DEVELOPING MENTAL HEALTH ADVOCACY AND SUPPORT FOR ETHNIC MINORITIES

Cairde
Challenging ethnic minority health inequalities

Maynooth University
National University of Ireland Maynooth

Coimisiún na hÉireann um Chearta an Duine agus Comhionannas
Irish Human Rights and Equality Commission

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We'd like to acknowledge IHREC for funding this work. The project was implemented in the backdrop of the COVID-19 pandemic. Hence, as we deal with its consequences, the need to maintain mental wellbeing and to provide appropriate mental health supports for vulnerable members of minority ethnic communities is even greater.

To all program participants, Wafa Abusharekh, Rawan Al-Zawadi, Dallal Bounekdja, Julija Kuts, Edita Jehelezi , Jennifer Harusekwi Auxiliah Chipa, Justyna Maślanka, Danut Nae, John Oghenetano Uwhumiakpor, Maria Smith, Xhulja Sula, Damian Trasha, Ayodele Yusuf, we would like to acknowledge your perseverance, love of learning, commitment to human rights, cultural and linguistic expertise, passion for improving people's mental health and wellbeing, your kindness, open heart, and support you gave to each other and to the people you engaged with.

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Cairde

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DEVELOPING MENTAL HEALTH ADVOCACY AND SUPPORT FOR ETHNIC MINORITIES PROJECT

INTRODUCTION

In response to the wellbeing and mental health needs of minority ethnic communities in Ireland, the 'Be Aware. Be Well. Migrant Mental Health Initiative' was established by Cairde in 2015. The overall aim of the initiative is to improve mental health outcomes for ethnic minorities in Ireland with emphasis on strengthening community based mental health promotion, equitable access to and quality of mental health services, and inclusive mental health policy.

At the beginning of the 'Be Aware. Be Well. Migrant Mental Health Initiative', an extensive consultation process with migrant communities was conducted and informed the development of an action roadmap, summarised in the report entitled '*Ethnic Minorities and Mental Health Barriers and Recommendations'* (2015). Since this initial work, Cairde, working in collaboration with the communities it serves, has developed a suite of resources for ethnic minority communities aimed to raise awareness about mental health and supports available. One such resource is the *'Pathways to Being Well'* community resource pack which includes a multilingual *Mental Health Guide and Directory for Ethnic Minorities* (2017), a two-hour workshop program, and a 20-hour training program for migrant community and faith leaders. As of October 2021, Cairde has distributed about 7000 of the guides, delivered workshops to approximately 1000 individuals, and trained 70 faith and ethnic minority community leaders. Cairde's on-going work in the area of mental health also includes delivering numerous presentations and representations to various stakeholder groups with the aim of strengthening the cultural competency of mental health services and providing policy inputs on same, including in relation to the development of the most recent national mental health policy *'Sharing the Vision. A Mental Health Policy for Everyone'* (2020).

Throughout their work, Cairde has identified/advocates that many issues leading to the exclusion of people living with mental health issues require leadership to emerge from within their communities, in order for these issues to be addressed. With this in mind, and as a natural evolution of and connection to their continuing work on the '*Be Aware. Be Well. Migrant Mental Health Initiative*' and '*Pathways to Being Wel*l', Cairde more recently scoped a new programme of work aimed to explicitly address identified gaps in mental health service provision for ethnic minorities, including the design and development of mental health and wellbeing advocacy and support for ethnic minorities.

In 2019-2020, Cairde was supported by the Irish Human Rights and Equality Commission to deliver the *'Developing Mental Health Advocacy and Support for Ethnic Minorities Project'*. The overall intention of the project was to help reduce the inequitable mental health care experiences of ethnic minorities by strengthening community capacity in mental health advocacy and cultural brokerage. To achieve this, the project designed, delivered, and pilot tested a tailored, culturally appropriate training programme and role scope for Mental Health and Wellbeing Advocate (MHWA) for ethnic minorities. The project was conducted in three phases (Figure 1) to delineate the delivery of the two distinct training phases and the subsequent research phrase utilised to evaluate the training and explore the role scope of the MHWA for ethnic minorities.

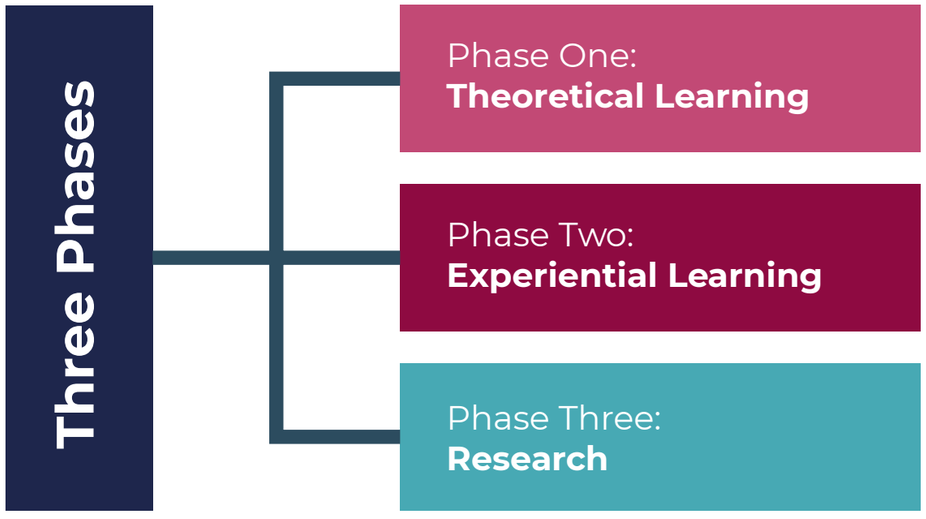


Figure 1. Illustrative Depiction of the Three Project Phases

INTRODUCTION TO TRAINING PHASE 1 & 2

The structure of the training included both theoretical (Phase 1) and experiential learning (Phase 2) components. The combination of theoretical and experiential learning in the training programme allowed participants to learn, test, and refine the role scope of Mental Health and Wellbeing Advocate (MHWA) for ethnic minorities and to develop a Code of Practice.

Recruitment of Trainees

Thirteen program participants were recruited. An expression of interest was sought among the participants of Cairde's previous programs. Following one-to-one interviews, selected candidates fulfilled at least two of the pre-set criteria: self/family experience of mental health issues, member of at-risk group, participant of Cairde's previous mental health programs. Selected trainees represented diverse backgrounds. Nationalities among the participants included - Lithuanian, Nigerian, Palestinian, Polish, Romanian (Roma), Syrian, Venezuelian, Zimbabwean, and fell under various immigration status, including residents of Dublin, Balbriggan, Monaghan, and Waterford.

Design of training programme

Drawing on their experiential knowledge in the field and an analysis of best practice models, Cairde utilised a community development approach working with 20 migrant community leaders, participants of previous Cairde's projects, clients with self/family experience of mental health issues, and staff members to; 1) envisage an initial draft role scope for Mental Health and Wellbeing Advocate for ethnic minorities ; 2) subsequently design and deliver a tailored and culturally appropriate training programme. The Irish Advocacy Network (IAN) were the primary training partner and, for specific specialist topics, were joined by trainers from Mary Seacole House and Big Picture Consultancy. The content and learning outcomes of the training programme were thematically mapped to the envisaged skillset and activities required from a Mental Health and Wellbeing Advocate which are outlined in Table 1.

Learning objectives	Exemplars	
1. Practice and model personal well-being and self-regulation strategies	▪ self-care ▪ resilience ▪ self-compassion	▪ coping with difficult emotions ▪ mental health promotion
2. Provide emotional support to a person / family	▪ communication skills and peer support skills ▪ deal with stigma	
3. Provide practical support to a person / family	▪ signpost to and advocate for appropriate health services, social welfare, immigration, child protection	
4. Understand relevant psychosocial concepts & practices	▪ trauma ▪ cultural competency	▪ community development ▪ advocacy
5. Create supportive communities. Provide community outreach.	▪ mental health promotion and awareness ▪ mental health stigma	
6. Collaborate with service providers and policy makers	▪ Be able to support both the client and the service ▪ Make recommendations for systemic changes	

Table 1. Breadth & Depth of Theoretical Learning - Training Phase 1

Phase 1: Theoretical Learning

In the first 12 weeks, 19 interactive teaching sessions, each 3 hours in duration and via Zoom, were delivered from June to August 2020. Simultaneously, the trainees attended recommended seminars and meetings to interact with other stakeholders to deepen their understanding of sector specific topics of relevance. A full outline of the training programme content is included in Appendix 1.

Phase 2: Experiential Learning

Following the theoretical part of the training program, the trainees completed 15 days/120 hours of field practice over a three-month period (August-October 2020) From the outset, the participants were encouraged and supported to draft individualised practice plans which clarified their areas of interest and identified the specific policies, practice approaches, methodologies, organisations, and services they wanted to learn more about. Trainees were assigned mentors from Cairde and IAN to virtually support the trainees in drafting and executing their practice plans. IAN mentored the trainees interested in supporting individuals attending mental health services and Cairde mentored the trainees interested in community outreach, awareness raising, and individual support and advocacy in the community setting. Mentorship of the trainees comprised of convening numerous individual and group mentoring / coaching calls, arranging placements with other organisations, actively participating in trainees activities if more guidance or input was required, and pointing towards additional professional development opportunities.

During the experiential learning phase, trainees completed a variety of individual and group projects encompassing mental health awareness, individual support, and building collaborations with service providers. Figure 2 provides an illustrative overview of the breadth and depth of trainees' activities during the experiential learning phase of their training programme.

Study Visits. Virtual study visits (Change, ENAR, psychologist, community activist) 1. Physical study visits) Intercultural Hub Mental Health Project, Shine Discovery)	**1. Knowledge and Skills Development.** **2. Community needs analysis (Edita DP survey).** **3. Mentoring on specific aspects of the role e.g. Mental Health Act.** **4. Individual support (face-to-face, online and on the phone).**	**Identification of and participation in external online seminars to further training and knowledge.** Stress Control, Mind Your Wellbeing, Mental Health and Racism and more (via organisations such as Aware, Harvard School of Public Health, HSE, Mental Health Reform etc).,
Community Awareness Campaigns. Recording videos, maintaining a social media presence and outreach to organisations about trauma in the Arabic language. Mental health awareness on social media for the Russian, Lithuanian and Ukrainian speaking communities.	**Designing and delivering awareness rising workshops and meetings.** A stress management session was organised for Direct Provision residents and Peer Support groups were established. As a result , a number of individuals came forward to seek help. They were offered emotional support, showed wellbeing and stress management techniques, signposted to services and encouraged to take part in available wellbeing programs like Stress Control.	**Awareness raised about issues within ethnic minority communities.** Among the issues highlighted: lack of training for Direct Provision Centre staff, intersectional issues affecting the Roma community, cultural differences in understanding mental health, stigma, psycho-social factors and more.

Figure 2. Breadth & Depth of Experiential Learning - Training Phase 2

INTRODUCTION TO RESEARCH PHASE

In the last phase of the project, Cairde worked in partnership with Dr. Rebecca Murphy, (Department of Psychology, Maynooth University) to conduct a small participatory piece of research to;

1) evaluate Cairde's Mental Health and Wellbeing Advocate training program for ethnic minorities.

2) explore and draft the role scope of Cairde's Mental Health and Wellbeing Advocate for ethnic minorities.

This study employed a mixed-method design informed by participatory methodology to collect qualitative and quantitative data. In partnership with a peer researcher, data were collected using a survey and two focus groups with trainees, individual interviews with a variety of internal and external stakeholders, including the programme trainers and staff members from the experiential learning placements, and a documentary review. The documentary review included a collation and analysis of data from the trainee's weekly reflection logs, their final presentations and practice portfolios. In Zoom meetings with the trainees and Cairde staff members, draft analysis of the data was reviewed, discussed, and refined.

This report consists of four chapters. Chapter one presents a contextual overview of the mental health needs of ethnic minority populations, and the scope, efficacy, and policy alignment of mental health advocacy for ethnic minority populations. The study methodology is then described in chapter two and the subsequent two chapters provide a comprehensive overview of the study findings, starting with results from the training evaluation (chapter three) and followed by a chapter on the perceived role scope of Cairde's mental health and wellbeing advocates (chapter four). The final chapter (chapter five) presents a summary of next steps and key recommendations.

NEED & RATIONALE FOR MENTAL HEALTH & WELLBEING ADVOCATES

ETHNIC MINORITY POPULATIONS IN IRELAND

Once a country of mass emigration, Ireland is now experiencing an era of superdiversity. Across the EU, Ireland has one of the highest percentages of 'foreign born' residents. The most recent census in 2016 reported 17.2% of the population in Ireland are 'foreign born' and represent over 200 different nations (CSO, 2016). People categorised as 'foreign-born' are typically first-generation migrants. However, as first-generation migrants continue to establish permanent roots, Ireland is experiencing an upward trend in the numbers of second and third generation people of ethnic minority backgrounds. This includes people of dual Irish nationality, the numbers of whom almost doubled to 104,784 in Census 2016 from 55,905 in 2011. In addition to vast diversity in ethnicity, the socio-demographics of Ireland's ethnic minorities vary extensively in accordance to religious beliefs, residency/visa status, economic and social backgrounds, education, and work experience (CSO, 2016).

