or national support phone lines**, many of which are operated by peers and volunteers. It was commonly mentioned, however, that there is a lack of available services, and services are typically inaccessible both in terms of literacy and cultural relevancy, and, in some cases physically. There are also special-purpose projects to increase access to health services, such as Cairde's **Ukranian Project**, their **Be Aware. Be Well Migrant Mental Health Initiative** and their **HealthConnect** website. Participants reported **informal community group gatherings** providing opportunities for crafts, arts, book clubs, gardening, walking, mindfulness, fitness and social engagement. These were reportedly led by professionals, peers, and community lay members, both independently and in partnership. This is consistent with the findings from the scoping review, although the community group interventions therein were more structured in terms of documentation and evaluation. To further align with best practice found in the scoping review, and subject to resourcing and guidance, there is scope to include digital based group interventions and to include cultural adaptation where necessary.

Officially, **Social Prescribing services** are used by organisations representing older people and disadvantaged communities. Other organisations use the social prescribing model in link working without engaging formally with the services per se. Family Carer's Ireland have **community support managers** on staff who link carers around the country to community resources. It was mentioned that Social Prescribing services may be overwhelmed or

overprescribed due to lack of available services. The Creativity, You and Me pilot programme, a collaboration between Social Prescribing services delivered through Family Resource Centres (FRC's) and Creative Ireland, is a promising link-working initiative with a more targeted approach for people in disadvantaged communities. Programmes such as this can encourage interagency collaboration while serving to adapt broader evidence-based initiatives to local contexts and carry a further benefit in that these programmes are nested within existing mental health promotion infrastructure in Ireland. In the spirit of this initiative, there is scope to expand Social Prescribing services to work with specific priority populations, subject to proper resources being made available. It was noted that FRC's, by their presence in the heart of communities in most need, act as a physical means of link working. Considering the paucity of evidence regarding the effectiveness of Social Prescribing services for priority groups, it is important to support communities to document and evaluate their efforts.

From a more upstream perspective, a large **upskilling project** is being undertaken to develop a National Domestic Sexual and Gender-based Violence (DSGBV) Training Programme for HSE staff to recognise, respond and refer people experiencing DSGBV, and this includes a website redesign in collaboration with people with lived experience. The ability of HSE frontline and acute hospital staff to recognise and engage appropriately with priority groups should not be overlooked in terms of its effects on their mental wellbeing. The link between primary health care and community organisations is highlighted in the literature as an enabler in this approach (PHE, 2015), thus knowledge of available specialised services and training is key in engaging with priority groups in a manner that is empathetic and motivating. This may also help foster integration of priority groups into Irish mainstream, a key concern of many participants.

Participants in the consultations noted that the choices of community members are limited and dictated by the structure of the services, which oftentimes does not account for the social determinants of health and are oftentimes not co-produced, thus there is a need to emphasise meaningful participation, so that priority groups have the capacity to direct their own services. Additionally, participants noted that inappropriate or untailored communication approaches can essentially 'lock out' those in most need of services, thus antiquated perceptions of 'accessible communication' should be revisited to include audio and video supports rather than solely 'plain English' written resources.

Interventions with Volunteer & Peer Roles

Peer representation in policy making and advocacy was most commonly reported. FRC's and some organisations, such as Pavee Point and Cairde, are **managed and staffed** by members of their communities, thus peer-led and volunteer-led approaches are custom. Cairde also provide training to **mental health advocacy and support volunteers for ethnic minorities** who provide advocacy support to their peers and help them access the needed services. Cairde's **Ukranian Project** and **Roma Education Programme** enable peer-to-peer support, along with skills-building classes that are peer-codelivered. The training is tailored for ethnic minorities and is led by ethnic minority community members. The **peer-led DAVINA project** developed by The Saol Project, a community organisation for people experiencing DSGBV, is promising. The partnership between The Saol Project and the HSE's National Social Inclusion Office ensures that this priority group is represented within health services. Family Carers Ireland offer staff-facilitated online and in-person peer support groups along with their **online Forum**, where carers with shared experiences can support one another. LGBTQI+ populations are supported with peer support groups including the **Married Women Peer Support Group** and **First Out for Gay/Bi Men Peer Support Group**. Participants' comments echoed the scoping review findings, highlighting the mutual benefits of these peer approaches. The scoping review found that more structured programmes and mentorship were most effective, and peers with some level of supervision or intervention support were associated with lower attrition rates. The level of existing intervention support for peers in Ireland was not clear from the consultations.

Existing **befriending services** are available for older people, people from disadvantaged communities and LGBTQI+ populations. ALONE have visitation and telephone services for older people as well as their BConnect app. FRC's have a telephone and befriending service that is operated by community members and LGBT Ireland have a volunteer-led telefriending service.

National organisations are oftentimes resourced to respond to local needs particularly with regards to migrants and refugees. LGBT Ireland, for example, have **integration workers and multi-lingual translators** to lead support for people seeking international protection. FRC's

likewise have recently been resourced to employ Ukranian **support workers** to respond to the needs of Ukranian refugees. From the consultations, it appears peer and volunteer roles for migrants and refugees, rather than forming their own priority group, are typically implemented as a subgroup within other priority groups showcasing, again, the large degree of intersectionality between priority groups.

Participants acknowledged that peer and volunteer roles are best practice but noted that training peers and volunteers is challenging and existing funding streams do not seem to account for this. Over-and-above facilitation skills, a certain level of foundational literacy is needed in programme delivery, and engaging in sensitive topics with vulnerable communities requires a level of professional qualification. Some organisations mitigate this challenge through co-delivery alongside external professionals who are trained and experienced in engaging vulnerable populations. It was also reported that fully volunteer-based models are unstable and difficult to manage. Success of these models can be based on appropriate volunteer matching, thus efficient resourcing to account for administration and coordination is a key enabler. The importance of understanding cultural preferences when assigning peer leaders was noted. Participants echoed the findings in the scoping review that peer-led and collaborative approaches are an effective way to ensure the cultural appropriateness of supports.

Interventions Based on Collaborations & Partnership

Pavee Point's **Primary Health Care Project for Travellers** was highlighted as a successful example, where consultation participants report that Travellers receive most of their information through these projects. They are implemented by members of the Travelling community and serve not only as a means to provide peer-led supports, but also as a means for Travellers to voice their concerns, which in turn drives priority setting and advocacy efforts for their community (i.e., co-production and meaningful participation), and open a dialogue between Travellers and healthcare service providers. Likewise, the co-designed **Mind Your Nuck website** was developed by Travellers for Travellers and was a response to concerns raised by the Travelling community themselves. These initiatives exemplify community development on many levels: meaningful participation, collectivity and community empowerment, while fostering a sense of trust. Cairde's co-produced **Mental**

Health Guide & Directory for Ethnic Minorities embodies a similar ethos. These collaborative projects are consistent with the findings in the scoping review. The establishment of **Disabled Persons' Organisations** is promising, and they are in the beginning stages in Ireland in terms of localising efforts. These organisations, that are led by people with disabilities, aim to drive inclusive policy, research and practice, and emphasise the principles of self-advocacy and equal civic participation. Some organisations, such as Family Carers Ireland, have carers in their governance structure who also contribute to decision-making as part of committees and boards.

FRC's are currently implementing evidence-based family support programmes such as **Community Mothers, Parents Plus, MindOut, Start from the Heart** and **Putting the Pieces Together**. These are delivered mostly by FRC staff or volunteers who, in both cases, are members of the local community, thus embodying the principles of collaboration and partnership. Family Carers Ireland, likewise, is currently implementing evidence-based programmes such as **Parents Plus and Minding Your Wellbeing** and these have been adapted for delivery to caregivers and, in many cases, co-delivered by caregivers. Their **Mental Health and Family Caring** programme was co-produced with participation by family carers. The Aligning with best practice identified in the scoping review, Family Carers Ireland endeavours to match facilitators and participants who share similar experiences and continue to provide support after programme delivery. While the MyMind programme for LGBTQI+ populations included partnership approaches, funding has recently shifted causing uncertainty in future implementation. LGBT Ireland coordinate an **Irish Allied Group** which facilitates the **Rainbow Internships programme** in workplaces. Cairde have their co-produced **HELLO, How Are You** and **Thrive** Bilbraggin mental health promotion initiatives.

Sláintecare Healthy Communities **work alongside organisations from the community** and voluntary sector, adding a level of local partnership, and this was viewed by participants as being a successful model, especially when adding collaboration with FRC's as an additional partnership layer. With this approach, Sláintecare Healthy Communities aim to collaborate at all levels of implementation from priority-setting to evaluation and dissemination.
Criss Cross, a European pilot initiative, aims to increase general awareness and the capacity of professionals working with young people in the prevention of gender-based violence in leisure spaces. The initiative includes consultation with stakeholders with lived

experience at a local level in Dublin, along with collaborative programme and resource development, and broader consultation at the European level. Family Carers Ireland, likewise, have their **Patient and Public Involvement (PPI) Panel**, a network of family carers who advise and work with researchers carrying out research that involve family carers. Cairde have engaged in CBPR with their **Cultural Humility in Mental Health Services Study (CHUMS), Flemington Community Research Project** and **Proiecto Romano**. A more upstream approach is adopted with older people, where ALONE facilitate an **Enhanced Community Care Programme** and **Community Impact Network** with the aim of enabling integrated care through partnerships at local, regional and government levels in both statutory and community-based capacities. Their **National Network of Community Service Hubs** empower both older people and the organisations that represent them.

Participants noted that co-production approaches are most preferred, however, as with peer and volunteer approaches, the levels of baseline training, facilitation skills and other upskilling are underestimated, and existing resources do not reflect the complexity of this undertaking. Related is the importance of building capacity in communities so that they are enabled to meaningfully participate in collaboration and partnership to identify and set their own priorities and engage in solutions, implementation and evaluation. Some organisations noted that priority groups, such as carers who are in unsustainable caring roles, do not have the time or energy needed to engage in the co-production process and require a different level of supports. With resources in place, there is scope to further adapt evidence-based programmes, such as Community Mothers, for co-delivery with priority groups. Additionally, it was reported that the true values of CBPR should be emphasised; that is, meaningful participation and shared decision-making. It was noted that incorrectly implemented CBPR can become harmful, by exacerbating mistrust, if no further action is taken or if findings are not appropriately discussed with research participants.

Interventions to Strengthen Social Networks

Exemplifying an assets-based approach, **Family Resource Centres** are particularly well placed, both physically and psychosocially, to respond to dynamic local contexts and carry the potential to reach all priority groups intergenerationally. Their physical presence within communities and the lived experience of staff are significant enablers of success. Indeed, FRC's can offer a safe and private location for local organisations to deliver programmes and supports (important particularly for priority groups such as those experiencing DSGBV), while simultaneously serving as a means of link working and participant engagement. The Saol project is a promising avenue for strengthening the community of people experiencing DSGBV by providing volunteer-led brunch meet-ups. Structured, tailored approaches to strengthening communities were rarely reported. Where resources allow and local champions are in place, Sláintecare Healthy Communities staff will recruit **small, homogenous groups** so that culturally specific issues that arise can be addressed by facilitators, who are oftentimes community organisation representatives serving the interests of these groups.

Cairde's **Pathways to Wellbeing** is a trauma-informed, culturally tailored intervention underpinned by theories of positive psychology and lifestyle medicine, aimed at empowering migrant women to care for their mental health and wellbeing. While not officially co-produced or peer-led, a pilot study evaluation showed positive impacts on mental health measures, subjective wellbeing and engagement. With supports in place, there is scope to further adapt programmes such as this to reflect the specific needs of priority groups. One such programme is the Minding Your Wellbeing programme which has been adapted for delivery to carers and will be formally piloted in the near future.

Additional evidence-informed community-based mental health promotion approaches being implemented in Ireland include the **New Communities Men's Shed** and the **Minding Your Wellbeing Programme** adapted for older people in community settings. These were identified by researchers and not revealed through the consultations. Based on evidence of effectiveness, the Irish Men's Sheds Association is a well-established organisation whose value in Irish society has been recognised domestically and across Europe. Recent efforts to increase diversity and target communities that are new to the area, such as migrant or ethnic minority communities, are promising and serve to strengthen these communities while also

empowering them with personal skills that will help them integrate into Ireland. The Minding Your Wellbeing programme, an intervention underpinned by positive psychology, was recently adapted to be delivered in partnership with community organisations that represent older people. Initial findings from a feasibility and pilot study show individual benefits while also improving social connection among participants (Keppler & Barry, 2024).

Existing efforts align with the findings of the scoping review with opportunity for stronger emphasis, particularly in the case of ethnic minorities and migrants, on champions (representing the priority group) and community wellbeing champions ('lay providers'). Participants emphasised that while evidence-based programmes are best practice, the power of simply connecting peers in a social environment should not be overlooked. Coupling this with opportunities to celebrate culture and/or using empowerment and personal skills-building approaches is particularly promising. It was also noted that the most successful approaches are ones that build on existing programmes or are embedded within existing services.

Figure 3.3, on the following page, offers a summary of interventions mentioned throughout the consultation process.

Supporting Community-based Mental Health Promotion for Priority Groups in Ireland

Throughout the consultations, certain common implementation enablers and challenges were raised. These fell within five overarching categories: contexts, trust, involvement, funding and evaluation. Each are discussed in turn following.

Mapping the Contexts

Contexts can be further subdivided into the broader context and local contexts. In terms of the broader context, it is clear from the consultations that community development must occur within the backdrop of a whole-of-society approach. This is echoed in community engagement literature that calls for a whole systems approach (PHE, 2015; WHO, 2020), as well as evidence in the Irish policy sphere that calls for nationally stewarded, community-led population-level mental health promotion approaches that are underpinned by intersectoral, whole-of-government collaboration (Barry et al., 2023). This approach serves to prevent a

Figure 3.3. Overview of existing community-based mental health promotion supports offered in Ireland using PHE (2015) framework of family of approaches.

Access to Community Resources

- Informal community group gatherings (crafts, arts, book clubs, gardening, walking, mindfulness, fitness, social engagement etc.)
- Special-purpose projects: Ukrainian Project, Be Aware. Be Well Migrant Health Initiative, HealthConnect website (Cairde)
- Volunteer- & peer-operated national support lines
- Social prescribing services & link working including through FRC's
- Community Support Managers (Family Carers Ireland)
- Upskilling frontline staff to streamline referral pathways to specialised services (DSGBV).

Volunteer & Peer Roles

- Mental Health Advocacy & Support Volunteers for Ethnic Minorities, Ukranian Project, Roma Education Programme, skills-building classes (Cairde)
- Family support programmes: Community Mothers, Parents Plus, MindOut, Start from the Heart and Putting the Pieces Together (FRC's)
- Parents Plus for Children with Additional Needs, Mental Health & Family Carers programme & PPI Panel (Family Carers Ireland)
- The Saol Project's DAVINA peer-support initiatives (DSGBV)
- Married Women Peer Support Groups & First Out for Gay/Bi Men Peer Support Groups (LGBT Ireland)
- Staff-facilitated peer support groups & online Forum (Family Carers Ireland)

- Befriending Services (ALONE, FRC's, LGBT Ireland)
- Multi-lingual integration workers & migrant & refugee peer support work as a sub-group within many priority groups (e.g., Cairde, FRC's & LGBT Ireland).

Collaboration & Partnership

- Advocacy work
- Primary Health Care Project for Travellers & Mind Your Nuck website co-design (Pavee Point)
- Co-produced Mental Health Guide & Directory for Ethnic Minorities & HELLO, How Are You & Thrive Bilbraggin MHP initiatives (Cairde)
- Disabled Persons Organisations (Inclusion Ireland)
- Organisations are managed &/or staffed by priority group members (e.g., FRC's, Pavee Point, Cairde) &/or in the governance structure (Family Carers Ireland)
- MyMind programme and Irish Allied Group & Rainbow Internship programmes in workplaces (LGBT Ireland)
- Sláintecare Healthy Communities work alongside community organisations, in further partnership with FRC's
- Various CBPR (Cairde) & PPI (Family Carers Ireland)
- Criss Cross European project with participatory research to increase awareness & capacity of professionals (DSGBV)
- Enhanced Community Care Programme, Community Impact Network & National Network of Community Service Hubs (ALONE)

Strengthening Communities

- Assets-based approaches using FRC's
- Volunteer-led brunch meet-ups (DSGBV)
- Small, homogenous groups to be culturally appropriate (Sláintecare HC)
- Pathways to Wellbeing (Cairde)
- Minding Your Wellbeing Programme for older people in community settings & for carers (ALONE & Family Carers Ireland)
- New Communities Men's Sheds.

kind of 'lifestyle drift' where the burden is placed on the shoulders of individuals and communities to 'fix their own problems', when the roots of their problems are systemic. In other words, it is important that all community-based interventions fall within a broader plan to address the social determinants of health. More national support, capacity building and infrastructure would help to ensure that problems are not left at the doorstep of the community.

Additional considerations in the broader context include a call to shift emphasis from policy development to policy *action*. Most participants feel that policy development is strong in Ireland, but implementation may be lacking. There may be existing policy commitments that have not yet been acted upon, communication on these and other national priority setting efforts may be necessary.

Furthermore, there is a sense of 'programme fatigue' where programmes are piloted with no further implementation or post-programme supports, another example of development without sustainable action. Findings from the scoping review add strength to this suggestion, where supportive infrastructure beyond the initial intervention development and delivery is highlighted as being critical for intervention efficacy.

Participants also highlighted the need to shift mainstream health paradigms from pathology (fixing once it has broken) to prevention and early intervention in order to lighten the load of services which currently do not meet the need. Indeed, two of the guiding principles in PHE's whole system approach are 'shifting mindsets' and 'bold leadership and radical change' (PHE, 2020). Lack of services and extensive waiting lists were mentioned commonly as a significant challenge. Finally, it was suggested that there is significant need to address the cost-of-living, post-pandemic and international protection crises, which are wider impacts on community-based mental health promotion implementation.

In terms of the local contexts, tailored, accessible and understandable communication that reflects the preferences of the local community is vital, and there may be need for a more sensitive understanding of what 'accessible' communication is. In line with the scoping review findings, structural barriers such as language and transport should be addressed in order to facilitate active participation.

With certain priority groups, there may also be a need to address potential perceived stereotyping pro-actively, perhaps in partnership with community organisation representatives. Appropriate framing and communication of parenting programmes, for example, can help alleviate discomfort in parents who feel they are being judged and stereotyped. It was suggested that national strategies

should include specialist groups for each priority group with specific actions in mental health promotion or community development. Currently, these efforts are not dedicated and thus difficult to ensure consistency across communities in Ireland. There is scope to incentivise intersectoral and multi-agency partnership for sharing of resources and comprehensive engagement of communities (e.g., the Creativity, You & Me pilot delivered with Social Prescribing services in County Kerry through FRC's and Creative Ireland, and partnerships between Healthy Ireland, Sports Partnerships, CYPSC's etc.). Finally, participants mentioned that a key enabler of community-based mental health promotion is the freedom to co-design creative solutions and real-time responses to changing needs and contexts in the community. This reflects the call to balance national consistency with autonomy at the local level when implementing population-level mental health promotion (Barry et al., 2023). While project-specific funding is helpful in general, stable, core funding is more suited to this approach.

Building Trust

Participants highlighted trust as a key ingredient to successful community-based efforts for priority groups. One participant called this initial relationship-building phase an 'invisible layer' that should be considered as a preliminary phase; a *pre*-planning, *pre*-implementation phase. The goal of this invisible layer would be to establish the conditions for engagement. Understanding the local socio-ecological context and community dynamics and preferences are crucial to engaging priority groups and thus should be prioritised. The most successful trust-building approaches reported by participants related to advocacy work, where familiarity with their groups and family ties, and an intimate knowledge of dynamic contexts, is crucial. The most significant enabler was reported as core, stable funding. Meaningful participation and the capacity to direct their own supports and services were also mentioned as important ways to cultivate trust with priority groups. It was noted, importantly, that those in the most need are typically hesitant to engage in community initiatives. Personalised engagement of these community members requires significant time and resources.

It was highlighted that there is a need to build trust within the wider context through reforming legal gaps, ensuring culturally appropriate or intercultural services, communication and knowledge translation, and addressing mainstream attitudes and stigma toward priority groups. Upskilling existing service and health care providers to build meaningful relationships with priority populations with culturally appropriate communication is a key driver of trust-building. Examples include gender-affirming care and other empathetic approaches, where service providers demonstrate a level of understanding of the wider impacts on the health of priority groups. Finally, upskilling staff in smaller organisations and/or mentorship programmes with well-established national organisations

could help to build trust within these organisations, some of whom reported feeling isolated and stymied due to lack of guidance, capacity or competencies in mental health promotion.

Encouraging Community Involvement & Connectedness

It was clear from the consultations that a shared understanding of 'meaningful participation' is needed. On the one hand, inauthentic participation is perceived as tokenistic and on the other these approaches do not effectively address genuine community priorities. Community development is a method of meaningful participation that ensures efforts are community-led in terms of identifying collective concerns and solutions, community strengths and weaknesses, disseminating accessible and culturally appropriate information, and delivering services and supports. Professional development and capacity building at all levels including community organisation staff, volunteers and peers is important. In general, it is important to acknowledge the significant amount of training, time, resources and funding needed for successful community-led approaches. Most participants mentioned the need for national guidance in addition to sufficient supports in this endeavour. This type of guidance would be helpful for community organisations to ensure their work aligns with the evidence base in a consistent manner across communities in Ireland.

Stable Funding

Existing funding streams were reported as a major enabler of success, and the most successful organisations reported a helpful level of stable core funding through various funding streams. All participants, however, note that they are under-resourced and under-staffed. Participants suggested dedicated funding streams for mental health promotion in each priority group so that approaches are not ad hoc and not dependent upon the discretion of a local champion. Dedicated funding and permanent posts were commonly reported as an enabler to support activities that are not project-specific such as IT, administration, awareness-raising and essential trust-building phases. Stable, core funding will also ensure long-term commitments that reflect the intergenerational timescales of building trust and community capacity for partnership. Stable, core funding will also help to ensure appropriate salaries and career supports for staff in the field of community development. It was reported that staff are difficult to retain in the current economic climate and staff turnover is a significant obstacle to success. It was also mentioned that post-programme funding is crucial for maintaining connectedness and reducing the potential harm that can arise from education without enablement, and this was reflected in the scoping review. Finally, core, stable funding will enable communities to pro-actively prevent crisis conditions in the future. For example, community organisations for older people should be enabled to offer promotion and prevention supports to

Ireland's aging population, and community-based prevention and early interventions can mitigate overwhelmed health services.

Strengthening the Evidence Base

Participants called for comprehensive, holistic indicators that adequately capture community-based efforts of mental health promotion. Suggestions for these indicators included contextual factors, quality of life, social wellbeing, community development and empowerment, and the benefits of prevention and early intervention. Disaggregated data was highlighted as a crucial way to inform targeted responses, evidence-based policy making and to capture the added value for investment. High quality research was commonly cited as a political motivator and enabler of successful community-based mental health promotion. Participants suggested emphasising research to understand the difficulties in community-based approaches, such as engaging peers and co-designing accessible communication. Participants were of the opinion that stronger commitment is needed for Irish research to develop and investigate specific, tailormade solutions and to contextualise the international evidence. Finally, it should be noted that in terms of identifying best-practice examples, a great deal of good practice is currently not well documented as there is an absence of robust evaluation approaches in the Irish context.

Strengths & Limitations of this Study

The participants who were consulted in this study have a strong understanding of the priority populations they work with and also have a clear appreciation of the wider policy and community practice context in Ireland. They also have a very clear view of what enablers are needed to advance a greater focus on integrating mental health promotion within current community-based initiatives. Thus, significant strengths of this study lie in its contribution to understanding community-based approaches to promote the mental health and wellbeing of priority groups within the Irish context, and to open a conversation between the key players driving its implementation.

As expressed in the scoping review, the breadth of this undertaking may have proved limiting. The complexities of intersectionality and sub-populations within priority groups made it difficult for participants and the researcher to accurately categorise community-based efforts. Due to the time-limited scope of the current project, in most cases only one representative organisation was consulted per priority group. A larger scale project with a much longer timeframe would offer a more comprehensive understanding of community-based mental health promotion efforts across Ireland. The short timeframe, which involved conducting consultation over the summer months added to the challenge of limited availability of participants. Recruitment of participants was solely through

senior decision-makers in the HSE, which limited the diversity of the sample of priority group representatives in Ireland. Finally, and significantly, there does not appear to be a shared understanding of mental health promotion across the community. This is due in part to the use of varying terminology across sectors, but also may be due to a lack of dedicated mental health promotion priority setting and overlapping perceptions regarding addressing mental health difficulties as separate from supporting mental health and wellbeing. A clear, shared understanding of community-based mental health promotion and dedicated strategic objectives of such for each priority group, would alleviate this layer of ambiguity.

Conclusion

The consultations with the stakeholders involved in delivering community-based support and services to the pre-defined priority groups revealed that community-based practices in Ireland align with the international evidence in terms of implementation principles and foundational values, including meaningful participation, connectedness, trust, cultural and contextual appropriateness, and sustainability. Existing efforts could benefit from a more structured approach along with ensuring communication is culturally appropriate, empathetic and accessible. There is a crucial role for health services in this regard, and an opportunity to support professional development. Peer-led and co-produced approaches require significant training, time, resources and core, stable funding and this may not be reflected in current policy priority setting and funding commitments. In general, positioning community-based efforts within the wider context of addressing the wider determinants of mental health is critical. Finally, considering the differences in terminology mentioned at the beginning of this section, there is an opportunity to integrate mental health promotion actions within existing community development frameworks, namely the *All Ireland Standards for Community Work* (Community Work Ireland, 2016), that are currently used in the community and voluntary sector in Ireland, given the overlap in core principles and processes.

There are promising evidence-informed community-based initiatives in Ireland, and these could be enhanced through further co-adaptation and co-delivery with target populations in order to capture their specific needs and preferences. Family Resource Centres emerged as a vital asset in communities with the power to bring a sense of cohesion to community-based efforts while simultaneously bringing a sense of cohesion to all priority groups, interculturally, intersectionally and intergenerationally, within communities. Building the capacity of communities to align with international best practice within the Irish context through commitment, guidance and sustainable

resources is crucial, and key recommendations based on this study are included below. Finally, supporting the documentation and evaluation of community-based efforts and a commitment to strengthening research will ensure efforts contribute to a growing understanding of the impact of community-based mental health promotion for priority groups in Ireland.

References

Barry, M.M., Keppler, T. & Sheridan, A. (2023). *Development of a National Mental Health Promotion Plan: Report prepared for the Department of Health, Ireland.* HPRC, University of Galway. Accessible at https://www.gov.ie/en/policy-information/706608-healthy-ireland-policies/#mental-health-promotion-plan

Community Work Ireland (2016). *All Ireland Standards for Community Work.* Galway: All Ireland Endorsement Body for Community Work Education and Training. Accessible at https://www.cwi.ie/wp-content/uploads/2016/03/All-Ireland-Standards-for-Community-Work.pdf

Ní Dhubháin, M. (2023). You and Me Creativity: A report on the Creative Ireland Kerry Social Prescribing Pilot Project, delivered in partnership with the National Forum of Family Resource Centre's Mental Health Project, Kerry County Council Arts Office, and Cork Kerry Community Healthcare. Accessible at https://www.creativeireland.gov.ie/en/creative-youth/creative-youth-partnerships/kerry-local-creative-youth-partnership/

Department of Health. (2015). *Connecting for Life: Ireland's National Strategy to Reduce Suicide*. Dublin: Department of Health. Accessible at https://www.gov.ie/en/publication/7dfe4c-connecting-for-life-irelands-national-strategy-to-reduce-suicide-201/#:~:text=Connecting%20for%20Life%3A%20Ireland's%20National%20Strategy%20to%20Reduce%20Suicide%202015%20%2D%202024,-From%20Department%20of&text=Connecting%20for%20Life%2C%20Ireland's%20national,self%2Dharm%20in%20our%20communities.

Department of Health. (2020). *Sharing the Vision: A mental health policy for everyone*. Dublin: Government of Ireland. Accessible at

https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/

EU Joint Action for Mental Health and Well-being (2016). *Mental Health in All Policies: Situation analysis and recommendations for action.* Accessible at https://www.mentalhealthandwell-being.eu/the-joint- action/

Foettinger, L., Albrecht, B. M., Altgeld, T., Gansefort, D., Recke, C., Stalling, I., & Bammann, K. (2022). The role of community-based men's sheds in health promotion for older men: a mixed-methods systematic review. *American Journal of Men's Health, 16*(2). https://doi.org/10.1177/15579883221084490

Gilmartin, D., Mercado-Garrido, E., Harte, P., & Barry, M.M. (2024). *A Scoping Review of the Evidence on Community-based Mental Health Promotion Interventions for Priority Groups.* A report prepared for the Health Service Executive, Ireland. Health Promotion Research Centre, University of Galway.