This heterogeneity in Ireland's ethnic minority populations means a 'one size fits all approach' to supporting their mental health and wellbeing is ineffective. Instead, tailored approaches, which are inclusive of and responsive to socio-ecological health determinists, are required to effectively meet the distinct intersectional wellbeing needs of ethnic minority populations.

WHAT ARE THE WELLBEING AND MENTAL HEALTH NEEDS OF ETHNIC MINORITY POPULATIONS?

Disproportionate rates of mental health difficulties

International evidence demonstrates that ethnic minority populations experience mental health difficulties at a comparatively disproportionate rate to their ethnic majority counterparts (Maura and de Mamani, 2017). Susceptibility to developing mental health difficulties amongst the heterogeneous communities labelled 'ethnic minorities' differ in accordance with socio-demographic characteristics, distinct migratory experiences, and endurance of more or less supportive environments within the host country. For example, persons with a background of forced migration (e.g., refugees and asylum seekers) are particularly vulnerable due to their cumulative endurance of pre-and post-migratory stressors including experiences of torture and trauma in their country of origin and hostile asylum reception conditions in host countries. For other ethnic minority populations, susceptibility to developing mental health difficulties appears to be determined by post-migratory stressors. For example, research evidence indicates a 'healthy migrant effect' in the early phases of resettlement into new host countries. This is where persons with a migrant background tend to be among the healthiest in the overall population. However, counterbalancing this 'healthy migrant effect' is a corpus of research which suggests that as length of stay within the resettled country increases, risk of experiencing mental health difficulties also increases. In this regard, we must examine contributing socio-structural factors such as enhanced

exposure to health risk behaviours and inequitable access to housing, health and welfare services, education, and the opportunity to work (Murphy and Leavy, 2014). Further to such socio-structural concerns are ethnic minority populations' endurance of hostility and rejection on racial grounds by ethnic majority populations and oppressive systems (Haynes and Schweppe, 2017).

Inequitable access to and quality of mental health care

Alongside a disproportionate susceptibility to developing mental health difficulties, ethnic minority populations also experience inequitable *access to and quality of* mental health services (Maura and de Mamani, 2017; Bhui et al 2008; Anderson et al, 2014; Barnett et al, 2019). Research indicates ethnic minorities utilise mental health services at a comparatively lower rate and are less likely to have pathways to care with General Practitioner (GP) involvement (Anderson et al, 2014; Barnett et al, 2019). Instead, they experience more complex and aversive pathways to care including increased use of emergency services, increased entry to care with police involvement, and increased involuntarily admissions (Anderson et al, 2014; Barnett et al, 2019).

When ethnic minorities do engage with mental health services, they experience poorer quality of care, relatively poorer outcomes, and are less satisfied with the care received (Maura and de Mamani, 2017). In comparison to their ethnic majority counterparts, people from ethnic minorities have higher rates of secure unit admissions, longer inpatient stays, and more readmissions (Barnett et al, 2019). Treatment disparities are also evident for specific subsets of ethnic minorities, specifically people from Black minority ethnic backgrounds who are more likely than their White counterparts to receive higher drug dosages and more depot pharmacotherapy, to endure coercive and restraining practices (Maura and de Mamani, 2017; Barnett et al, 2019) and to experience reduced provision of talking therapies. The treatment gap experienced by ethnic minorities extends into mental health outcomes. Evidence indicates they are between 40%–80% more likely to prematurely disengage from treatment and are less likely to receive regular outpatient care after discharge. Indications also suggest that they are also less likely to experience symptom remission and to improve their global functioning to return to work (Maura and de Mamani, 2017).

Several overlapping systemic, cultural, socio-demographic, and socio-structural factors determine ethnic minority populations inequitable pathways to and experiences of mental healthcare. These factors can be examined through the lens of the three '**A's**, specifically **A**wareness, **A**cceptability, and **A**ccommodations. A lack of **Awareness** about mental distress and mental health services is cited as a major barrier to receiving appropriate care. Lower levels of mental health literacy and higher levels of mental health stigma can contribute to ethnic minority populations experiencing inequitable delays in accessing mental health care. Further, research suggests that ethnic minority populations may feel uncertainty about what kind of support they could receive in MHS, may face difficulties in navigating an unfamiliar mental health care system, and may lack the knowledge about their legal entitlements to accessing mental health care. The **Acceptability** of MHS for ethnic minority populations is primarily mediated by the degree to which they experience **Accommodations** for their cultural and linguistic needs whilst accessing and attending MHS. Many individuals from ethnic minority populations ascribe to indigenous, spiritual, and/or psychosocial knowledges about mental distress (Kirmayer, 2009; Fernando, 2017). These knowledges mediate their recognition and presentation of symptoms, their help seeking behaviours, and their treatment preferences (WHO, 2018). However, in MHS provision, which predominantly operates from a biomedical, ethnocentric, and global north knowledge about mental health and distress, there is often an under-provision of culturally appropriate care, and therefore limited integration of indigenous, spiritual and/or psychosocial knowledges about mental distress. Further, research also suggests that ethnic minority populations are provided with limited linguistic accommodations when attending MHS, often experiencing difficulties in accessing an interpreter and appropriate translated materials.

WHO ARE MENTAL HEALTH & WELLBEING ADVOCATES AND HOW CAN THEY HELP?

As a means to achieving culturally responsive mental health service provision and to improve equity of access to and quality of mental health care for ethnic minority populations, it is globally recommended that mental health services work in partnership with mental health advocates, cultural brokers and/or cultural mediators from ethnic minority communities (Kirmayer et al., 2003; Nadeau and Measham, 2005; Raval et al, 1999). Within the field of ethnic minority health, Mental Health Advocates can have many formal and informal facets to their role, including providing; 1) advocacy; 2) psychosocial support; and 3) cultural brokerage.

At an individual advocacy level, the range of advocacy practices can include encouraging clients to voice their needs and concerns, ensuring their clients are aware of their rights and entitlements, empowering and assisting them to make decisions, to make a complaint or seek redress, and supporting them to access healthcare and/or other services such as access to social welfare, housing or other social entitlements or services (Ridley et al., 2018; McDaid and Ní Bheara, 2017). At a community and collective advocacy level, many Mental Health Advocates work to amplify and ensure representation of the needs and perspectives of their representative communities at local, regional, and national mental health services and policy platforms.

To promote wellbeing in their communities, Mental Health Advocates often provide psychosocial supports which facilitate strengthened social connection and sense of belonging, in addition to providing strengths-based encouragement, emotional support, and social prescribing. Mental Health Advocates can also play a key role in enhancing ethnic minority populations' receptivity to engaging with formal support services including educating the community about the types of services available, where to seek information, the potential benefits, and how to navigate healthcare systems.

Finally, advocacy within the field of ethnic minority health can also encompass cultural mediation or cultural brokerage practices. Mental Health Advocates working for ethnic minority populations are often individuals who are immersed in the worlds of both the ethnic minority and ethnic majority populations, and as a result, can act as a linguistic and cultural bridge between the client and the services or professionals (Jezewski and Sotnik, 2001; Owen and English, 2005). Such cultural brokerage work can help mental health practitioners to fully understand the socio-cultural context of a client's distress, minimise cross-cultural differences, and inform the development and prescription of culturally sensitive interventions. In the field of mental health, such linguistic and cultural brokerage is deemed particularly valuable as clear communication and understanding of cultural differences in thoughts and behaviours are integral to the establishment of safe and effective therapeutic relationships (Hseih et al., 2013).

The distinct efficacy of mental health advocacy and cultural brokerage for ethnic minority communities has yet to be empirically tested (Newbigging and McKeown, 2017; Newbigging et al., 2013). However, in the broader field of mental health advocacy, research evidence indicates that people who have the support of advocacy services experience enhanced access to appropriate mental health supports, and feelings of increased self-determination, self-confidence, self-esteem, and validation (Weller et al., 2019; Ridley et al., 2018; Colson and Francis, 2009). In addition, a growing number of exemplars in culturally responsive mental health service provision (Brar-Josan and Yohani 2019; Miklavcic and Leblanc 2013) and a burgeoning corpus of complementary literature strongly recognises the valuable role of cultural brokers in increasing ethnic minority populations access to preventative supports and mental health services, increasing intercultural competence amongst mental health practitioners, strengthening communication and therapeutic alliance (Raval, 2005; Singh et al., 1999), and increasing confidence in the appropriateness of diagnosis and treatment (Kirmayer et al., 2003; National Center for Cultural Competence, 2004; Brar 2010; Rotich and Kaya 2014; Yohani 2013).

HOW DO MENTAL HEALTH & WELLBEING ADVOCATES ALIGN WITH CURRENT HEALTH POLICY PRIORITIES IN IRELAND?

Historically the distinct health and service needs of ethnic minorities were inadequately and/or disparately integrated within and across Irish health policies. While differing in depth and breadth of detail, the inclusion of ethnic minority populations specific mental health needs now features in most of the current core health policy legislations. There also appears a convergence of ideas across Irish health policy legislature that is reflective of and responsive to the socio-geographical, socio-political, socio-economic and socio-cultural contexts which both inform and mitigate the mental health of ethnic minority populations. Bolstering the accountability of such health policy commitments is the Public Sector Equality and Human Rights Duty, stated in Section 42 of the Irish Human Rights and Equality Commission Act 2014, which "places a statutory obligation on public bodies to eliminate discrimination, promote equality of opportunity and protect the human rights of those to whom they provide services" (IHREC, 2019, p.2)

Conceptual mapping across core Irish health policy legislation reveals a consistency of commitment to three core features pertinent to the role of the Mental Health and Wellbeing Advocate; 1) a whole systems approach/outlook; 2) a requirement to tackle health inequalities experienced by ethnic minority populations; 3) a commitment to community based, peer-led approaches within a collaborative model of health care provision.

Whole systems approach

The relevancy and value of the Mental Health and Wellbeing Advocate role aligns with the overarching goals of many of the current health policy frameworks in Ireland, including; 1) the mental health focused policies 'Sharing the Vision; A Mental Health Policy for Everyone' and 'Connecting for Life'; 2) the broader health and service provision policies of 'Sláintecare' and 'Healthy Ireland 2013-2025' and; 3) with population specific policies such as the 'Intercultural Health Strategy 2018-2023'.

A complementary ethos running through many of these populations health, mental health and service provision policy frameworks is a broad based, whole systems approach to address the wellbeing of the whole population. This signifies an intent for all health service provision, including mental health systems, to firmly situate people's mental health and wellbeing within their socio-geographical, socio-political, socio-economic, and socio-cultural environments. This understanding of mental health and wellbeing reflects the explanatory models of mental health that the peer advocacy role aligns to and which many people from ethnic minority populations believe in. As a result, this shared consensus indicates strengthened potential for effective partnership working and ultimately, if effective, the creation of culturally safe mental health supports.

In the mental health policy field specifically, the recently launched 'Sharing the Vision' applies a population-based planning approach to the design, development, and distribution of mental health services. In so doing, it explicitly commits to the provision of distinct, context specific interventions and supports systems which span across the entire wellbeing spectrum from community, to primary, to secondary and tertiary care. A stepped care approach is outlined (Figure 3), specifying the various types and degrees of support and services individuals can avail of in accordance to their specific mental health needs. This policy stamped approach to stepped service provision not only validates the valuable contribution of community based models of mental health support provision like MHWAs but also harmoniously links with international best practice models of protecting and improving migrants' mental health and psychosocial wellbeing, wherein a multi-sector, pyramidal and phased approach encompassing preventative and early intervention measures, alongside specialised targeted and therapeutic interventions is also recommended (WHO, 2018).