Gilmartin, D., Mercado-Garrido, E., Harte, P. & Barry, M.M. (2024a). *Defining Priority Population Groups at Risk of Poor Mental Health Outcomes: A* report *to guide a scoping review of the evidence on community-based mental health promotion interventions for priority groups*. Report prepared for the Health Service Executive, Ireland. Health Promotion Research Centre, University of Galway

Health Services Executive (2022). *Stronger Together – The HSE Mental Health Promotion Plan* (2022-2027). Dublin: HSE. Accessible at https://www.hse.ie/eng/about/who/healthwell-being/our-priority-programmes/mental-health-and-well-being/hse-mental-health-promotion-plan.pdf

Health Services Executive National Social Inclusion Office (2023). *Recognise, Respond, Refer: A review of the approaches used by frontline HSE staff to ask about domestic, sexual and gender-based violence*. Dublin: HSE. Accessible at

https://www.hse.ie/eng/about/who/primarycare/socialinclusion/domestic-violence/a-review-of-the-approaches-used-by-frontline-hse-staff-to-ask-about-dsgbv-23.pdf

International Union for Health Promotion and Education (2021). *Critical Actions for Mental Health Promotion*. Paris: IUHPE. Accessible at https://www.iuhpe.org/images/IUHPE/Advocacy/IUHPE_Mental-Health_PositionStatement.pdf

Johnson, Z., Howell, F., & Molloy, B. (1993). Community mothers' programme: randomised controlled trial of non-professional intervention in parenting. *BMJ (Clinical research ed.), 306*(6890), 1449–1452. https://doi.org/10.1136/bmj.306.6890.1449

Johnson, Z., Molloy, B., Scallan, E., Fitzpatrick, P., Rooney, B., Keegan, T., & Byrne, P. (2000). Community Mothers Programme – seven year follow-up of a randomized controlled trial of non-professional intervention in parenting. *Journal of Public Health Medicine*, *22*(3), 337–342. http://www.jstor.org/stable/45161298

Keppler, T. & Barry, M. M. (2024). *Adaptation of the Minding Your Wellbeing Programme and Train-the-Trainer Model for Delivery to Older People in Community Settings prepared for the Health Service Executive, Ireland.* Health Promotion Research Centre, University of Galway.

Kuosmanen, T., Keppler, T., Dowling, K., & Barry, M. M. (2022). *Evidence Synthesis of Impact of Mental Health Promotion: A systematic rapid evidence assessment of the effectiveness of mental health promotion interventions across the lifecourse*. Health Promotion Research Centre, University of Galway.

McCabe, C. & Keyes, F. (2005). *A Review of Travellers' Health using Primary Care as a Model of Good Practice: Pavee Point Primary Health Care for Travellers' Project*. Dublin: Primary Health Care Project for Travellers C/o. Pavee Point Travellers' Centre. Accessible at: https://www.lenus.ie/handle/10147/45253

McGrath, A., Murphy. N, & Richardson, N. (2021). *Sheds for Life Impact Report: The Impact of Implementation Phase one on the health and wellbeing outcomes of participants*. Irish Men's Sheds Association (www.menssheds.ie) & Irish Research Council. Available at: https://menssheds.ie/wp-content/uploads/2021/06/Sheds-for-Life-impact-report-june-21.pdf

McGrath, A., Murphy, N., Egan, T., & Richardson, N. (2022). Sheds for life: health and wellbeing outcomes of a tailored community-based health promotion initiative for men's sheds in Ireland. *BMC Public Health, 22*(1), 1590. https://doi:10.1186/s12889-022-13964-6

McGrath, A., Richardson, N., & Murphy, N. (2022a). Strategies for effective implementation and scale-up of a multi-level co-designed men's health initiative "Sheds for Life" in Irish Men's Sheds. *Frontiers in Health Services, 2*. https://doi:10.3389/frhs.2022.940031

Michael, L., Marchelewska, E., Omidi, N. & Stewart, I. in collaboration with project participants & facilitators. (2024). *Wellbeing and Integration program for women. Evaluation Report.* Cairde. Accessible at https://cairde.ie/wp-content/uploads/2024/03/Pathways-to-Wellbeing-Empowering-Migrant-and-Refugee-Women-Mental-Health-and-Integration-2024.pdf

Michael, L., & Ogutu, G. (2024). Evaluation of a mental health and well-being programme for international protection applicants: *'Pathways to well-being: Empowering migrant and refugee women mental health and integration'* [Unpublished draft]. Cairde.

Public Health England (PHE) (2015). *A guide to community-centred approaches for health and wellbeing.* London: Public Health England

Public Health England (PHE) (2020). *Community-centred public health: taking a whole system approach.* London: Public Health England

Rickwood, D.J. and Thomas, K.A. (2019). Mental wellbeing interventions: An evidence check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for VicHealth, Melbourne, Australia. Available at: https://www.saxinstitute.org.au/evidence-check/mental-wellbeing-interventions/

World Health Organization. Regional Office for Europe. (1986). *Ottawa Charter for Health Promotion.* Copenhagen: World Health Organization. Regional Office for Europe. Accessible at https://apps.who.int/iris/handle/10665/349652

World Health Organization (2020). *Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the People*. Geneva, Switzerland: World Health Organization. Accessible at: https://www.who.int/publications/i/item/9789240010529

World Health Organization (2021). *Comprehensive Mental Health Action Plan 2013-2030*. Geneva: World Health Organization.Retrieved from: https://iris.who.int/bitstream/handle/10665/345301/9789240031029-eng.pdf?sequence=1

World Health Organization (WHO) (2022). *World Mental Health Report: Transforming mental health for all.* Geneva: World Health Organization. Accessible at https://www.who.int/teams/mental-health-and-substance-use/world-mental-health-r

Chapter 4 – Key Recommendations to Support Implementation of Community-based Mental Health Promotion Interventions for Priority Groups in Ireland

This study aimed to identify community-based mental health promotion interventions that have been implemented for selected priority population groups in Ireland who are at increased risk of poor mental health outcomes. These groups were defined as:

- Ethnic minority populations including Traveller communities and Roma communities
- Migrants and refugees
- People living with disability and their families
- People experiencing social isolation and loneliness
- People living in deprived and disadvantaged communities
- Family carers
- People who have experienced domestic sexual and gender-based violence
- Members of the LGTBQI+ community.

The overall project aim was to review national and international best practice to inform a set of recommendations on community-based mental health promotion initiatives for priority populations that could be appropriately resourced and scaled in the Irish context. At the conclusion of this project, findings were consolidated from the three perspectives from each phase of the project:

- The process of identifying priority populations in Ireland who are at higher risk of poor mental health outcomes.
- A scoping review of the evidence on community-based mental health promotion interventions for priority groups.
- Consultations with stakeholders in Ireland who work with priority groups and who are implementing community-based mental health promotion and community development interventions for their priority groups.

Findings and insights from these phases of the project were synthesised in order to provide a set of key recommendations to support effective implementation of community-based mental health promotion interventions that could be feasibly adopted and scaled-up in the Irish context. These recommendations are presented on the following page to conclude this report.

KEY RECOMMEDATIONS

- A whole-systems approach is needed to ensure that community-based mental health promotion is positioned within a broader plan to address the social determinants of health that are at the root of the health discrepancies experienced by priority population groups.
- Policy action planning and dedicated funding streams should reflect a commitment to community development and partnership approaches. As meaningful participation is central to these approaches, these commitments will also foster meaningful participation within priority communities.
- Supporting organisations, and particularly smaller organisations, with national training and guidance on mental health promotion will help ensure they have the capacity to pro-actively address the needs of their communities while ensuring cohesion across communities in Ireland. This is particularly important given that the terminology used is so different in the Community and Voluntary sector.
- Commitment to an initial trust-building phase that establishes the optimal conditions for engagement is critical for future community-based mental health promotion efforts. Effective implementation is enhanced with the ability to respond to changing contexts and community dynamics. Core, stable funding and resources enable initial community engagement and a level of autonomous problem solving.
- Sustainable resourcing that reflects the long-term nature of community-based mental health promotion outcomes will ensure that efforts maintain integrity and consistency. Additionally, supportive infrastructure beyond the initial intervention development and delivery is key to ensure community engagement is supported sustainably.
- Streamlined referral pathways and upskilling for health services is needed so that frontline staff are aware of community services and can engage appropriately with an intercultural and gender-affirming approach.
- Building upon existing initiatives for priority groups that have existing infrastructure in Ireland can afford ‘early wins’ that can help establish momentum. This includes co-adapting existing evidence-informed programmes and co-delivering them with priority groups. Social Prescribing services, Men’s Sheds, and Community Mothers are a few examples. Efforts that are not currently evidence-informed should endeavour to be more structured and documented, to build the evidence base.
- Mapping community assets collaboratively will strengthen asset-based approaches to promoting community mental wellbeing, such as identification of the key role of Family Resource Centres.
- To be most effective, peer- and volunteer-led approaches should be supported with training, upskilling, supervision and other intervention supports.
- Methods of communication should be tailored to ensure that information is accessible, culturally appropriate and reflects the preferences and needs of priority groups.
- Community-led evaluation will encourage ownership, strengthen the evidence base and ensure that efforts are on-track, while reinforcing political commitment. Communities will need guidance and resources to build their capacity for meaningful evaluation of community-based mental health promotion.

APPENDICES

APPENDICES FOR CHAPTER 1 – DEFINING PRIORITY POPULATION GROUPS AT RISK OF POOR MENTAL HEALTH OUTCOMES

Appendix 1.1 Identifying Priority Groups Search Terms

Population*	**AND**	**vulnerable**	**AND**	**"mental health"**
OR		**OR**		**OR**
Group*		**underserved**		**"well-being"**
		OR		**OR**
		disadvantaged		**wellbeing**
		OR		**OR**
		marginalised		**"mental disorder"**
		OR		**OR**
		deprived		**"mental illness"**
		OR		**OR**
		"high risk"		**"psychological health"**
		OR		**OR**
		"at risk"		**"mental disease"**
				OR
				stress
				OR
				Depress*
				OR
				Anxiety
				OR
				"mood disorder"
				OR
				"psychiatric"

Appendix 1.2 Identifying Priority Groups Data Tables

Table 2. *Priority groups identified in national policy documents*

Policy	Overview
Connecting for Life. Ireland's National Strategy to Reduce Suicide 2015-2020.	Priority groups in this document include: People with mental health problems of all ages; People with alcohol and drug problems; People bereaved by suicide; Members of the LGTB community; Members of the Traveller community; People who are homeless; Healthcare Professionals; and Prisoners. Other groups with potentially increased risk of suicidal behaviour where the research evidence is either less consistent or limited include: Asylum seekers; Refugees; Migrants; Sex Workers; and People with a chronic illness or disability (CSO suicide statistics and National Registry of Deliberate Self-Harm). Irish studies also found specific factors such as young people; unemployed people; and marginalised groups like men living in rural communities, and survivors of institutional sex abuse.
Connecting for Life. Implementation Plan 2023-2024.	Priority groups as defined in Connecting for Life (2015-2020), and: Those who have engaged in repeated acts of self-harm; people who come in contact with the criminal justice system (e.g., prisoners), people who have experienced domestic, clerical, institutional, sexual, or physical abuse, middle aged men and women, and economically disadvantaged people; and professionals working in isolation (e.g., veterinarians, farmers).
Sharing the vision: A Mental Health Policy for Everyone (Irish Department of Health, 2020).	Priority groups are defined as in Connecting for Life (2015-2020), adding the following groups across the lifecycle: Childhood: Children who have been exposed to Adverse Childhood Experiences (ACEs) such as domestic violence, alcohol or drug abuse, mental health difficulties and bereavement. Adulthood: unemployment and financial insecurity Older people: reduced mobility, chronic pain, frequent illness, loneliness, loss, and bereavement. Additional groups include: children in care, care leavers; and people who have severe-to-profound deafness.
Better Outcomes: Brighter Futures (2014-2020).	Priority groups include: Child victims of trafficking; Those in care and whose families are not able to care for them; children members of the Travelling and Roma communities; Migrant and asylum-seeking children; and children with special needs. In addition, groups who may be particularly vulnerable to bullying and discrimination: LGBT; those in detention or in care; and children and young people from minorities.

Stronger Together: The HSE Mental Health Promotion Plan (2022-2027).	Priority groups as defined in Connecting for Life (2015-2020)

Table 3. *International surveys and reports – a brief overview of prevalence of and risk factors to mental health.*

Study / Report Name & brief overview	Prevalence and risk factors (age, sex & other factors)	Region of Focus
The Global Burden of Disease Report 2019	More than 1 of 10 (or 293 million) individuals aged **5 to 24 years** globally live with a diagnosable mental disorder. One-fifth of all disease-related disability (considering all causes) attributable to mental disorders among this population (Kieling et al., 2024).	Global
Eurobarometer Flash Report – Mental Health- June 2023 Respondents Age 15+, across 27 member states, data collected June 2023	46% report depression/anxiety last 12 months **AGE 15- 24** group most at risk 52% **Females** vs 39% males –report psychosocial difficulties **Risk factors**: living conditions, financial security, social media, social contact.	Europe
Mental Health of Children & Young People in England 2023 (Wave 4 –follow up to 2017 survey) Respondents rate: 2,370, aged 8-25 yrs data collected Feb - April 2023	1 in 5 of 8-25 yrs. "probable mental disorder"- Age 20-25 most vulnerable 8-16 yrs. Male: Female equal risk 17-25 yrs. Male: Female 1:2 **Risk Factors:** socioeconomic factors, bullying, climate change concerns	UK
Mental Health Australia 2023 Report to the Nation Respondents 2,133 18+yrs, 308 0-17 yrs. Data collected June 2023	**Age 18-39** yrs- most at risk Females significantly lower MH rating than Males **Risk factors**: housing crisis, rising cost of living **Vulnerable populations identified:** indigenous people, carers, LGBTQI+, people with experience of poor mental health.	Australia
Mental Health Research Canada (January 2024 National survey), 6–12-week intervals 3,224 respondents	**Worst self-rated MH since pandemic ended** **Age 18-34 yrs.** most at risk **Risk Factors:** personal screen time, climate change concerns, chronic pain, economic concerns, access to affordable MH support	Canada

Table 4. *Life stage specific risk factors for poor mental health – international evidence*

Risk factors **across all life stages**:

Age, gender, socioeconomic status, social connectedness, exposure to neglect, violence, abuse (physical/sexual), living in poverty, living with chronic illness, bereavement, access to services…..

Life stage specific risk factors:

Childhood	**Adolescence/ Young Adults**	**Adulthood**	**Older adults**
	Prior adverse life experiences, those who become carers, educational attainment, employment status…		
Parental MH Quality of family life (structure, parenting) ACE (Adverse Childhood experiences)	Pressure to conform, exploration of identity, peer relations, quality of home life (WHO, 2021) Substance misuse (Gariépy, Danna, Hawke, Henderson, & Iyer, 2022) Climate change concern (Newlove-Delgado T, 2023) Depressive symptoms, poor educational attainment increase risk to NEETS (Veldman et al., 2022)	Male / female Female: Perinatal period (Agrawal, Mehendale, & Malhotra, 2022; Wong et al., 2023) Intimate partner violence (White et al., 2024) Adolescent MH (Castelpietra et al., 2022; Clarke & Lovewell, 2021)	Social isolation & Loneliness Ageism Abuse Being an older carer (spouse) (WHO, 2023)

Table 5. *Risk factors for poor mental health of vulnerable population groups – international evidence*

Vulnerable group specific risk factors:

Migrants	**LGBTQ+**	**Disability**
Marginalisation, legal / social discrimination, stigma, bullying, social exclusion / lack of social connectedness		
• Immigration system & process, residency/legal status • Communication/language barrier (Abubakar et al., 2018; Gleeson et al., 2020). • Separation of families, pre-migration exposure to armed conflict (Mesa-Vieira et al., 2022) • Living conditions in host country: suitability, lack of control, unpredictability (Hou et al., 2020; Jannesari, Hatch, Prina, & Oram, 2020).	Gap in qualitative research – limited understanding. • Sub-group specific risk factors (Tankersley, Grafsky, Dike, and Jones (2021). • Minority stress • 59 unique risk factors (e.g.: bathroom safety, transphobia experiences, access to affirmative medical care, specific legal discriminations) (Wallace, O'Neill, & Lagdon, 2024) • Intersectional variables evidenced by Hill, Bourne, Mc Nair, Carman, Lyons (2020): LGBTIQ+ with disability, form multicultural backgrounds, living in rural /remote areas = > risk.	• Subgroup specific risk factors: -neurodiversity -intellectual disability -physical disability -acquire disability. (Mahjoob et al., 2024) (Totsika, Liew, Absoud, Adnams, & Emerson, 2022) • Ableism (Kattari, 2020).

Table 6. *Life stage specific risk factors – national Evidence*

Childhood	Adolescence/Young Adults	Adulthood	Older people
Children who have experienced: Negative life events (e.g. family violence) (IDH, 2020; ESRI, 2021). Low sense of connection to schools (ESRI, 2021). Bullying (Planet Youth; Silke et al., 2024). Children in care (Coulter et al., 2020). Lower social class groups (GUII; Smyth et al., 2022). Children from one parent families (ESRI & TCD, 2023). Authoritarian parents/high levels of criticism (Kotera & Maughan, 2020).	Care leavers (Power et al., 2015). Early School Leavers (My World Survey. Dooley et al., 2019). Young people engaged in after-post primary education that is not higher education (My World Survey. Dooley et al., 2019). Women aged 15-24 (Ipsos MRBI, 2023; Silke et al., 2024).	People who is unemployed (Ipsos MRBI, 2023; Power et al., 2015). People living in rural communities (Cleary et al., 2012). People living with financial insecurity (My World Survey. Dooley et al., 2019) People living in urban areas (Healthy Ireland Survey, 2023). Parents/Guardians of children with disabilities (Growing up in Ireland. Gallagher & Hannigan, 2014) Carers (College of Psychiatrists of Ireland, 2019).	Isolation (TILDA; Ward et al., 2022). Childhood sexual abuse (TILDA; Kamiya et al., 2015).

APPENDICES FOR CHAPTER 2 – SCOPING REVIEW OF THE EVIDENCE ON COMMUNITY-BASED MENTAL HEALTH PROMOTION INTERVENTIONS FOR PRIORITY GROUPS

Appendix 2.1 Scoping Review Search Terms

Table 1 Search concepts and terms

PRIOIRTY POPULATION TERMS		MENTAL HEALTH TERMS		INTERVENTION TERMS		SETTING TERMS
LGTBQ+ OR "sexual and gender minorities"	AND	"Mental health"	AND	Intervention*	AND	Communit*
OR		OR		OR		OR
Travel* communit*		"Well-being"		support		"Community-based"
OR		OR		OR		OR
Roma		wellbeing		Program*		Service*
OR		OR		OR		OR
Asylum seeker		"social inclusion"		Promot*		Grassroot*
OR		OR		OR		
Refugee*		psychosocial		population approach*		
OR		OR		OR		
Migran* OR Transient		Social emotional		education		
OR		OR		OR		
Depriv* communit*		Psychological health		training		
OR				OR		
Disadvantage* communit*				Prevent*		
OR						
Chronic Ill* OR Chronic diseas*						

OR						
Carer* OR Caregiver*						
OR						
NEET OR Not engaged in education, employment or training						
OR						
Social isolation						
OR						
Lonel*						
OR						
Domestic Violen*						

Note: **Denotes any ending including singular/plural, "" denotes phrase search*

Appendix 2.2 Scoping Review Data Extraction Tables

Table 3 People living with disabilities

Author, Year, Country, Type of review	Aim of Review	Number of studies included in review	Number of studies which report on community-based mental health interventions	Intervention type and aim	Community based mental health Intervention name, implementation details	Intervention outcomes	Overall findings of review
1) Brand et al. 2023 United Kingdom Systematic review	To outline the key characteristics of befriending interventions for adults with intellectual disabilities, to explore and synthesise the psychological and social outcomes of such interventions, and to identify future research directions required to advance the evidence base.	11.	1 (Ali et al., 2021)	One-to-one befriending for people with intellectual disabilities and depressive symptoms. Aim: To provide emotional support and to facilitate access to activities in the community for adults with ID.	Ali et al (2021) Pilot RCT (participants (N = 16) were randomised to the intervention group (matched to a volunteer befriender (N = 12) for 6 months or the control group who received usual care). One hour weekly; >50% of activities to be community-based. Sample activities: visiting cafes/restaurants, walks, conversation at home.	Increase in social participation outcome measures for both control and intervention groups. Lower depression scores after 6 months in the intervention group compared with the control group. [mean GDS-LD scores of 12.9 (SD: 6.7) and 17.5 (SD: 6.5), respectively]. * Not statistically significant	Increased community participation, positive changes to social networks and mood were frequently reported outcomes for befriendees. Increased knowledge, new experiences and opportunities to 'give back' were most reported for befrienders.
2)Giummarra et al. 2022	This review systematically identified and	522	17 studies reporting mental health outcomes; n = 10, plus	**1)** Active and passive animal	**Animal companionship** (typical	**Animal Companionship Interventions**:	Overall, interventions that support people to

Australia Systematic review	synthesised the available evidence of the effectiveness of interventions or supports for improving social, civic and community participation of people on the autism spectrum, or who have intellectual or psychosocial disabilities		studies reporting emotional/psychological wellbeing n=7)	companionship interventions **2)** Enhancing community linkage **3)** Befriender Programmes **4)** Peer-based befriending programmes **5)** community-based peer support groups; **6)** community group participation **7)** music-based programmes **8)** Farm, ecotherapy, gardening and horticultural interventions and groups for people with psychosocial disabilities. **9)** Outdoor recreation and leisure programs	intervention): 14 X 1 hour walking Sessions continuous or 50 mins to 3-hrs p/w **Community group participation linkage** (typical intervention): 30-min staff introduction or 30 hours of meetings with a recreational therapist over 9-10 weeks. **Befriending interventions with a non-disabled volunteer:** 2 hrs/week for 6weeks to 12 months **Peer-based befriending programs:** 35-38 X 3-hour sessions **Peer support in the community:** 1.5 to 2 hour sessions for 4-weeks up to 12-months **Community group participation:**	Improvements in social-adaptive functioning, reduction in depression symptoms, and enhancements in self-esteem, self-determination, and psychiatric symptoms. Study quality: Low to moderate. **Community Linkage**: Increased social networks, reduced loneliness, and no increase in service support costs. Study quality: Low to high. **Befriender Programs**: No effects on loneliness, social functioning, networks, well-being, or psychiatric symptoms, but increased perceptions of social support. Study quality: Moderate to high. **Peer-Based Befriending Programs**: Increased social	have both the capacity and access to social and community participation opportunities improved participation for people on the autism spectrum, and with intellectual or psychosocial disabilities. It is important that people have access to personalised supports, where possible, and that they are given the opportunity to practice skills with active support or mentoring in the community in real-life settings.

					1.5-to-2-hour sessions for 4-weeks up to 12-months **Music based programmes:** 1 to 6 sessions for a total of 45 mins to 2 hours per week **Art-therapy:** 2 hours per week to unlimited access to an open studio **Farm, ecotherapy, gardening and horticultural interventions:** 1 to 3 sessions of 1.5-3 hours per week 2 X to 3 hours sessions per week for 12 weeks **Outdoor recreation and leisure programs**: 1-5 weekly 1-3 hour sessions	contacts and perceived support, improved mental health, but no effect on loneliness, social network size, psychiatric symptoms, or service use. Evidence: Inconsistent. **Community-Based Peer Support Groups**: Felt welcoming and promoted social belonging and connectedness. Mixed results in well-being, social belonging, connectedness, empowerment, hope, and self-efficacy. **Community Group Participation**: Improved social satisfaction and social network, but no change in loneliness, depression, physical health, or quality of life. Study quality: Low to high.	

						Music-Based Programs: Reduced anxiety, inconsistent effects on depression, cognitive functioning, psychiatric symptoms, and quality of life. Study quality: Low to moderate. **Art-Based Activities**: Increased social inclusion, sense of belonging, engagement, mutual support, social connections, friendships, meaning in life, self-esteem, happiness, and confidence. Study quality: Low. **Farm, Ecotherapy, Gardening, and Horticultural Interventions:** Reductions in loneliness, increased social activity and participation. Study quality: Low to high. **Outdoor Recreation and Leisure Programs**:	

						Enhanced connectedness, relationships, personal growth, confidence, well-being, self-determination, empowerment, and reduced loneliness and depression. Study quality: High.	

Table 4 People experiencing loneliness and isolation

Author, Year, Country, Type of review	Aim of Review	Number of studies included in review	Number of studies which report on community-based mental health intervention	Intervention type and aim	Community based mental health intervention name, implementation details	Intervention outcomes	Overall findings of review
1) Li et al 2018 Singapore Systematic review	To synthesize existing studies on the social effects of exergames on older adults. * Exergames involve a combination of digital gaming and physical exercise.	10	N = 3 (studies reporting loneliness n= 2 (Jung et al. 2009; Kahlbaugh et al., 2011); studies reporting loneliness and social anxiety n= 1 (Xu et al., 2016)) .	**Jung et al (2009)** To compare playing exergames (N=30) with playing traditional board games (N=15) **Kahlbaugh et al (2011)** To compare playing exergames with a partner (N=16) with watching television programs with a partner (N=12) with no visits (N=7) **Xu et al (2016)** To compare playing exergames with their peers (N=31), playing with an adolescent (N=26), and playing alone (N=31)	**Jung et al (2009)** 3 sessions per week over 6 weeks. **Kahlbaugh et al. (2011)** One session per week over 10 weeks. **Xu et al (2016)** 3 sessions per week over 1 week.	**Jung et al (2009)** Decrease in loneliness. (t43=5.34, P<.01) **Kahlbaugh et al (2011)** Decrease in loneliness (F2,30=6.24, P<.005) **Xu et al (2016)** Significant decrease in loneliness (F1,83=.57, P<.05) No significant change for social anxiousness Significantly increase in sociability after playing exergames (F1,83=3.95, P=.050)	Overall, the majority of exergame studies demonstrated promising results for enhanced social well-being, such as reduction of loneliness, increased social connection, and positive attitudes towards others. The implications for health care researchers and exergame designers are also discussed.
2) Reindhardt et al. 2021	To assess the impact of social prescribing	9	3 (studies reporting loneliness and wellbeing n= 3)	**Museums on Prescription (Todd et al., 2020).**	**Muesum on Prescription**	**Museum on Prescription (Todd et al., 2020)**	Individuals and service

UK Systematic review	(SP) programmes on loneliness among participants and the population			Case study (N=20) Aim: To support the wellbeing of socially isolated and lonely older people by assessing the impact of participation in 12 Museum on Prescription programmes. **Doncaster Social Prescribing (Dayson et al., 2016).** Pre-post study (N=215) Aim: To help with the effects of long-term physical and mental health conditions. **Wellspring Wellbeing Programme (Kimberlee et al., 2014).** Pre-post study design (N=128) Aim: To connect, be active, take notice, keep learning and give.	Implementation details not reported. **Doncaster Social Prescribing** 254 participants completed an intake questionnaire and either 3- or 6-month follow-up **Wellspring Wellbeing Programme.** 128 Participants completed interviews and questionnaires pre and post intervention.	Participants reported feeling less lonely, more able to develop meaningful connections and friendships, greater confidence, more mental stimulation, and more feelings of happiness. **Doncaster Social Prescribing (Dayson et al., 2016)** Participants felt less isolated or alone post-participation, 'feeling like they had someone they could turn to'. 19% increase in people having 'enough social contact' * No direct evidence or discussion on the loneliness measure used **Wellspring. Wellbeing Programme. (Kimberlee et al., 2014)** Decreased in social isolation from 67.8% (n=59) to 33.4%	providers view SP as a helpful tool to address loneliness. More research is needed into the impact of SP programmes on participants, populations, and communities in terms of loneliness, isolation, and connectedness, especially in light of the surge in SP activity as a key part of pandemic response