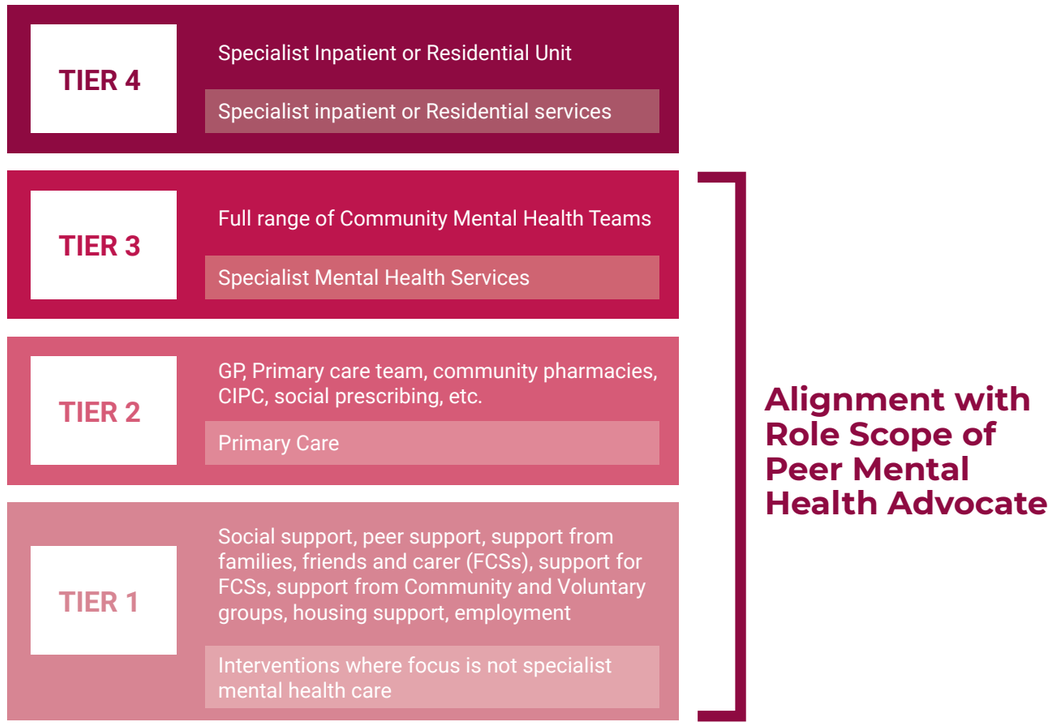


Figure 3. Alignment of MHWA role with Sharing the Vision's Stepped Care Approach

Population specific commitments

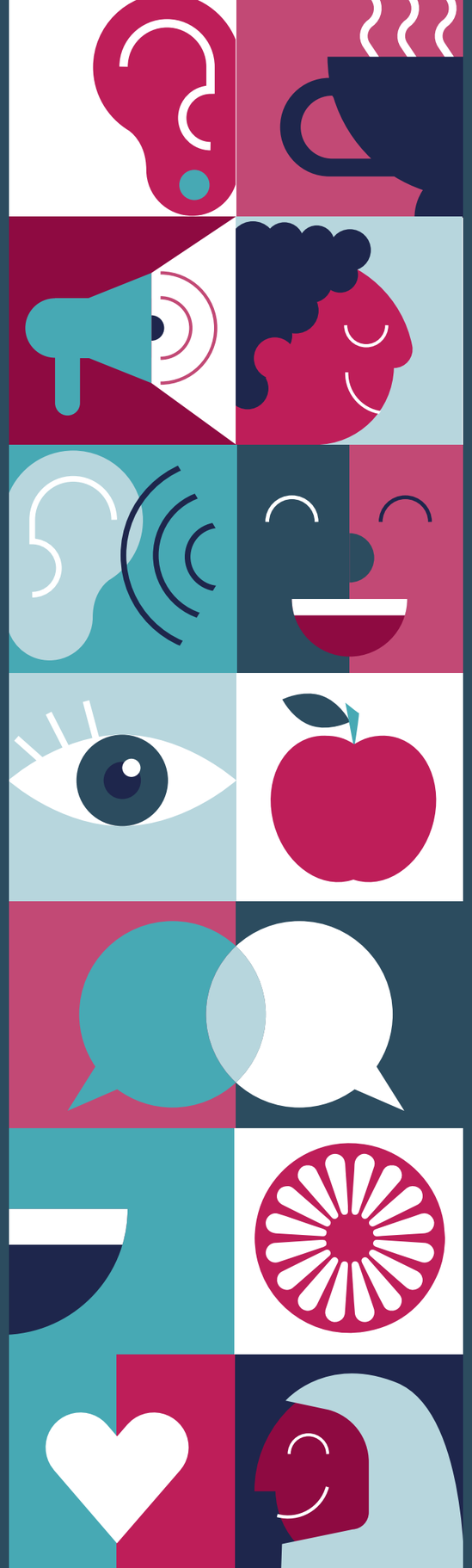
Across Ireland's health policies, ethnic minority populations are identified as priority groups requiring additional supports and targeted interventions to mitigate their experiences of inequitable access and quality of health provision. Detailed consideration of the who, what, when and where of delivering effective, culturally responsive initiatives is outlined in most comprehensive detail in the 'Intercultural Health Strategy 2018-2023' and, specifically to mental health systems, 'Sharing the Vision'.

The 'Intercultural Health Strategy 2018-2023' articulates a commitment to enhance access to services through empowerment of service users, ensure provision of culturally responsive services, and strengthen service providers cultural competence. Specifically, within Goal 2 of the strategy, the need to address the mental health inequities experienced by ethnic minorities is explicitly identified. Across the policy's comprehensive recommendations, there is a consistent commitment to working in partnership with people from ethnic minoritized populations to implement policy recommendations and to resourcing their involvement in the design, planning, delivery, and evaluation of services.

Sharing the Visions' social inclusion recommendations harmoniously link to the recommendations cited in 'Intercultural Health Strategy 2018-2023' and explicitly highlights that "a more developed framework for the implementation of cultural, diversity and gender competency is required". It includes in its recommendations requirements to resource the delivery of diverse and culturally competent mental health supports throughout all services, including the availability of qualified interpreters at no cost to the service user, and strengthened access to tiered mental health services through primary care and specialist mental health services for persons resident in Direct Provision and refugees arriving under the Irish refugee protection programme. A key underpinning narrative in both policies' recommendations is working in partnership with people from ethnic minority populations and resourcing their community based, peer-led initiatives.

Commitment to community based, peer-led approaches

In 'Sharing the Vision', 'Intercultural Health Strategy', and 'Connecting for Life', the value and need for peer led supports in the community are explicitly acknowledged and included in policy recommendations. Across the policies, there is shared understanding that peer led models of support are effective in promoting health information and enhancing access to health services. In 'Sharing the Vision', it is stated that peer-led support services are integral to generating positive mental health and facilitating preventative and recovery enhancing approaches to health and wellbeing, including the organisation of social activities to facilitate social inclusion and integration. The explicit integration of social prescribing within the stepped care approach in Sharing the Vision provides a clear mandate to strengthen referral partnerships between primary and secondary care services with Voluntary and Community Sector supports and services, including peer-led support services such as MHWAs. In this vein, Sharing the Vision's recommendations include a commitment to "Enable the development of service user-led and responsive social prescribing through identified community links and supports". In addition, Sharing the Vision recommends the continued integration of peer and outreach workers within the competency portfolio of the CHMT in addition to strengthened availability and promotion of advocacy supports within MH services, but also for persons with mental health difficulties living in the community. The policy states "The right to advocacy needs to be re-emphasised and the development of additional advocacy services pursued."



RESEARCH METHODS

RESEARCH METHODS

INTRODUCTION TO RESEARCH

This chapter provides an overview of the aim and objectives of the study, with a description of the mixed methods approach used to evaluate Cairde's training programme and to explore the role scope of PMHA for ethnic minorities. It includes information about the study's research design, data collection methods, the recruitment of participants, and data analysis. The ethical considerations of the study are also addressed.

Study objectives

The objectives of the study were to:

1. evaluate Cairde's Mental Health and Wellbeing Advocate training program for ethnic minorities.

2. explore and draft the role scope of Mental Health and Wellbeing Advocate for ethnic minorities.

RESEARCH DESIGN & DATA COLLECTION METHODS

This study employed a mixed-method design informed by participatory methodology to collect data using qualitative and quantitative methods. In partnership with a peer researcher, data were collected using individual interviews, focus groups, surveys and a documentary review. The peer researcher assisted participants to complete the survey and also co-facilitated the focus groups. The peer researcher also inputted into the development and piloting of the survey, interview schedules in addition to providing valuable feedback on drafts of data analysis.

Surveys

A survey (Appendix 2) was designed consisting of a mixture of closed and open-ended questions focused on participants' self-rated appraisals of the knowledge and competencies developed as a result of the training, and the effectiveness, appropriateness and relevancy of the training modality, delivery and content. The survey was comprised of four sections A) participant demographics; B) self-rated knowledge; C) self-rated confidence, and D) satisfaction with training. To optimise the response rate, the survey was designed to be completed online via Qualtrics and the questions were constructed in such a way that response time did not exceed 15-20 minutes.

In Section A, standard demographic questions were asked including participants age, gender, education, years living in Ireland, language proficiency, and previous experience of working in the field of mental health. In Section B, participants were asked to self-rate their knowledge, on a scale of 1-5 (1=strongly disagree and 5= strongly agree), on five core knowledge competencies including knowledge of; 1) Client Needs; 2) The Mental Health System; 3) Mental Health legislation;4) the Advocacy and MHWA Role. In Section C, participants were asked to self-rate, on a scale of 1-5 (1=Not at all confident and 5=Very confident), their confidence in performing five core role competencies

including their confidence in; 1) supporting clients; 2) community advocacy; 3) individual advocacy; 4) practising the advocacy role. In Section D, participants' satisfaction with the training programme was assessed using questions relating to the quality, depth and relevancy of training content, teaching modalities, delivery of training and their experience of learning together. Open-ended questions were included to elicit participants' views on the most and least helpful and most and least challenging aspects of the training, as well as suggestions for possibly improving the training programme.

Survey participant profile

Of the 11 survey participants, eight were female and 3 identified as male. Two of the participants identified as a person with self-experience of mental health difficulties whilst the remaining identified as a person interested in supporting persons with mental health difficulties. Survey participants nationalities included Albanian, Polish, Venezuelan, Algerian, Lithuanian, African-Irish and Palestinian. Seven of the survey participants were educated to undergraduate degree level with the remaining participants educated to master's degree level (n=3) and diploma level (n=1). In terms of previous experience working in the field of mental health advocacy, six of the participants had no previous experience and five had previous experience of working with/volunteering in Cairde. Finally, all of the participants were multilingual with proficiency in four languages (n=6), three languages (n=1) and two languages (n=4).

Focus Groups & Individual Interviews

Two semi-structured focus groups were conducted with the trainee participants and six semi-structured interviews were conducted with a variety of internal and external stakeholders including the programme trainers and staff members from the host training placements. Informed by existing literature on the topic and the distinct study objectives, interview topic guides (Appendix 3) for the focus groups and 1-1 interviews were developed. Participants were also encouraged to add any new information they felt was relevant to the research aims.

Focus groups conducted with the training participants examined their appraisals on the effectiveness, appropriateness, and relevancy of the training programme, as well as their perspectives on future training needs and improving future training programmes. The focus groups also explored the training participants perspectives on what key tenets and practises should be encompassed in role scope of the MHWA. The semi-structured interview guide included similar topics to those in the survey but with more specific and detailed questions to consolidate the key occupational tenets and practices of a MHWA for ethnic minorities.

Six 1-1 interviews were conducted with the programme trainers and key individuals from the organisations with whom the MHWA engaged with during their training placements. The interviews garnered their perspectives on the need, value, and potential impact of the MHWA role, and the factors which, in their view, may facilitate/hinder the integration of the MHWA role in their organisation.

Documentary Review

The Documentary Review included a collation and analysis of data from the trainee's weekly reflection logs, their final presentations and practice portfolios. The reflective learning logs captured data on participants' appraisals of the knowledge and competencies developed, the effectiveness of the teaching modality and content, and the key occupational tenets and practices of a Mental Health and Wellbeing Advocate (MHWA) for Ethnic Minorities. The participants' final presentations and practice portfolios captured data on the feasibility of the role and competency development in three core MHWA activities; individual advocacy and support; community support; and service provider and policy maker support.

DATA ANALYSIS

Focus groups were recorded and transcribed by the peer researcher. Data from the focus groups, individual interviews, and responses to open-ended survey questions, were entered into NVivo (Version 12) and analysed using thematic analysis (Braun and Clarke, 2006). Data were analysed firstly through a process of open coding. Individual transcripts were read numerous times and open codes identified and condensed into general themes. Once all data were coded, each code was examined to identify the relationships and connections between themes. Any overlapping codes were collapsed to form larger, more inclusive categories. This initial coding structure was presented, via an online group meeting, to the peer researcher, trainees, and Cairde trainer to elicit their contributions. Their feedback was subsequently integrated into the data coding structure and thematic analysis proceeded by examining associations and discrepancies in the coded data. This process provided repeated opportunities for the researcher to cross-check the raw data against emergent themes, thus ensuring analytical development was robust, rigorous and trustworthy. An initial written draft of the analysis was provided to the peer researchers and Cairde programme trainer. Feedback was subsequently incorporated into the final draft of the study report. Participants' responses to the survey were entered into the IBM Statistics 26.0 (IBM Corporation 2019). Descriptive statistics including frequency distributions were generated to describe the data. The open-ended questions were analysed thematically, using the same coding framework as developed for the focus groups/individual interview. Similarly, the documents collected were read, reread and analysed to assist the team to identify and triangulate data within the documents with data gathered from other sources.

ETHICAL CONSIDERATIONS

Ethical approval was secured from Maynooth University Research Ethics Committee (ID: SRESC-2020-2420980). The rights and dignity of participants were respected throughout by adherence to models of good practice related to recruitment, voluntary inclusion, informed consent, privacy, confidentiality and withdrawal without prejudice. The rights of the participants and their well-being were given precedence over data collection. The voluntary nature of participation was emphasised throughout the data collection process and participants were free to withdraw from the study at any time without fear of penalty. Return of the survey was taken as evidence of implied consent. Both written and verbal consent was obtained before the focus groups/ individual interview. The survey data was anonymous and no identifying information was requested; however, when this did occur, identifying information was removed prior to analysis. Similarly, all identifying information was removed from the qualitative data.