						(n=15) 3 months post-intervention	
3) Hoang et al. 2022 Canada (specific countries not reported) Systematic review	To evaluate interventions, targeting older adults, associated with a reduction in loneliness and social isolation	70	31 (studies in community settings; mental health outcomes not reported) **Total numbers do not match with the previous information*	**Animal Therapy:** 2 studies were done in community settings. Aim not reported. **Combination and multicomponent interventions:** 2 studies were done in community settings. Aim not reported. **Exercise:** 5 studies were done in community settings. Aim not reported. **Music:** 1 community study. Aim not reported. **Occupational therapist-guided interventions:** 2 community-based studies. Aim not reported. **Social Intervention:** 5 community-based studies. Aim not reported. **Technology:** 7 community-based studies. Aim not reported.	**Animal Therapy:** Generally, participants interacted with living animals such as dogs or robotic animals (seals or dogs). **Combination and multicomponent interventions:** Interventions included exercise with arts and crafts, home care with nursing outreach and educational resources, Tai Chi and CBT, and pain management programmes. **Exercise**: Dance, yoga, Tai Chi, and strength and balance training delivered in group format **Music**: Interventions included group rhythm instruments and a choir programme **Occupational Therapist-guided interventions:** Interventions	**Outcome:** Loneliness reduction **Animal Therapy:** ES of −0.41 (95% CI, −1.75 to 0.92; I 2 = 87%; P = .005) **Combination and multicomponent interventions:** ES was −0.67 (95% CI, −1.13 to −0.21; I 2 = 0%; P = .704) in community **Exercise:** ES was −0.15 (95% CI, −0.44 to 0.15) and heterogeneity was low (I 2 = 35%; P = .19) in community **Music:** ES of −0.34 (95% CI, −0.55 to −0.13). **Occupational Therapist-guided interventions:** ES was −0.63 (95% CI, −1.96 to 0.71) with substantial heterogeneity (I 2 = 90%; P = .002) **Social Intervention:** ES was −0.02 (95% CI, −0.21 to 0.17)	In this study, animal therapy and technology in long-term care had large effect sizes, but also high heterogeneity, so the magnitude of the effect size should be interpreted with caution. The small number of studies per intervention limits conclusions on sources of heterogeneity. Overall quality of evidence was very low.

					included occupational therapist-guided technology or assistive devices training. **Social Intervention:** Interventions included befriending a volunteer, formation of social groups with discussion topics, and intergenerational programming. **Technology:** Interventions included computer training (in person or online), videoconferencing (either with family or a trained interviewer), and pedometers to provide fitness goals and track activity.	with low heterogeneity (I 2 = 7%; P = .37) **Technology**: ES was −0.19 (95% CI, −0.51 to 0.14; I2 = 59%; P = .03)	
4) Lee et al. 2021 UK Systematic scoping review	To explore the breadth and characteristics of the recent UK literature on community-based interventions intended to address (non-clinical) risk factors for poor mental health in older age.	54	54 Connector Interventions = 12 (6 reporting social isolation/loneliness) Gateway Interventions = 7 (5 reporting social isolation/loneliness) Direct interventions = 36 (17 reporting	**Connector Interventions** (n=12; 6 reporting on social isolation/loneliness): Provide support to access and engage (with direct support available in communities, such as social activities or befriending).	**Details of 30 papers in Lee et al. (2021)*	**Details of 30 papers in Lee et al. (2021)*	The literature is wide-ranging in focus and methodology. Greater specificity and consistency in outcome measurement are required to evidence effectiveness – no single category of intervention yet

			social isolation/loneliness) System approaches = 4 (2 reporting social isolation/loneliness)	**Gateway Interventions** (n=7; 5 reporting social isolation/loneliness): Optimise infrastructure that helps older adults to connect or remain connected with their community. Examples include the built environment, digital/technology; and community transport. **Direct Interventions** (n=36; 17 reporting on social isolation/loneliness)**:** To support older adults to maintain and improve social connections and relationships. Includes intervening to directly support forming of new connections and social activities and psychosocial support to change thinking and actions. **System approaches** (n=4; 2 reporting social isolation/loneliness)**:** Concerned with			stands out as 'promising'. More robust evidence on the active components of interventions to promote older adult's mental health is required.

				developing community environments supportive of older adults' mental health. The actions of key stakeholders in public mental health (e.g. local government, NHS, community, voluntary and faith sectors, local businesses) working together to enable and facilitate community-based actions that respond to local strengths, needs and context.			
5) Gunnes et al. 2024 Norway Scoping review of reviews	This scoping review of reviews aims to map and synthesize existing evidence on the effectiveness and scope of Information and Communication Technology (ICT) interventions targeting loneliness and social isolation in community-dwelling older adults, elucidating types of technology, impacts, facilitators, barriers, and research gaps	39	25 (Studies reporting mental health (anxiety and depression) = 16) *Setting: 'Virtual communities'	Individual intervention and aims are not reported	Individual programme characteristics are not reported	Individual results are not reported. Overall, the majority of the reviews evaluating the impact of Social Networking sites (SNSs) and other types of Internet-supported communication reported positive effects on reducing social isolation and loneliness. However, some reviews reported mixed results and	This review sheds light on the diverse range of ICTs, their impact, and the facilitators and barriers associated with their use. Future investigations should prioritize refining outcome measures, addressing gender differences, and enhancing the usability and accessibility of interventions.

						found the relationship to be inconclusive It was noted that the positive effects were primarily short-term and did not persist for more than 6 months. Passive engagement in social networking sites was associated with participants' experiencing higher levels of loneliness than those in direct communication via social networking site	
6) Yu et al. 2023 China Systematic review	To identify and compare the effects of various non-pharmacological interventions on loneliness in community-dwelling older adults.	37 (n=14 studies reporting mental health)	N = 3 (Li et al. (2017); Singapore, Larsen et al. (2021); Sweden, Baez et al. (2017); Italy) (Li et al., 2017; Larsen et al., 2021; Baez et al., 2017)	All 3 were exercise with social engagement interventions *Individual intervention and aims are not detailed	Individual programme characteristics are not reported	Individual results are not reported. Consistent with the results for non-digital social support interventions, active care ingredient to promote social interaction might be crucial to combat loneliness through exercise engagement. Nevertheless, the small number of studies precludes subgroup analysis to confirm this observation.	This review highlights the more superior effects of psychological interventions in improving loneliness among older adults. Interventions which have an attribute to optimize social dynamic and connectivity may also be effective.

7) Foettinger et al. 2022 Germany Mixed methods systematic review *Individual studies were predominantly conducted in Australia, UK, Ireland, New Zealand, Canada and Denmark.	To provide an extensive overview of current research on the effectiveness of Men's Sheds on self-rated health, social isolation, and well-being by applying a mixed method approach.	52	52	Individual aims are not reported	Individual characteristics are not reported	Individual results are not reported Participation in Men's Sheds is associated with subjective well-being, especially for people with diagnosed mental health.	While there is evidence for the relationship between Shed participation and each individual outcome (self-rated health, subjective well-being, and social isolation), the analysis also showed that these outcomes are strongly interwoven with each other. Referring to improvements in mental health, "Aspects that are frequently said to contribute to better mental health include better physical health and energy levels, improved confidence, better partner relationships, new friendships, etc." (Flood & Blair, 2013, p. 17)
8) Fischer & Hartle 2023 Brazil & New Zealand	To summarise clinical trials from 2020-2022 that assess loneliness as an outcome measure, evaluating the research	82 *Mental health outcomes not reported	Individual papers characteristics are not reported.	Individual papers characteristics are not reported.	Individual papers characteristics are not reported. However, group-based interventions focusing on social identity as a key	Individual papers characteristics are not reported.	Lack of social identity may be determinants of higher rates of loneliness in big cities, especially for

Meta-analysis	landscape and the effectiveness of interventions in urban settings.				cognitive factor may be especially effective in enhancing health and reducing loneliness. An example is the Groups 4 Health program, which has shown promise in recent studies involving younger adults. A randomised controlled trial with young adults in Australia compared this programme to traditional cognitive-behavioural therapy, finding improvements in both depression and loneliness for participants in both groups.		minority groups and new communities. .

Table 5 People living in deprived and disadvantaged communities

Author, Year, Country, Type of review	Aim of Review	Number of studies included in review	Number of studies which report on community-based mental health interventions	Intervention type and aim	Community based mental health Intervention name, implementation details	Intervention outcomes	Overall findings of review
1) Harrison et al. 2023 UK Narrative review	To identify and evaluate the benefits of Nature-Based Interventions (NBIs) in socio-economically deprived communities.	18	5 (studies reporting mental health or wellbeing n= 5)	Community nature-based interventions (home gardening; community gardening; sustainable building and park prescriptions) **Chalmin-Puy et al. (2021); UK** Within subjects and between subjects **Korn et al. (2018); Peru** Within-subjects. **Gray et al. (2022);** Australia Within-subjects. **Davies et al. (2020); UK** Within-subjects **Razani et al. (2018); USA** Between subjects (alternative intervention)	**Chalmin-Puy et al. (2021)** Home gardening. (n = 42) **Korn et al. (2018)** Home Gardening. (n = 44) **Gray et al. (2022).** Community gardening. (n = 23 + 42) **Davies et al. (2020).** Sustainable building project. (n = 93 young people NEET+ 55 asylum seekers, unemployed, and men with depression) **Razani et al. (2018).** Park prescriptions. (n = 78)	**Chalmin-Puy et al. (2021)** Significant decrease in perceived stress post-intervention Statistically significant improvements in cortisol patterns No significant difference in wellbeing scores post intervention **Korn et al. (2018)** Non-significant increase for QoL at 6 months and 12 months Increase in perceived stress scores at 6 and 12 months. **Gray et al. (2022)** Decrease in satisfaction with health (M=64 years for those who reported being less satisfied with their health post-test compared with M=52 years for	Gray et al. (2022) suggest that an increased self-awareness of health limitations through the gardening process may have contributed to the decrease in satisfaction with health post-intervention of some participants. Additionally, the average age of participants was an influencing factor (see outcomes). Results demonstrate there are clear benefits of NBIs on economic, environmental, health and social outcomes. Further research including qualitative analyses, more stringent experimental

						those who reported improved satisfaction with their health post-test) Increase in shared emotional connection score **Davies et al. (2020)** Decrease in depression scores (large effect), anxiety (large effect) and resilience (medium to large effect) * For participants that had baseline scores falling at or below the cut-off threshold only Significant increase in social connection for young people NEET who reported difficulty at baseline **Razani et al. (2018)** No statistically significant change in perceived stress between the intervention and comparison groups (supported and independent park prescription groups) at the 1 or 3-month follow-ups	designs and use of standardised outcome measures is recommended

2) Tracey et al. 2023 Australia Systematic review	To identify the benefits of community gardening (CG) for vulnerable populations reported in the literature and determine if there are specific program characteristics associated with such benefits	33 (studies reporting mental health n= 21)	1 (Jackson & Ronzi, 2021); UK	Community-based participatory research (CBPR) approach Study collected information on demographics, perceptions, experiences of CG, and CGs' impact on health, wellbeing, and community inclusion. *Aim not specified.	Implementation details not reported.	Results not reported.	Findings revealed that CG provides a wide range of benefits for vulnerable populations, with social connection, health, education, and nutrition being the more commonly cited. The quality of studies was evaluated as moderate with little information provided about program characteristics.

Table 6 Carers of people who experience chronic illness

Author, Year, Country	Aim of Review	Number of studies included in review	Number of studies which report on community-based mental health interventions	Intervention type and aim	Community based mental health intervention name, implementation details	Intervention outcomes	Overall findings of review
1) Sherifali et al. 2018 Canada Systematic review and meta-analysis	To examine the impact of internet-based interventions on caregiver mental health outcomes and the impact of different types of internet-based intervention programs.	13	3 (Blom et al. (2015); Netherlands, Hattink et al. (2015); UK and Netherlands, Smith et al. (2012); USA)	**Hatink et al. (2015)** Internet-based information or education plus professional psychosocial support (PPS) intervention **Blom et al. (2015)** Internet-based information or education plus peer and professional psychosocial support (PFPS) intervention **Smith et al. (2012)** Internet-based information or education plus combined intervention.	**Hattink et al. (2015)** (N = 142) Information or education plus PPS intervention Participants: caregivers of people with dementia Included personalized training portal and 2-4 months of course materials, interactive exercises, and connection with a Facebook community. **Blom et al. (2015)** (N = 149 + N = 96) Information or education plus PFPS intervention Participants: caregivers of people with dementia Included both a Web-based 8-week course and coaching,	Positive programme effects on mental health outcomes across all 3 studies: depression (Bloom et al., 2015; Smith et al., 2012), anxiety (Bloom et al., 2015), stress (Hattink et al, 2015), and QoL (Hattink et al, 2015) *Heterogeneity wrt types of internet-based interventions	The review found evidence for the benefit of internet-based intervention programs on mental health for caregivers of adults living with a chronic condition, particularly for the outcomes of caregiver depression, stress and distress, and anxiety.

					monitoring, and evaluation Facilitator: psychologist **Smith et al. (2012)** **(**N = 15 & N = 17) Information or education plus combined peer and professional psychosocial support intervention Participants: spousal caregivers of stroke survivors 11-week educational programme supported by an experienced cardiovascular nurse manager.		
2)Ruggiano et al. 2018 USA Systematic review	This systematic review sought to address the following questions: (a) What types of technological platforms are used for interventions targeting dementia caregivers? (b) To what extent do researchers identify rural/urban community settings as a relevant variable? (c) To what extent are such interventions	30	1 (Torkamani et al. (2014); UK, Spain and Greece)	A computer-based platform that provides education, social networking, care recipient assessments, and alert system to contact provider.	Torkamani et al. (2014). ALLADIN. RCT (n=60) Participants: caregivers of those with Alzheimer's disease and related dementias Duration: 6-months.	Decrease in burden, No significant difference in distress Increase in QoL *Sample size too small to determine efficacy.	Studies were more likely to report improved psychosocial outcomes of intervention groups, with few reporting positive effects on caregiving skills/self-efficacy.

	tested among rural dementia caregivers? and (d) To what extent are technology-based interventions effective in supporting and educating dementia caregivers?						
3) Boyt et al. 2022 UK Systematic review Griffiths et al (2016). USA Gustafson et al (2019). USA Cristancho-Lacroix et al (2015). France. Finkel et al (2007). USA.	To explore the effectiveness of internet-delivered interventions in improving psychological outcomes of informal caregivers for neurodegenerative-disorder (ND) patients	51	4	**Griffiths et al. (2016); USA** Individual (psychoeducation) group (social forum). **Gustafson et al. (2019); USA** Individual psychoeducation group (social forum). **Cristancho-Lacroix et al. (2015); France** Individual psychoeducation group (social forum). **Finkel et al. (2007); USA** Individual psychoeducation group (social forum)	**Griffiths et al. (2016) (**N = 30) Daily internet-delivered video modules (six per week) plus weekly group videoconferences over 6 weeks **Gustafson et al (2019) (**N = 31) Website providing access to online Forum, professional messaging Service, access to multimedia information & areas to enter individual information **Cristancho-Lacroix et al. (2015) (**N = 25 + N = 24) Multimedia website providing information modules and	Individual results are not reported.	This review demonstrated some evidence for the efficacy of internet-delivered interventions targeting informal ND-caregivers. However, more rigorous studies, with longer follow-ups across outcomes and involving NDs other than dementia, are imperative to enhance the knowledge base

					anonymised peer access via an online forum. Accessed via Internet- connected computer. **Finkel et al. (2007)** **(**N = 46) Computer-Telephone Integration System (CTIS) providing access to caregiving information, facility to make & receive calls, send & retrieve messages, conference with several people simultaneously.		
4)Liu et al. 2018 China Cochrane systematic review	To assess the electiveness of mindfulness-based stress reduction (MBSR) in reducing the stress of family carers of people with dementia.	5	3 (n=3 studies from the USA that had depressive symptoms as their primary outcome, and anxiety as secondary outcome. (Brown et al., 2016; Oken et al., 2010; Whitebird et al., 2013)	**Brown et al. (2016)** RCT with parallel group (N = 38) **Oken et al. (2010)** RCT with parallel group (N = 28). **Whitebird et al. (2013)** RCT with parallel group (N = 78).	**Brown et al. (2016)** Underpinning theoretical model: MBSR (Kabat-Zinn, 2013) 8-week programme, with MBSR weekly groups and a social support group **Oken et al. (2010)** Underpinning theoretical model: MBSR (Kabat-Zinn, 2013) and cognitive theoretical framework	Three trials found that MBSR can reduce carers' depressive symptoms compared to active control interventions (SMD -0.63; 95% CI -0.98 to -0.28; P<0.001; 135 participants; low-quality evidence). One trial also suggested MBSR might reduce carers' anxiety compared to active controls (MD -	Results from three studies involving 135 carers indicated that those receiving MBSR may experience lower depressive symptoms post-treatment compared to those receiving an active control treatment. However, there was no clear evidence of any effect on depression when MBSR was

					7-week programme with weekly mindfulness meditation and weekly group education. **Whitebird et al. (2013)** 8-week programme, with weekly group MBSR and standard community caregiver education and social support (CCES). *MBSR practices included body scans, mindful hatha yoga, sitting meditation, and other mindfulness practices	7.50; 95% CI -13.11 to -1.89; P=0.009; 78 participants; low-quality evidence). *High risk of bias and imprecision reported	compared to an inactive control treatment. Additionally, mindfulness-based stress reduction may also reduce carers' anxiety symptoms by the end of treatment.

Table 7 Migrants and refugees

Author, Year, Country, Type of review	Aim of review	Number of studies included in review	Number of studies which report on community-based mental health interventions	Intervention name, implementation details, intervention components	Individual Intervention outcomes	Overall review findings
1.Balaam et al. 2021 UK Systematic Review	To synthesise the literature exploring the nature, context and impact of perinatal social support interventions on the well-being of asylum-seeking refugee women.	16	5 (n=5 studies reported on Community Befriending / Peer support interventions; 3 of these reported on mental health / social support outcomes)	**Perinatal support project (Lederer j.,2009)** Delivered by community volunteer befrienders **Mental Health service for asylum-seeking mothers and babies (O' Shaughnessy R et al., 2012).** Delivered by home start volunteers **Befriending for pregnant asylum-seeking and refugee women (Mc Carthy et al., 2013).** Delivered by community volunteer befrienders and sought to prevent social isolation	Reduced depression and anxiety, Better social support, more confident as parents Befrienders gained in confidence Women positively evaluated the intervention. Mother & baby attachment relationships improved. "Beneficial to the women". No outcomes regarding social integration reported	Interventions successful in alleviating the feeling of being alone Emotional support increased Increased confidence of both the befriender and the recipient Women valued a community befriending / peer support approach most
2. Bunn et al. 2022	To synthesise available data on family-based mental health social/psychological	10	6 interventions delivered in community setting	**SANAD (Lakkis et al.,2020)** **(n=125)**	***SANAD (Lakkis et al,.2020)*** Improvements in parenting stress,	The overall evidence base for family- based mental health interventions with

USA Systematic review	interventions for refugee families that aimed to improve mental health or psychosocial wellbeing of family members .		1 intervention delivered in community and home setting 1 intervention delivered in the home setting	21 weekly sessions x 120-180 mins. Delivered by external expert, supervised by licensed professional. **War child Holland's Caregiver Support Intervention (CSI) (Miller at al.,2020) (n=151)** 9 consecutive weekly sessions. Delivered by lay community member, supervised by licensed professional and primary research team member **African Migrant Parenting Program (Renzaho & Vignjevic, 2011) (n=39)** 8 sessions x 120 min over 15 months. Delivered by community member and external expert **"I Am Not Alone" (Stewart et al., 2015) (n=85)** 7 months of bi-weekly sessions of 60-120 mins. Delivered by lay community member and external expert.	parenting and disciplinary style **CSI (Miller at al., 2020)** "Significant improvement in all parent- reported outcomes in the intervention group" (Bunn et al.,2022, p. 30). **African Migrant Parenting Program (Renzaho & Vignjevic, 2011)** Change in parenting attitudes and expectations and child rearing practices with an increase in parental empathy towards children's needs. **"I Am Not Alone" (Stewart et al.,2015)** No significant improvements in loneliness, coping or parenting stress. **Tea and Families Education and support (TAFES), (Weine et al, 2003)**	refugee families is lacking Intervention delivery by lay providers and peers is feasible and "potentially effective" There is a need to clarify the effective intervention components and factors, and to consider cultural adaption to address the diversity of refugee communities The engagement of non-specialist and peer providers requires workforce capacity-building and training.

				Tea and Families Education and support (TAFES), (Weine et al, 2003) **(n=42)** 6 sessions over 8 weeks. Delivered by lay community member supervised by primary research team member **Coffee and Families Education and support (CAFES) (Weine et al., 2008)** **(n=197)** 16 consecutive weekly sessions x 75 mins. Delivered by lay community member, supervised by primary research team member. **Mother Child education program (MOCEP) (Ponguta et al., 2020)** **(n=106)** Delivered by external expert, supervised by licensed professional **Family strengthening interventions for refugees (FSI-R) (Betancourt et al., 2020)** **(n=105 adults)**	Adults "had a significant increase in social support, psychiatric contacts, knowledge and attitudes" (Bunn et al.,2022, p. 30). **Coffee and Families Education and support (CAFES) (Weine et al. 2008)** There was an increase in families ease of talking about mental health. **Mother Child education program (MOCEP) (Ponguta et al., 2020)** Child outcomes only; no improvements reported **Family strengthening interventions for refugees (FSI-R) (Betancourt et al., 2020)** No significant decrease in caregiver mental health problems. Positive mental health outcomes for children reported. Increase in family harmony	

				Delivered by community member		
3. Mahon, D. 2022 Ireland Systematic scoping review	To create a synthesis of interventions delivered by peers to refugees and asylum seekers	14	All studies are delivered by community peers.	**List of peer-delivered interventions:** **Bridge builders project: (Abrahamson, 2009)** Location: Sweden, **(n= 8),** mixed method and qualitative. A co-produced model designed to train refugees as peer workers. **Clubhouse model:** (**Block et al.,2018)** Location: America, **(n= 79),** Quantitative pre-post. Clubhouse model 8-week group structured but flexible based on manual. **Program Management plus (PM+):** (**De Graff et al.,2020)** Location: Amsterdam, **(n= 60),** pilot RCT. Manualised 5x 90 min sessions delivered weekly. **Community health workshop (CHW): (Im & Rosenberg, 2016)** Location: America, **(n=36),** Qualitative, participatory. Workshop sessions with varied focus. **Mobile phone support:**	**Overall outcomes across studies include:** Enabled integration, Building of community networks, Increased feelings of empowerment, Increased access to services, Increased perceived emotional health, Increased self-efficacy, Increased resilience, Increased hope, Improvement in health practice, Building of social capital.	This is the first scoping review of peer-delivered interventions for refugee populations This paper supports co-production / participatory research involving refugees reporting that the process leads to more culturally responsive intervention. Optimal training and support regime for peers is “unclear”

				(Koh et al., 2018) Location: Australia, (**n=111),** mixed methods. Free fixed dial mobile phone unlimited for a year & peer support training. **Cultural peer group: (Paloma et al.,2020)** Location: Spain, **(n=11;peers, n= 36; group participants),** Qualitative. Training of peers & delivery of community intervention based on chosen topics, personal strengths and community resources **Self Help, Plus (SH+): (Purgato et al.,2021))** Location: 6 European countries, **(n= 459),** RCT vs enhanced usual care. **Training:** Peer facilitators completed training which included listening to **audio** recordings, receiving instruction on the program content and practice in its administration. Supervision of peer facilitators was provided by psychologist / social worker. **(Tol et al., 2020)**		

				Location: Uganda, **(n= 613),** Cluster RCT vs enhanced usual care. Standardised and manualised group intervention. **CROP (Cultural sensitive and resource orientated peer**) **(Renner et al.,2011)** Location: Austria, (**n= 4: peer** facilitators), **(n=94: participants).** RTC. Group workshops addressed group needs. **Peer support Intervention:** **(Stewart et al., 2012)** Location: Canada, (**n=58),** Qualitative participatory. Provision of direct support, and information, supplemented by 1:1 telephone support **Peer caseworker:** **(Shaw, 2014)** Location: America, (**n=9),** Qualitative. **ALMA (Latinas Motivando el Alma/ Latina friends Motivating the soul)** **(Tran et al., 2014)** Location: America, **(n=54),** Pre-post evaluation. **Mobile phone peer support:**		

				Wollersheim et al., 2013) Location: Australia, (**n= 10),** Qualitative, participatory. Mobile phone peer support to target psychosocial health.		
4. Gower et al. 2022 Integrative review	To explore peer mentoring programs offered to refugee and migrant women, identifying social and well-being outcomes and key components of programs	12 (Quantitative =1, Qualitative = 7, Mixed methods =3, Case study = 1)	Mental health =4 Social connectedness & social capital=7 Employment =	**Program development:** Participatory approach using collaborative processes to ensure cultural and content appropriateness. Liaison with community organizations working with the population highlighted. **Delivery:** A mixture of formats including group workshops, individual face to face mentoring, telephone mentoring. Delivery often determined by cultural and accessibility factors including transport **Duration:** varied from 8 weeks to 6 months No definitive optimum length identified **Mentor training & support:** Enhanced intervention effectiveness when	**Social Support and connection outcomes (Qualitative evaluation)** Increased access to social supports and connections Feeling less isolated Creation of social networks lead to increased social capital. Having a mobile phone increased social connectiveness between sessions. *Attrition occurred and attributed to poor mentor/ mentee relationships. **Well-being and personal growth outcomes (Quantitative evaluations from studies)** Positive programme effects: **Paloma et al. (2020)** Reported increases in post –traumatic growth overall mean (p = 0.001); appreciation of	Only outcomes for women have been reported in this review – there is a scarcity of evidence in the literature. Mentoring programs are effective in enhancing outcomes for well-being and social connection. Little evidence available for long term impact. Mutually supportive peer relationships evidence mutual benefit Use of migrants with lived experience evidence greater effectiveness Conclusive evidence for best practice requires ongoing research trialling and evaluation of interventions.

				mentors had same language and background. Training ranged from 8-48 hours. Details regarding training content is sparse. Supervision varied from ad-hoc supervision to structured weekly sessions. Lack of supervision resulted in attrition. **Barriers to effectiveness:** Cultural considerations, transport, childcare.	life (p = 0.007); personal strength (p = 0.001); relating to others (p = 0.000). **Goodkind (2005)** Reported significant positive impact on: English proficiency (p < 0.001); Citizenship knowledge (p < 0.05); Satisfaction with resources (p < 0.001); Quality of life (p < 0.05); Distress (p < 0.01) Most scores not maintained after intervention end but remained above baseline scores. **Overall Qualitative evaluation:** Mentees: increased sense of empowerment, confidence and self-efficacy Greater capacity to cope at individual and community levels Increased hopefulness about opportunities and possibilities. Mentors: Increase in empowerment and resilience **Paloma et al. (2020)** Improved access to community services English proficiency, citizenship knowledge,	

					navigation of education and health systems, increased trust in police and community services. No impact noted for female employment.	
5. Del Pino- Brunet et al. 2021 Systematic Review	To synthesise and analyse interventions to target promotion of social integration and prevention of radicalization of migrants.	18	3 studies (11 were omitted due to wrong target population, not community setting, no mental health /social outcomes, therapy focused. Of the remaining 7 studies, 4 fell outside the target time frame and were pre-2014).	**Thomas et al (2016)** **Aim:** promote transition of recent migrants. **Delivery:** pairing of mentors "Cultural Navigators" with migrants participating in the wider American Place (TAP) program. **Msengi et al (2015)** **Aim:** To support migrant women new to a community. **Delivery:** female migrant participants were paired with local female volunteers who acted as a "conversation partner". Participated in focus group discussions. **Bravo et al (2014)** **Aim:** To promote migrant women's social interactions and	**Thomas et al (2016)** Qualitative study: observational, focus groups and interviews. **Programme effects:** Helped establish relations with long term community residents. Provided emotional support. **Msengi et al (2015)** Qualitative study: informal observation, focus groups, questionnaires. **Programme effects:** Improved general well-being for mothers and their families. Participation in support groups helped participants overcome language, culture, poverty and discrimination barriers. **Bravo et al (2014)** **Programme effects:** Empowered women and strengthened bonds between them**.**	Many studies did not include information such as the origin and age of migrants, and intervention component details. There is a need for more comprehensive assessment of interventions – many lack or present weak measurements of effectiveness. Some of the most effective activities are those that pair recently arrived migrants with natives and/or long-term residents. Long term local community members acting as mentors, translators, or resource guides, benefits migrant and mentor. Migrants can feel more secure and less isolated in the new country.