TRAINING EVALUATION

TRAINING EVALUATION

INTRODUCTION

To evaluate Cairde's Mental Health and Wellbeing Advocate training program for ethnic minorities, data collected focused on participants' appraisals of the knowledge and competencies developed, and the effectiveness, appropriateness and relevancy of the teaching modality and content. Participants' satisfaction with the training programme was assessed using questions relating to the quality, depth and relevancy of training content, teaching modalities, delivery of training, learning strategies utilised, and their experience of learning together. Open-ended questions were included to elicit participants' views on the most and least helpful and most and least challenging aspects of the training, as well as suggestions for possibly improving the training programme.

The survey and focus group findings are presented in three overarching themes which are; 1) self-rated knowledge; 2) self-rated confidence to undertake the role and; 3) satisfaction with content, format, and delivery of the training programme.

1. Self-Rated Knowledge

The survey data indicated that most participants consistently confirmed they had garnered adequate knowledge across all four core competencies covered in the training programme. On a scale of 1-5 (1=strongly disagree and 5= strongly agree) participants were asked to self-rate their knowledge on four core knowledge competencies including knowledge of; 1) Client Needs; 2) The Mental Health System; 3) Mental Health Legislation; 4) the Advocacy and Peer Supporter Role. In understanding client's needs, the majority (10/11) stated they somewhat agreed or strongly agreed with the statements that they understand factors which influence development of mental health problems (9.1 % somewhat agreed; 81.8% strongly agreed) ; understand factors which influence a client's resilience (36.4% somewhat agreed; 54.5% strongly agreed); understand the recovery approach in mental health (45.5% somewhat agreed; 45.5% strongly agreed) and understand how trauma may impact a person's wellbeing (9.1 % somewhat agreed; 81.8% strongly agreed). Only one participant indicated that they strongly disagreed with all of these statements, as shown in Table 1.

	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
Knowledge of Client Needs					
I understand factors which influence development of mental health problems	9.1 (1)			9.1 (1)	81.8 (9)
I understand factors which influence a client's resilience	9.1 (1)			36.4 (4)	54.5 (6)
I understand the Recovery approach in Mental Health	9.1 (1)			45.5 (5)	45.5 (5)
I understand how trauma may impact a person's wellbeing	9.1 (1)			9.1 (1)	81.8 (9)

The majority of participants indicated they somewhat or strongly agreed with statements regarding their knowledge of the mental health system and legislation. 18.2% somewhat agreed and 72.7% strongly agreed that they were familiar with the role of the mental health care team. 36.4% somewhat agreed and 54.6% strongly agreed that they know how to support a client to get help from a mental health team for your client/s (e.g. signposting to GP, organisations etc).There was a slight variance in agreement to the statements regarding their awareness of relevant legislation (9.1% neither agree or disagree; 36.4 somewhat agree; 45.4 strongly agree), understanding the barriers to accessing services for Black & Ethnic Minority clients (9.1% strongly disagree, 9.1% neither agree nor disagree, 36.4% somewhat agree, 45.5% strongly agree) and how to support a client through the procedure for making a complaint in the mental health services (9.1% strongly disagree, 9.1% neither agree nor disagree, 45.5% somewhat agree, 36.4% strongly agree). Again, there was one participant who indicated they strongly disagreed with all statements regarding their knowledge of the mental health system and legislation.

	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
Knowledge of The Mental Health System					
I am familiar with the role of the mental health care team	9.1 (1)			18.2 (2)	72.7 (8)
I could support a client through the procedure for making a complaint in the mental health services	9.1 (1)		9.1 (1)	45.5 (5)	36.4 (4)
I know how to support a client to get help from a mental health team for your client/s (e.g. signposting to GP, organisations etc)	9.1 (1)			36.4 (4)	54.5 (6)
I understand the barriers to accessing services for Black & Ethnic Minority clients	9.1 (1)		9.1 (1)	36.4 (4)	45.5 (5)
Knowledge of relevant legislation					
I am aware of relevant legislation that I can use to support the rights of people with mental health difficulties (e.g UNCRPD, Mental Health Act)	9.1 (1)		9.1 (1)	36.4 (4)	45.5 (5)

With regards to their knowledge of the advocate and peer supporter role, there was again one participant who strongly disagreed with all statements, but the majority of participants indicated either somewhat agree or strongly agree to the statements; I understand the codes of practice for Mental Health Advocates (27.3% somewhat agreed; 63.6 % strongly agreed) and I understand scope (role boundaries) of the Peer Supporter role (9.1 % somewhat agreed; 81.8% strongly agreed). To the statement 'I understand the scope (role boundaries) of the MH Advocate role', 9.1% neither agreed or disagreed; 18.2% somewhat agreed; 63.6 strongly agreed.

	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
Knowledge of the Advocacy & Peer Supporter Role					
I understand the scope (role boundaries) of the MH Advocate role	9.1 (1)		9.1 (1)	18.2 (2)	63.6 (7)
I understand the codes of practice for Mental Health Advocates	9.1 (1)			27.3 (3)	63.6 (7)
I understand scope (role boundaries) of the Peer Supporter role	9.1 (1)			9.1 (1)	81.8 (9)

Qualitive findings and documentary evidence confirmed trainee participants high degree of satisfaction with the depth and breadth of knowledge they retained as a result of the training programme. They recounted about the many topics which they now not only understood but could perceive the nuanced connections between topics and the applicability of the knowledge garnered to specific concerns or issues within their distinct communities. Of note were participants narratives in which they describe actively integrating their newly accrued knowledge into their placement work and/or in their current work with Cairde. This indicates that many of the participants had transitioned from merely a retainment of training programme content to an advanced application and critical comprehension of knowledge utilisation.

> *One of my goals was to learn more about the Irish Health Service, including mental health support system and I also wanted to learn practical skills how to deal/interact with services or GPs to make sure that I really provide support to the client. During the training […] I have learnt about more varieties of supports which could be available to my clients, which gave me more confidence in exploring different options for my clients […]. Having better knowledge of the system, I find working with those organisations better as I am more confident in approaching the organisations and services (Portfolio, Trainee 2).*

> *Learning about documents related to mental health, including different policies, had a huge impact on increasing my confidence as professional, as well as gained knowledge around people's rights and getting more insight into defining and understanding discrimination, which is a big part of my job (Portfolio, Trainee 2).*

> *The important part of the training for me was to learn about stigma, trust and confidentiality as it helped me tremendously with my work by realising that stigma is related to culture, shame and tradition. I got a better understanding of my clients and why they might not want to engage in offered supports (Portfolio, Trainee 2).*

> *I have learned a lot, as well about stigma and how support people with mental difficulties […] discrimination and self-care as well. Also, the most important were for me human rights and capacity. Now I feel more confidential and professional (Survey Respondent 11).*

2. Self-rated Confidence

On a scale of 1-5 (1=Not at all confident and 5=Very Confident), participants were asked to self-rate their confidence in performing four core role competencies including their confidence in; 1) supporting clients; 2) community advocacy; 3) individual advocacy; 4) practising the advocacy role.
In supporting clients, all participants indicated they felt confident/very confident in facilitating conversations with clients about the factors which may challenge their resilience (45.5%; 54.5%), helping clients explore tools that support their resilience (36.4 %/63.6%), helping clients to feel safe in sharing emotions with you (45.5%/54.5%) and building trust between you and a client (45.5%/54.5%), initiating and sustaining empathetic, culturally sensitive, and non-judgmental relationships with clients (36.4 %/63.6%), facilitating conversations with clients to assess their support needs (45.5%; 54.5%), and assisting a client in developing goals to help alleviate his/her difficulties (36.4 %/63.6%). One participant indicated being just somewhat confident in co-creating an action plan with clients and utilising reflection to help clients feel validated while the remaining participants once again reported confident (54.5%/36.4 %) or very confident (36.4 %/54.5%) at these tasks, as seen in Table 2.

	Not at all confident	Somewhat confident	Confident	Very confident
Supporting Clients				
Facilitating conversations with clients about the factors which may challenging their resilience			45.5 (5)	54.5 (6)
Helping clients explore tools that support their resilience			36.4 (4)	63.6 (7)
Helping clients to feel safe in sharing emotions with you.			45.5 (5)	54.5 (6)
Building trust between you & a client.			45.5 (5)	54.5 (6)
Initiating and sustaining empathetic, culturally sensitive, non-judgmental, relationships with clients			36.4 (4)	63.6 (7)
Facilitating conversations with clients to assess their support needs			45.5 (5)	54.5 (6)
Co-creating an action plan with clients		9.1 (1)	54.5 (6)	36.4 (4)
Assisting a client in developing goals to help alleviate his/her difficulties			36.4 (4)	63.6 (7)
Utilising reflection to help clients feel validated.		9.1 (1)	36.4 (4)	54.5 (6)

Participants were also asked to rate their confidence in fulfilling the advocacy aspect of the role, both in terms of community advocacy and individual advocacy, as highlighted in Table 3. No participants reported feeling not at all confident in performing community advocacy. 60.0 % and 30.0 % respectively reported feeling confident or very confident in working with service providers to enhance cultural sensitivity in services. All participants reported feeling confident (80%) or very confident (20%) in organising and facilitating 'community conversations'. Implementing strategies to raise awareness and address stigma in the community also attracted high self-rated confidence ratings with 50% of participants indicating confident and 40% indicating very confident. One participant reported feeling just somewhat confident to working with service providers to enhance cultural sensitivity and implementing strategies to raise awareness and address stigma in the community.

	Not at all confident	Somewhat confident	Confident	Very confident
Advocacy in the Community				
Working with service providers to enhance cultural sensitivity in services (e.g. explain cultural issues typical for your community)		10.0 (1)	60.0 (6)	30.0 (3)
Organising & facilitating 'community conversations'			80.0 (8)	20.0 (2)
Implementing strategies to raise awareness and address stigma in the community		10.0 (1)	50.0 (5)	40.0 (4)

A little more variance was indicated in participants confidence levels with regards performing advocacy for an individual client. For the statements regarding negotiating access to mental health services for your client and to services in the community for your client, 10.0 % reported feeling somewhat confident, 60.0% were confident, and 30.0% were very confident. 40% of participants reported being very confident in facilitating the 'communication web' between clients and relevant support providers, with remaining participants reporting feeling somewhat (10%) or confident (50%). An even split was evident between participants in their indications of feeling confident (50%) or very confident (50%) when helping clients understand information provided by mental health teams/doctor.

	Not at all confident	Somewhat confident	Confident	Very confident
Advocacy for Individual Clients				
Negotiating access to mental health services for your client (e.g. to see a psychiatrist)		10.0 (1)	60.0 (6)	30.0 (3)
Negotiating access to services in the community for your client (e.g. accommodation, peer support group, training, medical card)		10.0 (1)	60.0 (6)	30.0 (3)
Helping clients understand information provided by mental health team / doctor			50.0 (5)	50.0 (5)
Facilitating the 'communication web' between clients & relevant support providers		10.0 (1)	50.0 (5)	40.0 (4)

As shown in Table 4, participants indicated their confidence in practising the MHA role by indicating their confidence to maintain professional boundaries and self-awareness in practice, critically evaluate their practice, seek guidance, pursue ongoing professional development, practising in accordance with the ethics and values of the profession, and perform a variety of self-care strategies. An even split was evident between participants in their indications of feeling confident (50%) or very confident (50%) to maintain professional boundaries when working with a client and practise in accordance with the ethics and values of the profession. 10% reported feeling just somewhat confident to maintain self-awareness in practice, critically evaluate their practice, seek guidance appropriately, pursue ongoing professional development, reduce their stress levels, build resilience and knowing how to take care of themselves while supporting a client experiencing trauma. The remaining participants reported feeling confident (40%) or very confident (50%) in these categories.

Table 4. Confidence in adhering to Accountability Measures (n=10)

	Not at all confident	Somewhat confident	Confident	Very confident
Practising the MHA Role				
Maintaining professional boundaries when working with a client			50.0 (5)	50.0 (5)
Maintaining self-awareness in practice, (e.g. recognizing your own personal values and biases, and preventing or resolving their intrusion into practice)		10.0 (1)	40.0 (4)	50.0 (5)
Critically evaluating your own practice, seeking guidance appropriately and pursuing ongoing professional development.		10.0 (1)	40.0 (4)	50.0 (5)
Practising in accordance with the ethics and values of the profession.			50.0 (5)	50.0 (5)
Reducing your own stress levels and building resilience		10.0 (1)	40.0 (4)	50.0 (5)
How to take care of yourself while supporting a client experiencing trauma		10.0 (1)	40.0 (4)	50.0 (5)

Qualitive findings and documentary evidence mirrored the survey findings in that participants also verbally articulated their high degree of confidence in their capacity to perform the role. In the focus groups, many of the participants described the myriad of skills they perceived to develop and strengthen as a result of the training. A recurring theme in participants narratives was a focus on their new ability to practise compassion and empathy for themselves and in turn apply these same strategies to support their clients. They also spoke of the interpersonal skills they developed to work compassionately and effectively with clients including active listening, management of expectations, and fostering a trusting atmosphere.

> *I have gained new skills for working with clients. Be non-judgmental, think differently, empathy, active listening, problem solving, time management, team working, be patient, think before reacting, compassion, encourage people, be positive and supportive (Portfolio, Trainee 9).*

> *Amazing Tutors gave us not only information, they taught us to be confident with ourselves, to manage our feelings and emotions, to "hear" our (and others) body language. We got some meditation lessons which really helps to concentre on tasks which we are doing. Stress release tools. While practising them on the class I identified that they worked for me and I definitely will recommend to others (Portfolio, Trainee 11).*

> *I have learnt how to talk to people with mental health issues: not promising anything but going with them step by step to know the client, to find out exactly what they need and then supporting them in achieving in it (Portfolio, Trainee 2).*

> *Understanding self-awareness and compassion and the process of building an atmosphere that enables clients to have confidence to express themselves (Survey Respondent 3).*

> *[…] You want to speak to him and to encourage him because everyone in the life have mental health, but in the different ways…In the different ways. You can support and encourage the people to do something positive, the people feel happy, and they pleased to do something. Maybe they didn't know it because you know sometimes, we have some shame and stigma for this subject. But when you speak to him more than one time and they understand what, what we mean of the mental health. This is my some rule in my life to to offer independent support to these people. (FG1, Trainee 1)*

> *I learned listening carefully, you know listening carefully to the patient and be kind, friendly and honest and be useful and helpful and treat others as a human beings. (FG1, Trainee 1)*

3. Satisfaction with Training Programme

In both the focus groups and in the survey, participants indicated their overall satisfaction with the training programme. Trainee participants described the training as a productive learning experience, often listing out the various topics they learned, indicating their appreciation of the breadth of knowledge garnered.

> *It was a very productive experience for me. I learned a lot relating to the role of a peer advocate. I contributed in my community during my practice and I would love to be part of other similar training (Survey Respondent 7).*

> *I am very happy with this training. For me it was very informative and productive. I found it very useful […] I had no information at all about peer advocacy and now I am able to support people (Survey Respondent 9).*

Survey data mirrored the positive appraisals of the training programme that were evident in the trainee participants narrative data. For example, 100% of participants were extremely/somewhat satisfied with the in-class training and the trainers. 90% were extremely/somewhat satisfied with the training placement element of training with one participant indicating extreme dissatisfaction. 100% rated the content and duration of the training programme as excellent and 100% reported they would definitely recommend the training to others.

In the open-ended questions and in the focus groups, participants provided further contextual insight into their appraisal of and satisfaction with the training programme. Their perspectives are provided under three thematic headings including; **1) In-Class Training Format and Delivery**; **2) Training Placement Experience**; and **3) Future Training Needs.**

1) In-Class Training Format & Delivery

Online Modality

As a consequence of the Covid-19 pandemic, in class training had to move to an online modality for the entirety of the training programme, with the exception of one in class session.

> *I think overall the training went well. It was, of course... it was a very strange time. We had to move online after the first session (Trainer 1)*

While all participants conceded to the necessity of moving online, missing the in-person training experience and all of its associated benefits was the primary factors cited by participants in answering the open survey questions "What did you enjoy least (or find least helpful) about the training?" and "What changes, if any, would you like to see made to the training?".

> *Covid-19 barrier of not having a classroom settings and physical conversation. (Survey Respondent 3)*
>
> *Because it is online, we didn't have any time for socializing. We couldn't meet the people we helped face to face (Survey Respondent 4).*
>
> *In my opinion, during this kind of training, we missed sessions face to face with tutors, participants and mental health services (it is not the same on phone or zoom meetings) (Survey Respondent 6).*
>
> *I would prefer that training in person but it is understandable the situation (Pandemic) (Survey Respondent 12).*

Trainers/Inclusive atmosphere

Participant's appraisals of the quality of training delivery were entirely positive. Of particular note, many of the participants commented on the inclusive atmosphere that the trainers fostered, even through the online modality of Zoom. Participants recounted that the sharing of their perspectives were encouraged and valued throughout the training. Participants felt comfortable to ask questions and seek further support from the trainers when needed.

> *Each trainers give us the best training, knowledge and experience which qualified us to help people suffering from mental health problems and how to develop mental health peer advocacy of the ethnic minority. And how to address mental health in the minorities and how to help about services (FG1, Trainee 1).*
>
> *I enjoyed the most the fact that I could share my thoughts in every step (Survey Respondent 9).*
>
> *Great tutors and great atmosphere during training (Survey Respondent 6).*
>
> *It was a very informative training and what I enjoyed the most was the fact that I felt involved in every step. I always had the possibility to ask and to express freely my opinions (Survey Respondent 7).*
>
> *How the trainers supported me during the training and they were opened to help with all the doubts I had (Survey Respondent 12).*
>
> *We had the chance to, to be more involved in every step we were asked our opinion and how we felt, how much have we learned in every session. So that was a very good thing [...] (FG2, Trainee 5).*
>
> *At the beginning I found it a bit difficult for me because it was the first time that I did the course of mental health, but fortunately we had amazing trainers, so week after week I felt more comfortable and I was really interested about the subject (Survey Respondent 8).*

Focus on Personal Wellbeing

Both Trainers and Trainee participants recounted that the training programme's strong focus on understanding, reflecting on, and maintaining one's own individual wellbeing was well received and deemed particularly valuable. By applying the training content to themselves and their own lives, both trainers and trainee participants perceived this facilitated a strengthened learning of the concepts, the language and the strategic approaches which they could then model and utilise when working with clients.

> *I think what worked well definitely was starting with an extensive part related to personal mental wellbeing […] because it helped the group to bond. It helped them to reflect on their own mental well-being and just have more insight and maybe they also have language to call certain internal happenings, you know, feelings, thoughts and etc. […] (Trainer 1).*
>
> *It was the first experience to me, so I am really satisfied of the training. Firstly, I gain a lot of informations from the trainers and it helps me to know what mental health means and how to become a peer advocate and peer support. Secondly, it helps me to know some aspects of my personality, so my confidence build week after week and the most important that I learn how to take care of myself and try to keep my resilience balanced each day. Finally, I feel that mental health becomes a part of my life and I will do my best to continue in the field of mental health (Survey Respondent 8).*
>
> *In the first […], I didn't know anything about mental health. But after finishing this excellent course, I've become fully aware of the important of mental health, yes and they helped me a lot in my life and made me more confident in facing and dealing with any difficult situation. It's also provided me with enough training to help others and even to give talk about mental health, you know.. And it's getting... It's gaining more confidence in myself, respecting other people believes, values, religions and to be a more human, you know, to and accept others.*
> *It was really supportive for me. It helped me to identify first my mental health and how to maintain a good mental health. If I feel good mentally I can be able to support all people around me that need help (FG1, Trainee 1)*
>
> *Sessions about self-understanding (first you need to know how to help yourself and after how to help to others) (Survey Respondent 6).*

2) Training Placement Experiences

In the original training programme, a period from June to August was intended for dedicated training placement wherein trainees would work in mental health organisations, services or alongside established peer workers. As a consequence of the Covid-19 pandemic related public health restrictions, the placements consisted of a blend of physical and virtual experiences.

> *Because of the coronavirus we were really restricted in a way it was difficult to get people into placements. So, our original idea was to provide them more, you know, skills and knowledge first and then lead them to engage with services through their field work. But that was... that was challenging (Trainer 1).*
>
> *When we did the placements, for instance, that the few weeks placements, you know when they wrote kind of portfolios and all the rest, they didn't really get that experience and from Advocacy Network point of view on...Covid is one thing, but you know I can only get them to talk to practicing advocate because we wouldn't be bringing in somebody, you know. For the best I can do is to get them to speak to the practitioners, to ask the questions they think they needed to ask, you know (Trainer 1).*

Many of the participants reflected that the absence of physical training placements was challenging for them. They noted that they would have liked opportunities to practice and apply the knowledge gained from the in-class sessions into real world contexts.

> *I found the most challenging thing was to put in practice everything we have learned. I think I did a good job but it was my first time and it was quite challenging (Survey Respondent 7).*
>
> *A challenge for me was putting in practice everything I have learned (Survey Respondent 9).*
>
> *Actually, I want to say there are the practical parts to it. Like for example, there's some people like this, or some students, like when I was in the hospital, there was lots of students who were joining the meetings an... with the doctors, you know, and they asked the patient: Is it OK we have a student here training or something? If we could add a practical part, so we could see on the real life how these things could be done. That will be perfect (FG1, Trainee 3)*
>
> *The only thing would be to have an opportunity to engage with community organisations that are supporting those with mental health issues in a physical space. The learning from this training has been theoretical, but the personal interaction with the peer support worker and peer advocate helped in understanding how to support people experiencing mental ill-health (Portfolio, Trainee 7).*

Perhaps in light of the perceived absence of opportunities to practice the knowledge and skillsets learned in class, a desire to shadow experienced peer workers was highlighted many times by both trainee participants and trainers.

> *But what I would need the most I think is practice. It's annoying, but it's easier for us to deal with people that we know. If you have someone that I don't know and comes from a different background or something like that, it would be challenging for me, so I would need someone to see in action. So, then I could perform or to have just a little bit more practice with the, with the actual peer advocate (FG2, Trainee 6)*
>
> *There are lots of opportunities to learn, but it might be a bit of a disappointment to not be able to practice with a patient on a one-to-one basis as well as meeting face to face due to the restriction in place at the moment (Portfolio, Trainee 7).*
>
> *What could have been better was that I would have liked to have been given the opportunity to visit some mental health services in person (Portfolio, Trainee 7).*

The need for a shadowing component to training was also strongly advocated by some of the trainers. They described the training process for peer advocates within their organisation, noting the essential need for new advocates to work alongside established peers prior to working on their own.

> *We will then put them on a shadowing. That means that they shadow an experienced advocate whose been working on this for a number of years, and all they do is first of all […] They just kind of observe really, sit with the with the client, obviously getting the consent from the client obviously if it is all right for this other person sit in. And so, they go through a period of that, and in some sense, they also make it a bit of shadowing later on from the manager and once everybody's satisfied, you know, and think this person is good to go, then they released to go to the wild themselves, you know […] But that shadowing is essential for us, you know, it's absolutely essential (Trainer 2)*
>
> *All our advocates are trained at [name of university] level 8 in advocacy […] if they pass the interview process, they go through then really in-depth training, so what ends up with the [name of university] level 8. At the end of the day, say if we started somebody tomorrow morning, just said to offer them a job they're not on the unit on their own for at least maybe 3 to 6 months. They have to go through a shadowing process and they go out with a trained advocate that has gone through the process. And at the end of the day, if the, if they don't come up to scratch with another three to six months period, they're not going to keep the role. But it would be stupid putting someone that just started the job one day and put them on unit the next day to say work away. Like, that's just not the way it works because we, we only create problems for ourselves […] that's a lot of diplomacy in it […] (Trainer 2)*

3) Future Training Needs

All participants expressed their wish for additional training in the future. Participants acknowledged that the training content and subject was very new to them. They articulated their understanding that, due to the sensitivities and vulnerabilities associated with mental health difficulties, a specialised skillset is required.

> *I hope additional training as well, yeah. […] if there is an additional training to develop myself in that way, because I know I gain information, but I need more. I know…. Because it's new for me (FG1, Trainee 4).*

Definitely, because I feel it's not something easy and like you are dealing with people and this is their life, their future, So, I think, I think you know what I would love to, I would love to learn [more] (FG1, Trainee 3).

For these reasons, many of the participants spoke of their wish to further broaden and deepen their understanding, their knowledge, and skillset competencies. Some participants identified particular areas they would like further training in, including broadening their knowledge of the aetiology of mental distress in addition to increased familiarisation with the myriad of support services available in Ireland, and to strengthen their interpersonal skillsets such as communication and mediation strategies.

Well to me, I think it was OK, but there is still some things missing for me, that I really need to know more about. There's still more to it than just in mental health, you understand, although we did a kind of, we went for some other aspects of talks, like in decision-making support, decision support system or something like that. Or there are, there other two, you know, like when you're going to college to do advocacy is not just about one particular thing, there are other aspects in. That's the way I feel. That is not just communication, is not just about resilience, there are still some other parts missing.[…] Tell us about the other services and we know they, they.. may have many services work for mental health like you say: SHINE and Decision support services. It is different organization each of one they help in different way (FG2, Trainee 7).

In my opinion, if you want to help a people, especially with mental health problems, it is not enough to have information where to get the help, services. Also, it is very important, that person who is helping, learns how to give that information. In my opinion, we need to learn psychology also, how to speak with people who have mental health problems (aggressive people, autistic, depression and lots of different types). It would be very useful to study various diseases associated with psychological health; symptoms; behaviour, even treatment and how it affects the patient and his family (Portfolio, Trainee 11).

Two of the participants also highlighted their desire for additional training and guidance in managing relationships with clients. They noted that during their training placement period, it was challenging to manage their time and maintain a professional objectivity with clients, disclosing that, in their enthusiasm to help as much as they could, they may have become 'very involved' with their client. In recognising this, they noted their need to instil stronger work/life boundaries and communicate clear service provision remits to potential clients.

The fact that we live in the same place wasn't so positive because we ended up helping her in different times over the day and we didn't put time boundaries. Another thing was that we got very involved and we wanted to help her as soon and as much as we could.

We would like to be more objective and not to get too involved into helping someone. We want to improve how to keep a distance with our peers even if we know them and to be more determined about the working time (Portfolio, Trainees 5 & 6).

We are in our first steps and there is always place for improvement, for example we would like to be more organised and to put some boundaries. Since we are living in the same centre people asked for our help at any time so we would like to define better our services and working time so everyone would be clear for what and when to contact us (Portfolio, Trainees 5 & 6).