				strengthen support networks and increase self- esteem. **Delivery:** once weekly sessions. An altruistic exchange space. Sharing of concerns, circumstances and needs.		
6. Mc Garity et al. 2023 Systematic Review	To establish Asian refugees' involvement in community-engaged participatory research to target psycho-social outcomes	44	12 published between 2014-2024) *This review did not differentiate between prevention, promotion and therapeutic interventions for psychosocial outcomes. *Populations with diagnosed conditions such as major depressive disorder, PTSD were included in some studies	**Types of interventions:** **Therapy**: CBT, Psychotherapy, CPT, Integrative adaptive therapy **Prevention / promotion:** <u>Parenting Intervention</u> **Ballard (2017)** **Shaw et al (2020)** <u>Community Gardens</u> **Gerber (2015)** **Hartwig and Mason (2016)**	**Prevention /promotion:** **<u>Parenting Intervention</u>** **Ballard (2017)** Decrease in child mental health symptoms but an increase in caregiver mental health symptoms due to increased awareness. **Shaw et al (2020)** Potential benefits for decreased emotional distress and increased family harmony. **<u>Community Gardens</u>** **Gerber (2015)** Improved social support Improved subjective mental health **Hartwig and Mason (2016)**	Asian refugees when involved in community-engaged participatory research are often involved in recruiting participants and collecting data and are much less likely to be involved as intellectual resources or partners to shape the research questions and interpret the findings. Therefore greater focus needed on promoting refugee involvement in the entire co-production process, including programme development and implementation. Initiatives adopting community-engagement approaches to research tend to be more culturally acceptable, have higher attendance and retention, and may be more effective than

					Improvements in depression, anxiety and sense of identity Increased social support.	researcher-driven interventions. There is a need for future community-engaged research to consider potential moderating factors which may impact outcomes such as: the specific refugee community, the length of time the refugee community has been resettled, refugees' country of origin and their migration experience.
7. Villalonga-Olives et al. 2022 Systematic review	To identify evidence for social capital-based interventions targeting mental health outcomes among refugees	7	4 Community level interventions (n=4) and 2 multilevel (n=2) (individual and group components)	**Community Level Interventions:** **Im and Rosenberg (2016)** **Design:** experimental cross-sectional study; qualitative evaluation **Aim:** to promote refugee wellness and healthy adaptation during resettlement **Delivery:** through focus groups. 8 sessions focussed on healthy eating and nutrition, daily stressors of resettlement, coping, psychological distress, and other mental health issues of the refugee community.	**Im and Rosenberg (2016)** **Programme outcomes**: Improved social capital Improved psychological wellness among participants	This is the first systematic review to investigate social capital interventions for refugees targeting mental health outcomes. Social capital interventions can improve the mental health of refugee populations The evidence is sparse and largely qualitative in design with a lack of validated measurement scales.

				Components: community wellness partnership-building, competency-based training of refugee leaders and service providers, fostering peer-to-peer learning. **Logie et al. (2016)** **Design:** cross-sectional study; qualitative evaluation. **Aim:** to address social isolation, community resilience, and access to resources among LGTBQ refugees. **Delivery:** community-based partnership with an AIDS service organization who implemented monthly peer-support groups. Facilitated by staff members. **Chen et al. (2017)** **Design**: secondary data analysis **Aim:** To evaluate data to establish how activities related to economic integration, acculturation, social capital and self-identity relate to mental health outcomes. **Ibrahim et al. (2019)**	**Logie et al. (2016)** **Programme outcomes:** Improved mental health- associated with reduced isolation Increased information-sharing Formation of social networks. **Chen et al. (2017)** **Qualitative outcomes:** Positive relationship between social integration and physical and mental health Factors associated with better outcomes included: communicating with locals, having friends from different ethnic or religious groups and attending a place of worship. **Ibrahim et al. (2019)** **Programme outcomes:** Psychological benefits	

				Design: cross-sectional study; qualitative. **Aim**: To deliver a community kitchens intervention to those experiencing food insecurity to promote their self-reliance and dignity. **Components:** Participants supported in developing their own social support groups and networks. **Multilevel interventions Garland et al. (2002) and Stewart et al. (2011) -** individual and group sessions (with some therapy focus).	A greater sense of social cohesion with greater community trust and confidence and support. **Multilevel programme outcomes:** Improved integration, improved psychological outcomes, better coping strategies, reduced stress	

Table 8 Ethnic minority populations

Author, Year, Country, Type of review	Aim of Review	Number of studies included in review	Number of studies which report on community-based mental health interventions	Intervention name, implementation details, intervention components (if specified)	Individual Intervention outcomes	Overall findings of Review
1) Baskin et al. 2021 UK Scoping Review	To establish existing evidence of on the effectiveness of community centred interventions targeting the mental health and wellbeing of ethnic minorities in the UK	7 studies (3 x RCT, 1 pilot RCT 1 cross-sectional mixed method study, 1 observational, pre-post study, 1 ethnographic study)	7	**Intervention Types** Peer support groups x 2 Educational leaflet x 1 Free gym access x 1 Family service program x1 Lay worker therapy style session x2 **Chaudry et al. (2009)** 6-10 weekly sessions (psychoeducation and a self-selected activity, for example yoga, social trip, or a shopping trip)	**Chaudry at al. (2009)** (Observational, pre-post pilot study (n=9)) **Programme effects:** Improvement in depression scores (SRQ). (p= 0.039) **Gater et al. (2010*)*** RCT (n=123) **Programme outcomes:** No effect on depression Improved social functioning score improved at 3 months (no effect at 9 months) Qualitative feedback was positive (worry free time) but there was resistance from family members regarding participation	There is a paucity of high-quality evidence regarding community-centred interventions targeting mental health of ethnic minorities 4 key intervention characteristics were identified: 1. Peer-to-peer support and social networking to address social isolation - Ensuring accessibility by addressing structural barriers in accessing care, transport issues and language barriers - Lay health workers (sometimes peers) facilitating programme delivery - Signposting provided to link participants to additional services.
2) Apers et al. 2023 UK	To synthesise evidence on mental health promotion and prevention interventions and non-	27 (review studies (n=3), quantitative n=9 (of which RCT=8), qualitative (n=6), mixed methods (n= 9))	3	**Intervention Types:** 3 community engagement interventions	**Knifton et al. (2010)** Mean stigma score calculated for the entire sample before and after the	Robust evidence is lacking.

Scoping Review	medical treatment for migrants and ethnic minority groups.			**Knifton et al. (2010)**, Participants were (n=257) black and minority ethnic community members. 26 mental health awareness workshops delivered to reduce community-based stigma. **Malone (2017**), (n= 150) Irish travelling community members: "Lived lives" methodology. Art-Science collaboration, community orientated suicide prevention intervention. **Mantovani et al. (2017)** A pilot outreach intervention (n=13 CWBC's) in South London based African and African Caribbean communities. Qualitative community participatory approach adopted. **General overview of all intervention Components:** Peer to peer support, social networking, psychosocial education, resilience enhancing	workshops resulted in a statistically significant difference. P = 0.000 (Z = -5.423, df = 1) meaning that there was less stigma reported after completion of the workshops. **Malone et al. (2017**), Qualitative evaluation. Participants reported the intervention was powerful and moving and that it succeeded in creating an opportunity to facilitate conversations around suicide. It also highlighted the devastating effects of suicide on bereaved family members. **Mantovani et al. (2017)** CWBC's used "circles of influence" to share knowledge of mental health & wellbeing Benefits reported for CWBC's and wider community with a strengthening of social networks and promotion of cultural shifts towards healthier living. No longitudinal evaluation.	Existing studies are small scale, many in pilot phase. Interventions targeting social and environmental circumstances report positive effects. Interventions targeting exercise, social functioning, knowledge of mental health and direct support from community member indicate "promising results". 3 principles to increase intervention success were identified: 1.Having a sound theoretical base 2.Making cultural adaptations to evidence-based interventions 3. Application of participatory approaches to intervention development and adaptation. There is a high need for tailored programmes

				interventions, culturally adapted interventions, use of lay people and peers to deliver interventions, group sessions, addressing structural barriers (language, culture, transport), exercise interventions, yoga, CBT, family interventions, co-production / user participation.		
3) Pool 2017 Type of review not specified	To identify effective interventions that improve social participation and minimise social isolation and loneliness in elderly ethnic minorities living in the community	6 studies Evaluating 5 Interventions All studies USA based	5 (settings: home and/or community (n=4) school (n=1))	**Senior CAN intervention (Collins et al. 2006)** (n=339) An educational 15 lesson intervention. Group Delivery **Tai Chai 12-week exercise intervention (Taylor Piliae et al., 2006)** (n= 39) Group delivery **Home based physical activity and group CBT intervention (Rejeski et al.,2014)** (n=178) Group delivery and individual feedback **Fall Prevention Programme (Batra et al., 2012)** (n=402) Group delivery	**Senior CAN intervention** **<u>Outcome:</u>** A significant decrease in *loneliness.* **Tai Chai exercise intervention** **<u>Outcome:</u>** A significant increase in social support (P=0.008) **Home based physical activity and group CBT intervention** **<u>Outcome:</u>** No effect size reported **Fall Prevention Program** **<u>Outcome:</u>** Social activities increased	First known review to focus on interventions promoting social participation, isolation, and loneliness among community-based minority elderly ethnic populations Small number of studies implies the potential for bias. All studies USA based so generalisability needs to be considered Features of effective interventions are: 1. A sound theoretical basis 2. Group format 3. Active participation

					(mean difference in change; 0.62, 6-week post-test, mean SD: 1.84 (1.0))	
4) Sanchez et al. 2023 Qualitative systematic review	To identify youth mentoring programs to improve youth mental health outcomes, and to identify barriers and enablers to the design, delivery and sustainability of these programmes	8	2 studies met our inclusion criteria for target age (age 16 years and above) and setting of community	**"We light the fire project" (Kts'ìihtła) (Fanian et al. 2015)** Hosted by local community action research team for participants aged 15-25 years Aim: to address high rates of suicide in local indigenous community Format: 5-day creative arts and music targeting youth resiliency **Outdoor leadership training program (Ritchie et al. 2010)** Local indigenous facilitators act as mentors to participants aged 12-18 years Format: 10-day community-led and co-produced.	*Evidence was qualitatively synthesised across studies 5 key components were reported as having a positive influence on social, behavioural, psychological, attitudinal and academic outcomes: 1.Establishing cultural relevancy 2.Facilitating environments 3. Building relationships 4.Community engagement 5.Leadership responsibilities.	Mentoring Programmes should be culturally tailored for effectiveness, and holistic involving strong community partnerships, and collaboration in design and delivery More research is required regarding mentoring use to address indigenous health and wellbeing Positive short-term effects have been identified. Long term benefits require further research.
5) Ellis et al. 2022 Systematic Review	To identify culturally adapted digital mental health interventions (DMHI) and to examine their efficacy and acceptability among racial and ethnic minority groups	32	32 studies Qualitative (n=8) Quantitative (n=24)	Interventions' focus across studies varied and targeted: alcohol reduction, resilience, depression, anxiety, healthy pregnancy, smoking cessation, mindfulness, trauma recovery.	meta-analyses of 15 studies, sample size (n=653) Effect of intervention was large and statistically significant ($g = 0.90$, 95% CI [0.60, 1.20], $p < .01$).	Culturally adapted DMHI are effective and acceptable. Cultural adaptions include: 1. language translation 2. modification of audio/visual content

						3. inclusion of culturally salient messages. This study provides strong evidence supporting the use of culturally adapted digital mental health interventions as effective interventions for racial and ethnic minority populations.

Table 9 People who experience domestic violence

Author, Year, Country, Type of review	Aim of Review	Number of studies included in review	Number of studies which report on community-based mental health interventions	Intervention name, implementation details, intervention components (if specified)	Individual intervention outcomes	Overall findings of Review
1) Rivas et al. 2015 Cochrane Systematic Review	To assess the effects of advocacy interventions within / outside health care setting in women who have experienced IPV	13 across settings of: Community Shelters Antenatal services Health care	**Outcomes measured** Advocacy (n=3) Abuse (n=11) Quality of Life (n=6) Depression (n=6)	**Interventions duration:** 30 min – 80 hours. Heterogeneity between studies regarding methodology and intervention delivery **Participants:** Women from healthcare settings, Domestic Violence shelters and refuges, community centres.	**Outcomes:** **Quality of life:** (meta-analysis of two studies; high risk of bias reported) Intensive advocacy slightly improved: Overall quality of life (women recruited from shelters) (MD 0.23, 95% CI 0.00 to 0.46; n = 343) at 12-months. Greater improvement in perceived physical quality of life- primary care study (high risk of bias; MD 4.90, 95% CI 0.98 to 8.82) immediately postintervention. **Depression:** (meta-analysis of two studies (healthcare settings with risk of bias deemed high and moderate) Fewer women developed depression (OR 0.31, 95% CI 0.15 to 0.65; n = 149; NNT = 4) with brief advocacy.	The impact of **advocacy interventions** regarding type and place is uncertain. Brief advocacy may provide short term mental health benefits. No clear evidence of effectiveness for intensive advocacy. Quality of evidence is moderate to low for brief advocacy interventions, and very low for intensive advocacy. **Brief advocacy and depression outcomes** One woman for every four to eight treated likely to benefit (abused women attending healthcare services and pregnant women) immediately after advocacy. **Intensive advocacy and depression outcomes** Women in shelters followed up at 12 and 24 months did not

					One study (high risk of bias) reported slight reduction in depression in pregnant women immediately after the intervention (OR 0.51, 95% CI 0.20 to 1.29; n = 103; NNT = 8). No evidence for reduced depression at ≤ 12-month follow-up with intensive advocacy (MD - 0.14, 95% CI - 0.33 to 0.05; 3 studies; n = 446) or at two years (SMD − 0.12, 95% CI − 0.36 to 0.12; 1 study; n = 265).	present with reduced depression. **Brief advocacy and quality of life outcomes** Trials found no benefit on quality of life. **Intensive advocacy and quality of life outcomes** Weak benefit in two studies in domestic violence shelters/refuges.
2) Ragavan et al. 2018 Systematic Review	A 20-year review of the literature which reports on community-based research approaches with interventions to support DV survivors	20 studies describe 19 interventions, but mental health prevention and promotion is not specifically addressed.	All studies identified as employing community based participatory research (CBPR) core values, but only 6 studies explicitly describe using a CBPR approach.	**Focus of interventions:** crisis management, safety planning, legal advocacy, career & professional development, decreasing PTSD, increasing self-care, emotion focused therapy. *Mental health interventions have a strong therapeutic focus (lack promotion focus) including: depression management, PTSD therapy, self-care, emotion focused therapy.	**Evidence:** Qualitative outcome data is provided for all 19 interventions, for all areas of focus. Statistical outcome data is not reported in this review. Improvements in depression and posttraumatic stress disorder are reported in the following individual studies **Galano et al., (2017)** Moms' empowerment Program (n=93) **Kelly & Pich, (2014)** (Focused on	The authors state that this is the first systematic review of interventions to support DV survivors, developed using a community-based research approach. This review has a strong emphasis on establishing the use of CBPR approaches and concludes there is a need for guidance for teams publishing community-based research. While mental health outcomes are reported