Some of the Trainers also highlighted the need for additional training in more specialised fields in mental health service provision, specifically when working with clients requiring support during their voluntary/involuntary inpatient admission. The trainers noted that a rigorous knowledge of mental health legislation and its application is required to support peers during this time. In addition, astute knowledge of organisational cultures within services and excellent diplomacy skills were identified as integral for peer workers to establish and maintain collaborative collegial relations in these specialised environments.

[…] talks were very good and listened very well and they were very interested but just the all the main is going to be mental health advocacy, they need to be very aware and going back again to the regulations and... and on that, on that you know, because like they really get under severe trouble afterward if they're not up to date with that. That would be me only now. It's not a concern, it's just… what would you call it. [INTERVIEWER: "Area for improvement?"] Yes, I know like at the end of the day, let's say, if we start the new advocate in the morning, they will know nothing about mental health, but they are trained up well before they actually get out (Trainer 2).

I think we gave them the basics. Support to advance further their advocacy skills and to be up to speed with legislation would have to be provided. It has become clear that this role should go beyond advocacy if we are serious about meeting the needs of disadvantaged clients. The trainees emphasised the need to help clients with self-regulation and self-management. We could start with existing training programs provided by the HSE and other NGO's, wellbeing programs such as Mind Your Wellbeing and Stress Control, WRAP. (Trainer 1).

Further, the placements proved the need for more extensive listening skills training that could be provided maybe by Samaritans as well as suicide and self-harm prevention like Assist Training (Trainer 1).

Some of the participants have availed themselves of the online training opportunities that were taking place at the time, and they participated in seminars. This way they not only gained knowledge on a particular topic but also got to know organizations and services and the

EXPLORING THE ROLE SCOPE OF MENTAL HEALTH & WELLBEING ADVOCATES

EXPLORING THE ROLE SCOPE OF MENTAL HEALTH & WELLBEING ADVOCATES

INTRODUCTION

To explore and draft the role scope of Mental Health and Wellbeing Advocates for ethnic minorities, a documentary review, in addition to two focus groups, and six individual interviews were conducted. The data captured identified the key occupational tenets, practices, and accountability mechanisms of a Mental Health Advocate (MHA) for Ethnic Minorities.

To aid the overarching conceptualisation of and communication about the MHWA's role scope, Figure 4 depicts the tenets, practices, and accountability mechanisms of the MHWA role in a Tree analogy. The key tenets or values of the role equate to the roots of the tree. The key practices are likened to the tree branches and the accountability mechanisms are illustrated as supportive scaffolding. Figure 5 illustrates the interconnected and dynamic nature of the tenets and practices of the MHWA role, nested within the accountability mechanism of mentoring and code of practice.

The study findings supporting the conceptual illustration of the MHWA role are presented the following sections under the three overarching themes including; 1) Roots of Practise; 2) Branches of Actions; and 3) Supportive Scaffolding.

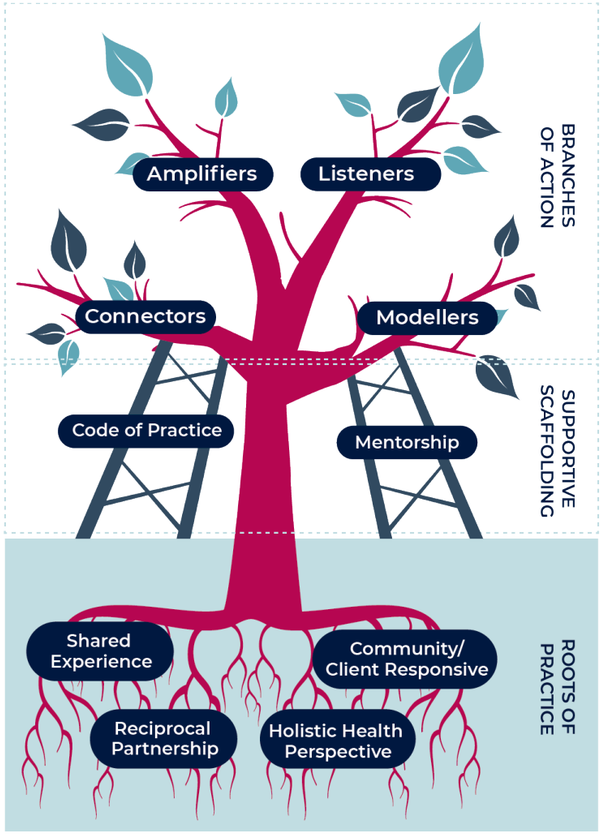


Figure 4. Overarching Conceptualisation of the MHWA Role Scope

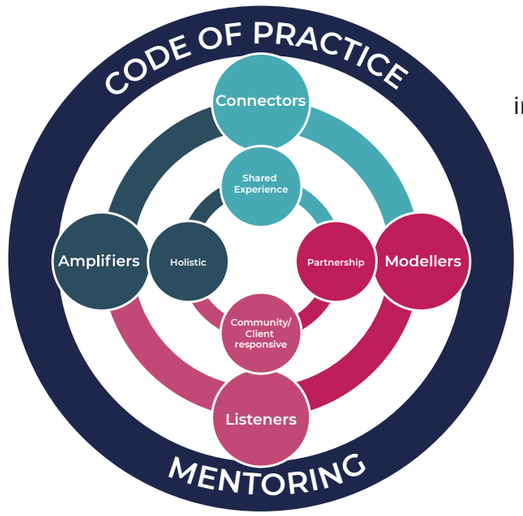


Figure 5. Illustration of the interconnecting role tenets & practices, nested in accountability mechanisms

ROOTS OF PRACTICE

Both Trainees and Trainers identified four fundamental tenets underpinning the Mental Health and Wellbeing Advocate (MHWA) role which would imbue through all MHWA occupational practices or, as we have coined them 'Branches of Action'. These key anchoring values include: 1) shared lived experience; 2) reciprocal partnership; 3) holistic perspective to wellbeing; and 4) a community responsive approach.

1. Shared Lived Experience

The MHWA programme is migrant designed and led. The MHWAs all have experience of migration and of living as a minoritized identity in Ireland. Both MHWA trainees and trainers spoke of the importance of shared identity and experience with clients. The shared experience of migration and experiencing Ireland as a minoritized community, in their opinion, fosters an enhanced empathy, understanding, and sense of belonging with their potential clients.

> *[…] in the beginning I didn't understand the words" peer advocate" at all […]. But then when I understand I found it something is really good and I wish I had a peer advocate when I was in the hospital because that would be very, very helpful for me and for my situation. […] I'm talking from my own experience, if I had like peer advocate, I wouldn't be thinking the way I used to think, like criticizing myself or why I'm like this, why I'm like that. […] the peer advocate role, somebody that lived the experience, when I talk to them I feel like I'm belonging to somebody rather than I'm talking to a doctor. Sometimes I feel like are they [the doctor] understanding me, am I exaggerating, you know. So it's [peer advocate], it's a really good role and I'm so glad that... that there is something called peer advocate […] (FG1, Trainee 3).*
>
> *[…] I love Irish people are so welcoming and everything, but they cannot understand quite... when I tell him about something it's like they feel very empathetic and they feel sorry for us and they want to help, they really want to, but they cannot understand what I really mean, or what we really have been going through[…] But if it was a person that is being through the same, like an asylum seeker who got papers and now is in another position he would understand what I went through. Or an [names a specific nationality] like [peer research assistant] said, [names specific nationality] would understand the way I think. Even one expression I say you would understand what is my problem or what I want or gesture with the way we move our hands. OK, yeah, so that will be easier, I think. (FG2, Trainee 5).*
>
> *I think that if you don't feel it, if you never felt the pain what I'm going through, you will never be able to help me. You can support me. Yeah, that's true, but you can't help me 100% for sure (FG2, Trainee 6).*

The Trainers and Hosts in Training Placements also highlighted the integral value of the shared identity between MHWA s and clients. Mirroring in some respects the peer support relationship, wherein peers "draw upon their lived experiences to share 'been there' empathy, insights, and skills, serve as role models, inculcate hope, engage patients in treatment, and help patients access supports [in the] community" (Chinman et al., 2008, p.1315), the trainers articulated that the experiential knowledge of MHWAs would facilitate a therapeutic connection between the MHWA and the people they work with.

> *If I go in there, I'm coming from a place of privilege and power imbalance and if you go in, there is somebody "listen that I was in hospital myself and I tell you, when I went home I had sour milk. Don't be doing that to yourself, right"? (Training Placement Host 1)*
>
> *[…] just because you're a peer does not automatically mean this is gonna be a good relationship? Don't take that for granted, you know […] But what I have found is generally, and you know mostly is, that the peer-to-peer relationship does work in the sense of feeling connected. Here's somebody speaks the same language, and that's a good start, you know. You know, of building trust, of having probably slightly at least a slightly and probably a better, far better understanding of what it is like to be in this position, having gone through some of the denser experiences in your life. (Training Placement Host 2)*
>
> *[…] So, that kind empathy and authenticity of kind of going through something similar, I would hope would enable people to be more....Genuinely, authentically empathic with the person. Help them feel a bit more connected through language and all the rest, because even just hearing somebody speaking the same language I think is probably extraordinary for some people in the mental health services, and building trust through that, you know. But these things have happened slowly sometimes, but at least it's a start and even just hearing that voice and stuff […] (Trainer 2)*
>
> *I've noticed, that, working with peers creates good foundations to reduce stress by increasing relatedness and sense of belonging, shared cultural expressions of distress and safety. One doesn't have to explain their cultural nuances, worry about things getting lost in translation (Trainer 1).*

All of the MHWA trainees mentioned trust as a primary component of their shared identity with clients and consequently facilitator of building successful working relationship with clients. They appraised that trust can often be absent from traditional relationships between service providers and minoritized communities. Consequently, limited trust of service providers can act as a barrier to people disclosing their concerns and/or accessing support.

> *Most of the people in our community is the trust, they don't trust anyone. Right, if you come [to] a Roma person to you now and you ask him something, never he don't say the truth, never. But, they come to me like, because I am Roma, they can tell me straight away, you know, "listen, I am like this, I'm like this, I'm like this" you know but to another people, no. And this is very difficult and this I explain [to] them because if you don't share your problem, your situation, how he can help you? (FG1, Trainee 2).*
>
> *The first thing is the language. Therefore, because if you got a person from different country, how they can understand each other. Trust. The second thing is trust. How can I share all my information to this person? Who is this person? How can I know this person? What he can do with my information on these kind of things? (FG1, Trainee 2).*

Indeed, a training placement host highlighted how, despite several attempts in the past, they had been unable to adequately facilitate access to their services for a specific minoritised community. Like the MHWA 's, the training placement host too cited the primary challenge to facilitating access as being about trust.

> *I was never going to get in there and I was never going to compare with management. And have been knocking on doors of quote, unquote asylum seekers just to be called years ago and given talks could never get access […] And then the people themselves were frightened to engage with this fricking big, White lad talking about mental health (Training Placement Host 1).*

In contrast, the MHWA's advised that their shared identity and minoritized experiences would facilitate a sense of trust in their working relationships with clients. They believed clients would see them as people who understood them, could genuinely empathise with them and consequently as people they could trust to assist them.

> *[…] but I think if I had someone that has gone through the same experience like me, or at least, has been dealing with asylum seekers before, I will build trust because I know that that person understands what I'm going through. But if it is a person from a different background and he has no clue what asylum seekers are or [what] our problems are, I would have the little bit problem [with] trust. (FG2, Trainee 5)*

It was noted that despite their shared identity, building trust would not be fostered automatically and still would require effort and time to flourish.

> *[…] most of people, they don't want to see anybody because they don't have trust. But if they see that someone is coming, someone is asking, they will not talk to him the first time, the second time, the third time, but on the fourth time they will stop, they will try that, they're gonna say, "oh, I'm gonna try this once. Let's see what will happen". (FG2, Trainee 6)*

Two of the MHWAs foresaw that trust would be a principal challenge to people working with them. During their work placement, they strategically took a soft approach to the support they offered people, choosing to discuss more practical information first to initialise and build up supportive relationships with people. In time, as people got to know them more and become familiar with their supportive roles, they developed their conversations towards more sensitive topics, like mental health;

> *To build trust, it's like we did in our centre when we opened our support group. First of all, we started helping people with information with small stuff, for example, you can apply for PPS here, you can apply for medical card there. And then after few days, they come to us talking more. […] We did a test for it just to see how, how the things went. So, to some people I start, I didn't start to talk about mental health right away, I just started to try to ask them if they have a problem or what do they need or information about stuff, because in our centre there were a lot of new asylum seekers without information at all. So, I started talking then to other, to another group of asylum seekers. I want to speak about mental health, if they are stressed or not and the answer was that, yes we are stressed but the stress will go away, we are humans and every human has a problem. I'm not sick. I don't want to talk about mental health. And the [other] group that I have, we help them with different information, then they started opening up more. We are human and we need some proof in the beginning, so….(FG2, Trainee 6)*

2. Reciprocal Partnership

In the spirit of co-production, reciprocal partnership was another core underpinning value highlighted in the narratives of both trainees and trainers. It was argued that reciprocal partnership should imbue both one to one relationship with clients, in addition to working relationships with other peer workers, support services, and organisations.

Within one-to-one relationships with clients, it was noted that MHWA s should work from a flattened hierarchy perspective wherein power dynamics between MHWA and the client would be minimised as much as possible. The knowledge and guidance of the MHWA would therefore not be prioritised and prescriptively delivered and subsequently applied by the client. Instead, a spirit of reciprocal collaboration between MHWA and client should be fostered.

> *Peer advocacy and peer support doesn't have to be anything magical […], complex, you know. I think some mental health professionals work to complicate things sometimes, but it can be so simple but so meaningful for the person. People don't realize how simple this is, but also how powerful that is, you know. So, that, yeah, so that just human contact, that kind of empathy, that kind of connectiveness, the authenticity, you know and just lastly, the non-hierarchical relationships. This isn't about our knowledge meaning more, me having power over you. This is about just us. Us trying to work aside together […] with that kind of flatten hierarchy is huge […] and making sure the person knows that there's no judgments here. […] (Trainer 2)*

Reciprocal partnership was also perceived as integral to establishing and maintaining effective working relationships with other peer workers, support services and organisations. For example, the advocates spoke of working together with other staff members in Cairde and with other organisations, pooling all sources of complementary knowledge to ascertain the most effective and least restrictive pathway to support services for individual clients.

> *And for this we can give advice, not promise for anything, because you sometimes you can't give him anything, but you can help him to connect the services and you can go, Like me, you know, when they came to Ireland and we have mental health problem and we have a problem of the health, you know. I connect with the Cairde and you know I connect with Emilia and I told her about the problems and together, Emilia helped them to connect with the services, with doctors, with anything they needed. In my way I support it with my knowledge I know, you know, and we work together to help the people (FG1, Trainee 1).*

In addition, some of the MHWA 's demonstrated their enacting of reciprocal partnership values with external support services, such as SHINE and Monaghan Healthy Ireland Partnership, during their training placements. In both exemplar cases, a blending of distinct knowledges and skillsets was evident wherein each partner equitably contributed to initiate and/or create effective initiatives for clients.

> *So for me looking at it now, I'm not talking for the organization, I would love a worker within our service who I could support. […] the skill and knowledge I have, and other people in this area of mental health, is gained over year but it's of no use, it's just like a closed book if there's nobody there to read it. So you need a librarian. You need somebody to present a range of topics or whatever to their cohort of people […] (Training Placement Host 1)*
>
> *So I needed her and she needed me […] She had vision, she had awareness and so I could use that in order to access and so we had an exchange of knowledge and skills […](Training Placement Host 1)*

Trainees and trainers identified that fostering harmonious working partnerships with established peer-led support services would facilitate an advantageous blending of knowledge and skillsets. For example, participants felt that an optimal provision of culturally appropriate and rights-based advocacy support for people from ethnic minoritized communities could be achieved via a collaboration between Irish Advocacy Network (IAN) and Cairde's MHWA.

> *They [IAN] said it themselves that they haven't really supported clients from ethnic minority backgrounds to the same extent as they are represented in the hospitals […] that may create a barrier because if you don't know what's IAN, and what's advocacy, you will never ask for help. I've worked with clients who had been hospitalized even a few times, but they never heard about the service. Majority of Cairde's clients are in the community but sometimes we get calls from a person in a hospital or from social workers. So […], maybe we will find a way to collaborate with IAN […] to make sure that their service with our support, supports clients from minority backgrounds that are in acute settings (Trainer 1).*

> *Yeah, I mean, we do come across people from ethnic minorities in the psychiatric ward, you know, and we do our best with them […] so I think would be good to see if there's some way of kind of joining forces [with Cairde], at least work jointly with our [IANs] advocate or else take over, you know, the case, if you want to call it 'the case' (Trainer 2).*

> *[…] the problem being in some of the units there's just no interpreters, full stop. That is a big problem. […] I find that could help us. I would be honoured if we could work to collaborate with Cairde on this […]. But there's, there's definitely a lack of it within acute units. There's, there's no doubt about that, you know. […] there's definitely an opportunity there for organizations to tally up with each other and work collaboratively on it, you know. (Training Placement Host 2)*

Importantly, it was recognised that, as with any partnership, shared expectations about how the partnership may work in practice would need to be agreed and adhered to. This would include ensuring harmonious codes of practice and, in certain environments, securing stakeholder acceptance and facilitation of the working partnership.

> *[…] I think what we would have to do is we would just have to look to see what you're doing and what we're doing and just basically say this is how we can work together […] you know we come across someone from ethnic minority who's on a ward and we have difficulty communicating with them, then if we could pick up the phone, there could be somebody there [from Cairde] to talk to them on the phone. Possibly coming to see them […] it is very difficult to get into the wards, I must say, you know. So the system would need to understand also that we work with Cairde, and that sometimes we may call on their services and bring them along with us and the service, to kind of work with people you know. So they [mental health system] would need to be ready for that, find it acceptable as well, you know. […] I suppose you know, it's just about understanding each other's role, how we operate, how they operate […] (Trainer 2)*

3. Holistic approach to wellbeing

In describing their work and their perspectives on the determinants of wellbeing, trainee and trainer's narratives indicated that the work of the MHWA would be underpinned by a holistic understanding of wellbeing. For some of the Trainees, this holistic approach was inspired by their own beneficial experience of engaging with mind, body and social activities to support their recovery;

> *To get well, I've started investing in my intellectual and spiritual development, self-care, quality of my health and life. I've realized also that people who are around me were also important for my peace, happiness and development. I worked in Cairde to help other people and I learned a lot. I have fantastic time with Mental Health Reform (grass root forum). I enjoy improving human rights for other people with mental health issues. (Portfolio, Trainee 8)*

The Trainers in particular spoke of the importance of engaging with a person's wellbeing along the entire continuum from prevention, early intervention and management, and in so doing responding to interconnected, psychosocial determinants of mental health and wellbeing including the physical, social, and psychological needs of their clients.

> *[…] we all need that support, that sense of belonging […] it comes back to Maslow, the pyramid of needs[1] […] (Trainer 1).*
>
> *[…] And I've seen how people were changing when supported by our trainees. Having one person who listened to them, validated how they felt, was willing to help, have made a huge difference. Also, if there was a progress with practical issues, you know they're getting their medical card, GP, they were seen by a psychiatrist, or they were moved to more suitable accommodation, things were all of the sudden brighter, you know, they're smiling and send emails saying they're happy or they have hope. So, social context of health experience was clear. Also, how physical and mental health interlinked. […] I'm arguing that there is need for type of support that incorporates this dynamic, that empowers and supports clients to make behaviour changes that may benefit their mental health and wellbeing, that helps them to solve practical issues […] (Trainer 1).*

1 Maslow's Hierarchy of Needs refers to Maslow's (1970) theory of motivation which suggests that there are five categories of human needs that must be met in order to reach self-actualisation. Once basic physiological needs are met (food, water, shelter), safety needs (such as security, employment etc) emerge, followed by belonging (connection, family) and esteem (respect, status).

The Trainees holistic approach to wellbeing was demonstrated during the Trainees experiential training phase wherein many of them incorporated culturally appropriate mind, body, and social practices into their amplifying, listening and modelling work. For example, in the below quote one of the Trainees describes the mind, body and social practices she leads in her Direct Provision residence.

> *"Every Monday and Wednesday in the morning from 09h30 we meet in the dining room with start with breathing meditation for 20 minutes. After that we start doing yoga for 30 minutes. If it is not too cold we go outside to do dancing exercises playing music or we do it inside and we started Zumba classes […] Wednesdays we start with breathing meditation, we go for a walk at [location] lake across the road, we tell stories, jokes and we laugh. There is space outside the house we play basketball. Fridays, we do gardening, planting flowers and vegetables" (Portfolio, Trainee 10).*

4. Community Responsive

Instead of a prescriptive model of support, it was articulated by one of the lead Trainers that the MHWA role would be responsive to the distinct needs of the varying minoritized communities they work with. In recognising the diversity of needs across minoritized communities, the trainer articulated the intention that the MHWA role would design and adapt the core focus of their work in accordance with a need's responsive assessment of the primary social-cultural, socio-political environments determinants of a specific community's wellbeing.

> *[…] we would love to employ mental health and wellbeing advocates to engage with their respective communities and to address their specific needs in a culturally and linguistically appropriate way […] (Trainer 1).*
>
> *The Role is likely to vary a bit depending on a community needs and depending on the person that actually does the work, their own professional background, competencies and strengths. Speaking in the terms of positive organizational scholarship you have to give people some flexibility to define their role within certain boundaries. Job crafting based on strengths improves many aspects of work engagement. Training participants brought this new role to life. Some people focused on individual support, some on outreach, improving mental health literacy, breaking the stigma as this was identified as a need in their community (Trainer 1).*

During the experiential training phase, the distinct, tailored activities of each individual MHWAs demonstrated how they each responded to the specific and prioritised needs of their own community. For example, to ensure they tailored their work to the prioritised needs of the community they were serving, one MHWA conducted a needs assessment survey at the start of the experiential training phase and subsequently planned their work in accordance to the results.

> *I prepared a survey to give to people living in the same direct provision with me. I wanted to know what needs for mental health they have and how they wished to get help. […] (Portfolio, Trainee 9)*

BRANCHES OF ACTION

The Amplifier role encompasses outreach awareness activities about Mental Health (MH) with minoritized communities as well as in-reach awareness activities with MH support services and staff about the MH needs of minoritized communities.

Exemplar 1

Two of the MHWAs worked together to create two connected videos in the Arabic language (one on Trauma and one on the Emotional Freedom Technique), with the aim of informing people of Arab and Muslim backgrounds living in Ireland about Mental Health. As one of the MHWA states; *"One of the most important reasons to share these videos is to raise awareness of Mental Health and it is a great opportunity to break the shame (stigma) in our community"*. To promote the videos, the PSWs extensively engaged with key stakeholders in the Arab Muslim community, including Dublin Mosque, Islamic Cultural Centre of Ireland Community Welfare Office, and the Palestinian Embassy. All stakeholders were very welcoming and encouraging of the initiative, particularly praising the leadership of the two PSWs, as two veiled Muslim women, in tackling the sensitive subject of mental health for the Arab Muslim community. The videos were posted on all the stakeholder's websites and social media pages. As a result of reaching out to promote the videos and establishing these initial connections, further amplifying activities were organised at the request and in collaboration with the stakeholders including an online webinar about mental health, conducted in the Arabic language, with the Imam and sister from Dublin Mosque, offering the Muslim community an opportunity to ask questions about mental health and help reduce the stigma and shame about it. Other potential initiatives are being planned for the future, for example establishment of regular mental health workshops with support group with the Islamic Cultural Centre. In connecting with community leaders, the PSW also disseminated mental health promotional materials like posters and mental health guides in the Arabic language and promoted the role of the PSW as a support service that the leaders could engage with if/when people in their communities come to them seeking mental health advice and assistance.

Underpinned by the 'Roots of Practice', trainees and trainers also identified four key occupational practices or, as we have coined them 'Branches of Action', including MHWA s working as; 1) Amplifiers; 2) Connectors; 3) Listeners and; 4) Modellers.

1. Amplifiers

There was consensus amongst all participants that a leading aspect of the MHWA role would be to amplify awareness. From these initial perspectives, the amplifying role would encompass; 1) *outreach awareness activities* about Mental Health (MH) with minoritized communities; 2) *In-reach awareness activities* with MH support services and staff about the MH needs of minoritized communities and the role of the MHWA; and 3) *regional/national awareness activities* at community development and policy platforms.

Outreach Amplifying

Participants recounted that outreach amplifying work would primarily consist of conducting MH awareness workshops in the community. The content of which would focus on understandings of and beliefs about MH, the potential causes and/or exacerbators, and the supports available. Participants envisaged that enhancing MH literacy amongst the community would contribute to increased acceptance and comfort in talking about and seeking assistance for MH.

> *We did zoom meeting with them and we explain everything about mental health and don't be afraid to talk, don't be afraid to ask for help, don't be afraid to for ask support…. And [Cairde coordinator] attend the meeting as well and they gives information if people have suffering from something you can ask them and you can go for to the Cairde and ask for help. And if people need because […] maybe they don't speak English, and if people need someone who help them or support them, can ask for me or [name of other* MHWA*] or [name of another* MHWA*] to help them […] (FG1, Trainee 4)*

> *And another purpose was to raise awareness about mental health, because a lot of different...since we come from different backgrounds we don't have enough knowledge about mental health(FG2, Trainee 6).*

The trainee participants in particular spoke about the need to incorporate anti-stigma awareness into these outreach amplifying activities. From their perspective, significant stigma and shame about mental distress existed in their communities which, for many, hindered people's willingness to accept, disclose and seek assistance for their difficulties. Outreach amplifying activities were framed by participants as a potentially effective strategy to enhance understanding about MH and in turn reduce stigma.

Exemplar 2

To amplify about mental health and reduce stigma about it in their direct provision centres, two MHWAs established a new support group called 'Failte'. They organized meetings to talk about mental health with the fellow residents and shared mental health literature about where people could seek help including different organizations who can help like Shine, JigSaw, Samaritans, and Cairde. The two MHWAs also organised online meetings with specific focus on stress relief and shared meditation techniques they had learning during their training.