				Overall intervention delivery: 16 interventions were delivered as in person workshops, delivered by peers/ professionals, 10 delivered as a small group and 6 as on an individual basis. 2 programs were digitally based. **Peer Delivered Intervention:** The Interconnection Project **(Nicolaidis et al. (2013))** (n=59) participants described as African American IPV survivors. A 6-month peer led education, skills training and case management service.	PSD, self-care, children, mindful eating, family, faith, and exercise) **McWhirter (2011)** (Group sessions (n=46). Focus on healthy relationships, coping strategies, goal setting) **Nicolaides al., (2013)** **Sullivan (2003).**	there is a lack of emphasis on prevention and promotion of mental health.
3) Baeza et al. 2023 Scoping Review	To identify and synthesise evidence on sources of well-being for Hispanic women following experience of IPV.	9 studies (8 from the USA and 1 Peru) Sample size: 703 Hispanic women		Strategies and interventions were identified under the 6 domains of The multidimensional Wellbeing Framework **(Prilleltensky and colleagues (2015):** Interpersonal, psychological, community, occupational, economic and physical well-being.	**Evidence of effectiveness:** **Cripe et al., 2015:** Connecting with peers, other women with IPV experience **Serrata et al., 2016:** Becoming a trained community advocacy leader (Promotorta model – Lideres Program) led to increased self-empowerment **Page et al., 2021:**	Evidence specifically focusing on the promotion of multidimensional wellbeing is limited. 5 of the 9 selected studies were published in the last 2 years. Quality of existing evidence is weak due to the predominance of qualitative study designs (n=6).

					Nurse led support group long term intervention facilitated empowerment	Authors believe this scoping review highlights an existing significant gap in IPV research related to wellbeing promotion.
4) Micklitz et al. 2024 Systematic review and meta-analysis	To exam the efficacy of psychosocial Interventions for IPV survivors regarding safety, mental health, and psychosocial outcomes	80 RCTS (Qualitative analysis) *40 of 80 (meta-analysis) due to insufficient reporting of the required data.		**Types of Interventions:** Advocacy Interventions = 29 (based on empowerment theory) Psychological interventions = 27 (Therapy focused: CBT, gestalt therapy, interpersonal therapy, humanistic, and systemic therapy) Integrative interventions = 24 (psychological trainings alongside safety planning and referral to specific services and resources): ***HOPE intervention*** (Johnson et al., 2011) ***HELPP intervention*** (Constantino et al., 2015). ***RISE*** (Iverson at al., 2021.) *Culture sensitive / culturally adapted; n=7 **Methods of delivery across interventions:** Individual/face to face (n=26) Group (n=25)	**Outcomes Measured** Safety related (n= 57) Depression (n=49) PTSD (n=32) Anxiety (n=11) Psychological distress (n=6) Suicidality (n= 2) QoL (n= 16) Social support (n=16) Self-esteem (n=15) Health service use (n=15) Self-efficacy (n=10) Alcohol use (n= 10); drug use (n= 6) Readiness **Mental health outcomes** **Depression**: Small significant overall effect reported: (SMD: −0.15 [95% CI [−0.25, −0.04]; p = .006] high-intensive interventions significantly reduced depressive symptoms when compared to controls (SMD: −0.47 [95% CI [−0.74, −0.01]; p=.04] **PTSD:**	Overall integrative interventions delivered with high intensity yield most effective outcomes for the safety, mental health and psychosocial wellbeing of IPV survivors. This review synthesises 30 years of research and concludes that overall quality of evidence is low. Long term evidence of effectiveness is weak. There are gaps in the literature with a need for research to address the need for interventions which are sensitive to gender inclusivity and cultural diversity.

				Multiple settings (n=7) Digital (n=9) Phone (n=3) Blended delivery (n=7) **Duration across interventions:** Varied from one time delivery to 52 intervention sessions over 12 months.	Small significant overall effect reported: (SMD: −0.15 [95% CI [−0.29, −0.01]; p=.04 with integrative interventions most effective. **Anxiety:** A meta-analysis of 4 studies reporting anxiety showed a large significant overall effect of interventions (SMD: −1.29 [95% CI [−2.23, −0.35]; p = .007]. **Psychosocial outcomes:** Self-esteem: medium significant effects (SMD: 0.67 [95% CI [0.32, 1.01]; p = .0001] Empowerment (SMD: 0.52 [95% CI [0.23, 0.81]; p = .0005], Social support (SMD: 0.30 [95% CI [0.09, 0.51]; p = .002] Self-efficacy (SMD: 0.17 [95% CI [0.02, 0.31]; p = .02] QoL (SMD: 0.14 [95% CI [0.03, 0.26]; p = .02] **Long term mental health outcomes:** A small significant effect of interventions on depressive symptoms was established through meta-analyses of studies reporting	

					follow-up scores 6 to 9 months post-intervention (SMD: −0.11 [95% CI [−0.21, −0.01]; p=.04].	

Table 10 LGBTQI+ populations

Author, Year, Country, Type of review	Aim of review	Number of studies included in review	Number of studies which report on community-based mental health interventions	Intervention name, implementation details, intervention components (if specified)	Individual Intervention outcomes	Overall findings of Review
1) Paudel et al. 2024 Narrative review	To assess the role of digital-based intervention in reducing suicidal thoughts and behaviours (STB) among LGBTQ individuals.	5	5	Online video (n=2) Mobile phone app (n=2) Online writing intervention (n=1)	Two studies measured feasibility and acceptability- used co-production approach; 3 studies measured suicidal ideation, help seeking behaviour **Kirchner et. al., 2022** Study design: RCT **Outcomes:** Improvement in help-seeking intentions of intervention group (T2: MC = 0.25 [95% CI 0.15 to 0.35], p < 0.001; MD = 0.28 [95% CI 0.01 to 0.54], p < 0.05, d = 0.09). **Han et al (2023)** **Outcomes:** Significantly improved depression and anxiety mental health literacy (mean difference = 1.25, 95% CI [0.31, 2.20], p = 0.010; mean difference = 1.50, 95% CI [0.56, 2.44], p = 0.002) and 1-month follow-up (mean difference = 1.88, 95%	Positive outcomes for feasibility and usability No clear evidence to indicate which modality is most effective. Mood logging increased awareness of feelings. Improvements in help seeking intentions reported.

					CI [0.93, 2.83], p < 0.001; mean difference = 1.96, 95% CI [1.01, 2.90], p < 0.001). *Intervention effect remained strongly significant at the 3-month follow-up (mean difference = 1.55, 95% CI [0.60, 2.50], p = 0.002; mean difference = 1.96, 95% CI [1.01, 2.90], p < 0.001) **Pachankis et al (2020)** **Outcomes:** Improvements in depressive symptoms (d=0.48) and general psychological distress (d=0.36) suicidal ideation (d=0.62) and drug abuse (d=0.59).	

APPENDICES FOR CHAPTER 3 – STAKEHOLDER CONSULTATIONS ON COMMUNITY-BASED MENTAL HEALTH PROMOTION INTERVENTIONS FOR PRIORITY GROUPS IN IRELAND

Appendix 3.1 Community Stakeholder Consultation Framework

1) Opening Questions

We'd like to gain an understanding of the priority groups you work with.

1a) Who are your groups?

- People living with disabilities
- People experiencing loneliness and isolation
- People living in deprived and disadvantaged communities
- People who have experienced domestic violence
- Carers of people living with chronic illness
- Ethnic populations
- Migrants and refugees
- LGBTQ+ populations

1b) What are their needs?

1c) In your opinion what is being done to promote their mental health and wellbeing?

1d) What approaches does your organisation (or organisations you are representing today) adopt to promote their mental health and well-being?

Here are some considerations to keep in mind:

- Are programmes/supports **tailored for specific priority groups**, and how?
- How are programmes received by participants?
- Can you think of any **specific interventions** that have been delivered in your organisation (or organisations you are familiar) with for the priority groups you work with that have been **effective** in improving their mental health and wellbeing?

- Are there additional initiatives/approaches/programmes/supports needed over and above what is already being offered to meet the needs of the priority groups you work with?

2) Participants & Facilitators

We'd like to get an understanding of the characteristics of the people who engage with you and the facilitators who implement your initiatives.

2a) What priority groups have engaged with the intervention(s) named above?

2b) In general, who is responsible for delivering the intervention?

Here are some considerations to keep in mind:

- What works best in terms of engaging and sustaining participants?
- Does it depend on the priority group?

3) Interventions/Initiatives/Programmes/Supports

We'd like to get an understanding of the characteristics of your approaches to supporting the mental health and wellbeing of your priority groups.

3a) Where/what settings have these programmes been delivered?

3b) What length of time/duration were interventions delivered over.

3c) Thinking about the programmes/supports your organisation currently offers for your priority groups, what do you think could help make programmes work better?

Here are some considerations to keep in mind:

- How are participants engaged?
- Is it difficult to engage participants?
- What could improve engagement?

4) Resources & Supports

We'd like to understand how you are supported to implement mental health and wellbeing support for your priority groups.

4a) How do you usually obtain resources for implementation of your programmes/supports?

4b) What is the extent of the mental health promotion training of your staff? Is there a need to improve this?

5) Strengths & Challenges

We'd like to understand more about the types of support and challenges you face in supporting the mental health and wellbeing of your priority groups.

5a) What are some of the supports you receive that stand out as most helpful when implementing your interventions?

5b) What are the challenges/barriers to effective programme delivery in your organisation (or organisations you represent)?

Here are some considerations to keep in mind:

- Are there barriers to engaging participants in programmes/supports?

6) Evaluation & Sustainability

We'd like to understand the extent to which your activities are evaluated or if the sustainability of your efforts is supported.

6a) Are programmes/supports evaluated? How?

6b) What supports are needed to sustain a programme/supports in your organisation/within the community?

7) Closing Questions/Remarks

If anyone knows of any report or other additional/supporting information on the programmes/supports you mentioned, we would appreciate if you could forward them to Tosca at tosca.keppler@universityofgalway.ie
Has anyone any additional comments?

Thank you!

Supplementary Questions

We understand that there may be few or no interventions in place for supporting the mental health and wellbeing of certain priority groups. In this case, please consider the following questions.

1) In your opinion, what types of initiative/activities/interventions should be available to your population? In other words, if you could wave a wand, what would you do to promote the positive mental health & wellbeing of your population? (Think about their needs, preferences and their specific strengths & challenges)

a. Would your dream scenario be feasible? (Think about resources, engagement & considerations at the individual, community & structural levels)
b. What could be done to make your dream scenario more feasible?
c. How would you evaluate your intervention? (How will you know if you are indeed improving the mental health and wellbeing of your groups?)

Appendix 3.2 Community Stakeholder Consultation Participation Information Sheet

Research Topic: Evidence Review of Community-based Mental Health Promotion Interventions for Priority Groups

Research Project: Current national policy frameworks including; "Connecting for life: Ireland's national strategy to reduce suicide 2015-2020" (Department of Health, 2015), "Sharing the Vision: A Mental Health policy for Everyone" (Department of Health, 2020) and "Stronger Together: The HSE Mental Health Promotion Plan 2022-2027" (Health Services Executive, 2022), list specific "at-risk" groups who are at increased risk of mental health difficulties and need more targeted mental health interventions. In the Irish context, priority groups include:

- People living with disabilities
- People experiencing loneliness and isolation
- People living in deprived and disadvantaged communities
- People who have experienced domestic violence
- Carers of people living with chronic illness
- Ethnic populations
- Migrants and refugees
- LGBTQ+ populations

This research, commissioned by the HSE, has been undertaken by researchers at the Health Promotion Research Centre at the University of Galway. The aim of this phase of the research is to identify the most effective community-based mental health promotion initiatives that have been implemented in Ireland to date for the priority groups listed above.

Your Role: Your participation in the focus group will help us to gain an understanding of what community-based interventions work best and under what conditions to promote the positive mental health and wellbeing the priority groups listed above.

Benefits of your Participation: Your input will allow University of Galway researchers gain insight into the real-world experience of implementing mental health promotion interventions for priority groups in the community. The researchers will then align your expertise and practical experience with evidence from the international literature base. The overall findings will be used to develop guidance on best-practice in community-based mental health promotion for priority populations for use by the HSE and community and voluntary organisations.

Risks: As the nature of this research is to gain an understanding of existing initiatives with the goal to develop best-practice guidance in community-based mental health promotion initiatives for priority groups, there are no identified risks in participation.

Contacts: For clarifications or concerns, please contact Tosca Keppler at:
tosca.keppler@universityofgalway.ie

Appendix 3.3 Community Stakeholder Consultation Participant Consent Form

Please complete and return this form to tosca.keppler@universityofgalway.ie prior to the online stakeholder discussions.

Research Study Title: Evidence Review of Community-based Mental Health Promotion Interventions for Priority Groups

Name and Contact Details of Researcher: Tosca Keppler, tosca.keppler@universityofgalway.ie

Name and Contact Details of Principal Investigator: Prof. Margaret Barry, margaret.barry@universityofgalway.ie

Affiliated Centre: Health Promotion Research Centre

University Data Protection Officer: email - dataprotection@nuigalway.ie / Tel - (091) 524411

Please initial the boxes below to confirm your acknowledgement and complete the signature line below to confirm your consent to participate in the online consultation.

	Please initial the box
1. I confirm that I have read the Participant Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any without giving any reason.	
3. I understand that the data collected during this study will be processed in accordance with Irish data protection laws.	
4. I consent for my contribution to the discussion to be recorded. The recording will be transcribed and analysed for the purposes of the research.	
5. I agree to take part in the above study.	

Name of Participant Date Signature