> *Sometimes we have some shame and stigma for this subject. But when you speak to him more than one time and they understand what you what we mean of the mental health. Even from our country, talking about mental health, it's like no, you're crazy or you're sick, you are, we don't talk about that. It's like a disease, but it's not, that is part of our health. People who start accepting then they will ask more information how they can get better, how they can relieve their stress. So, we should fight stigma (FG1, Trainee 1).*

> *I think that one of the main issues that asylum seekers have is the knowledge about mental health. Because when we started the training and we decided to open our support group, I started talking with our, with my friends here in our centre about stress, how do they feel and what do they do about stress, relief stress. And they all accepted that they are stressed, but to do something about stress, their answer was: "no, I'm not crazy. Go away. What are you talking about?" […] so, one of the main issues is for everyone to accept that there it's not a problem, it's not a disease, but it's something that we should know, that mental health affects our lifestyle. So if we if we raise information or awareness about this then people will start accepting, will ask more information how they can get better […] (FG2, Trainee 6).*

In-Reach Amplifying

To compliment outreach amplifying activities with communities, some of the trainee participants highlighted that MHS are primarily designed for the majority and consequently there may be deficits in the degree to which services are culturally safe for minoritized communities. To begin to strengthen the cultural safety of MHS services, they recounted that the MHWA amplifier role could also incorporate in-reach work with MHS staff and services focused on raising awareness about the specific MH beliefs, determinants, and supports needs of minoritized communities.

> *The services are designed for the majority, they are not designed for ethnic minorities, so that's the main problem. That's why we should educate services too […] We, as an asylum seeker, have lived with that problem because we have been here for a year and a half now and never have we seen mental health professionals come here, in our centre and just talk with people and we have people here with stress, we have people who are depression, we have syndrome or problems that they need and they don't know where [to go]. They stay all day close in their rooms because they don't know where to ask for help. And we have many other problems like stigma,*

we have a language barrier. We have cultural barrier, so yeah, I think it's very important to educate the services too, not only the people who will need the service, yeah (FG2, Trainee 5).

What was surprising to me here in Ireland was not the lack of information in Irish people, but in the medical staff. Because I had my own experience when I went to the doctor for my check-up and I told her that I'm an asylum seeker and I'm sure that she deals with asylum seekers all the time, and she said, OK, you're homeless and you are living in a shelter. And I was very surprised, as she's an educated person, she deals with asylum seekers all the time. How could she not know? If she had known that I am asylum seeker, maybe she would have known what problems I faced because she left on an appointment for mental health for me, but she left it months ahead, so maybe I was thinking, if she had known that how many problems I face everyday in what kind of accommodation I live and everything, maybe she would have asked me, do you need an appointment early or something? So I'm thinking maybe that's the work that a peer advocate can do for me. Maybe just be the bridge between me and doctor and give her the right information about what my problems are and what is an asylum seeker. But it was very surprising to me, that a doctor does not know, yeah (FG2, Trainee 5).

Amplifying the MHWA role

The described outreach and in-reach amplifying work was also thought to provide the added benefit of raising awareness of the MHWA role. The MHWA for ethnic minorities would be a very new occupational role in the field of mental health in Ireland. Consequently, both trainee and trainer participants highlighted the need to effectively communicate and widely promote the role and its distinct occupational remit within the communities but also across all support services along the spectrum of primary to MHS tertiary care.

We actually went round and actually sat with staff and provided information sessions to staff about what peer advocates do, what they don't do, etc. […] we need to be able to inform people and to reassure them as well that you're responsible, that there's nothing reckless […] what I've been thinking about it, who do we need to work with and who do we need to tell what we're gonna do and build that relationship from the trust and all the rest and ensure they know exactly what we're about. (Trainer 2)

[…] because an asylum seeker doesn't have the necessary information: what is peer advocacy, where they can find help […] (FG2, Trainee 6)

One of the training host participants articulated their vision that the MHWAs amplifying work would help inspire the natural formulation of an informal network of knowledge and awareness of MH and the supports available. In turn, a critical mass of informal advocacy in that community could flourish.

I would see everybody who accesses our service as an advocate. That they go out and tell somebody else about what's going on and that supports somebody else to access us, but then as they come in, get the support for mental health they do whatever (Training Host Placement 1).

Amplifying for Policy Inclusion

Beyond amplifying work within communities and MHS support services, the importance of conducting 'amplifying' work at regional community development initiatives and national policy platforms was also identified. The potential for MHWAs to represent ethnic minoritized communities at key local, regional and national initiatives was highlighted by one of the host training placement organisations.

I know that there's other structures within the Council that would be looking for representation from similar target groups like […] the PPN is Public Participation Network […] and they represent all of the community and voluntary organisations in the County, and they are direct link out to the community and ensuring that their voices are heard and their opinions are set in regards to services and supports that are needed for the citizens in the County […] there's all kinds of committees in the Council, […] committees have to have a certain number of community and voluntary reps on them. A lot of them reps are taken from or sought through the PPN network so, you know there would be an opportunity there for the likes of somebody coming through a Cairde program […] link with the PPN coordinator in their County and […] register onto the PPN network. […] being a member of the PPN network would be a way in for that group to have their say (Training Host Placement 3).

In [name of county] the partnership company is called [name of organisation] […] so they work with minority groups, different target groups. They would have what they call is cultural champions and those cultural champions would be from ethnic minority groups and they would do specific targeted work with those cultural champions […] So there is opportunities for them to have valuable input, you know. […] That culture champions structure does exist in the County, so I know it was another way or another opportunity to link some of the work that Cairde might do with ethnic minority groups. (Training Host Placement 3).

Working to amplify the mental health needs of ethnic minorities at national policy platforms and initiatives, one of the MHWA delivered two high profile presentations to the Mental Health Commission and to the Decision Support Service (Portfolio, Trainee 8). The MHWA drew from their lived expertise of mental health difficulties and experience of working with Cairde to outline ethnic minority populations' experiences of engaging with Irish mental health services and the required steps to improve their access to and the quality of mental health care received in the future.

2. Connectors

All participants identified that a core function of the MHWA workers would be to work as 'Connectors'. Participants described the connector remit as encompassing an informal signposting component in addition to a more formal facilitation of client's meaningful access to appropriate support services. Trainee participants in particular articulated that people in their communities may have limited knowledge about available support services in Ireland and/or about how to negotiate access to them. They perceived an integral aspect of their role would be to discuss all appropriate support pathways available to clients and if needed support them to initialise their first and, if needed subsequent engagements with the chose support options.

[…] this is perfect for me to help our community, just to explain them, or just to give them advice or what they can do or where they can go. I am not doctor […], but just to give them advice where they can go and

The Connector role encompasses formal and an informal facilitation of client's meaningful access to appropriate support services.

Exemplar 1

On learning about the organisation SHINE during the training, a MHWA reached out to the local branch in her area. She recognised that many people from ethnic minority community may not know about shine and the supports they offer. She reached out to the in her local Shine and together they worked to raise awareness about Shine's services amongst the ethnic minority community in their area. As people approached the MHWA about their mental health concerns, the MHWA, as a result of building a relationship with the staff there, was able to directly and efficiently connected them directly to Shine. For example, one male client had been staying all day in his room, passive, using laptop and getting tired, bored and depressed. The MHWA connected him with Shine they referred him to the local Men's Shed in the city. He thoroughly enjoyed it and continues to attend three times a week and has articulated that he is experiencing an improvement in his mental health as a result.

help them with direction because there's many people don't know the services. For example me before the training I didn't know for any services to help anyone who suffer from something, but when I joining this training that I know many services and we do a lot of meeting with them and now, we can as she said, if someone feel not well, we know the services maybe can help them […] (FG1, Trainee 2).

[…] first the client feel himself alone and he didn't know anything about mental health or [have] any instruction. And when you connect with him and tell him about the services and about the roles of the advocate, you can take the relationship between the client and the services and then easy, easy to him to tell it to [services] (FG1, Trainee 1).

It was foreseen by participants that this connecting component would be reciprocal in nature. The MHWA could reach into services as directed by their clients but also services could reach out to the MHWA when needing advice or guidance with their existing clients from minoritized communities.

[…] our focus will be more on the clients in vulnerable situations and they would come to us, if they are not able to get whatever they need from the mainstream service. And then, of course we can collaborate with services. We get phone calls regularly, from doctors but most often from social workers seeking cultural advice, just to see what's culturally appropriate in a particular situation. Or, I mentioned isolation, they often are looking to link a client with somebody in their own community […] that also shows the importance of resourcing migrant groups and having those networks to facilitate social prescribing (Trainer 1).

During the workplace component of their training, the MHWA s already began this connector component of their role. For example, one of the advocates worked closely with a mental health NGO in their local area. The MHWA and the organisation firstly undertook a number of reciprocal mentoring calls so as the MHWA became familiar with the organisations ethos, values and service remit and in turn the organisation became familiar with the MHWA 's role scope, skillset and the potential needs their community were facing. Together, they co-designed their partnership and how they could effectively work together to enhance initial access and sustained engagement, when required, to the NGO's services.

So, gave some literature, spoke a little bit about what we did in mental health and how we approached it and how we were available, and low and behold, even before we were officially up and running, we had two people accessing our service from direct provision through conversation. And it was quite interesting for me when the people came in. Even though they referenced who mentioned us, they didn't want...There wasn't the full level of trust either, but which was grand because it was never going to...and as they were speaking to me they got that we wouldn't break confidentiality, nobody would know that we're coming in. And so did two people who attended, there's one still attending, whatever it is.. 7 or 8 months later... and appropriately, and the other person got the support they wanted and off they went […] (Training Placement Host 1)

There is a men's shed in […], which is aimed directly at people in direct provision: whatever they make they sell. […] And so, we got one person from the direct provision who was nearly depressed living at home, a man in his 60s, to access there so he was attending there. So his life changed utterly, he could, go somewhere and it filtered down effect of that then on the whole family now […] (Training Placement Host 1)

It was evident from participant narratives and portfolios that the effectiveness of MHWA 's Connector role would be strongly facilitated by their capacity to build both formal and informal relationships with key stakeholders at primary, secondary and tertiary levels within the ecosystem of community and health service provision in Ireland. For example, when working in partnership with an NGO during the training placement phase, one of the MHWA also informally gained enhanced knowledge about other organisations and services in the area, how the ecosystem of support worked in that local area, who to talk to and where to go. Further, by virtue of working with and therefore being somewhat validated by the NGO, access to other people and networks was facilitated. This 'social or human capital' work, gained through the experiential doing of the role and developing strong networks was considered an important facilitator of effective connector work and streamlined service access for clients;

She got as much out of it as I did in the sense that we had a quote unquote peer to peer conversation. […] Because, you know this is not about me being in control or being in charge, this is about me asking you; "so what do you think would work best?" […] And as she spoke about different situations that may arise, me having the knowledge to [say] "well, that's where you go, you go down to the citizens information they give you a list of 10 places" but me knowing who to ask and me being, me having the gravitas to go to these places, and I think that's the issue with sending people out to find placements. They will get placements and people will love them, but how do you build that accessing you need to integrate yourself into these services. […] And you learn that through over the years through experience and also coming back to the gravitas and me sending somebody somewhere […] the gravitas is that they know that they can link it with me and I'm standing over what's going to happen, and that's something that I will take responsibility for. If we had that, regardless of all the people who work for us, the buck starts with me (Training Placement Host 1).

As to the information that is available, yeah, yeah. Once there is a right person with the right information, they'll be able to point you into the right direction (FG2, Trainee 7).

3. Listeners

Many of the participants shared their perspective that the role should encompass an element of basic emotional support to clients. Such support, as they understood it, would be providing a listening ear to client's difficulties, providing the time and space for them to share their worries and concerns. Many of the MHWA felt this important as they believed many people from their communities could be experiencing loneliness, having difficulty establishing supportive social networks and/or sharing their experiences with other people due to language barriers.
In offering them a listening ear, the MHWA felt they could be a source of comfort, motivation and encouragement for their clients. A number of the participants highlighted that their support could be a source of validation for clients, knowing that the MHWA understood them, and dedicated their time to care about them, support and encourage them.

At initial points of contact, the MHWA's listener role is often the first branch of action employed by the MHWAs. The Listener role firstly provides a safe, validating and trusting space for clients to share their concerns and worries. Secondly, the Listener role assists MHWAs to appraise client's needs and formulate appropriate pathways of support, after which MHWA often then enact their other interrelated branches of action as Connectors and Modellers.

Exemplar 1

In this exemplar, a PSW documents several support phone-calls they had with a client. On first phone call, the client shared their worries and concerns about her son who was experiencing schizophrenia. The client had little knowledge about the condition and had limited access to information in their language. The PSW sourced reliable information about Schizophrenia in the client's language and identified appropriate organisations that could help. On the second phone call, the PSW shared the resources with the client and guided the client through potential care pathways that she and her son could explore. On further talking with the client, the PSW also identified that the client herself needed practical and social support. The PSW, drawing on her connections with the specific community, identified a number of willing volunteers, who spoke the client's language, to provide her with practical help with the upkeep of her home and also offer befriending support to help alleviate the client's feelings of loneliness. The support phone-calls provided a space for the client to feel heard and supported, whilst simultaneously identifying needs and actioning supportive pathways. The following quote from the PSW illustrates the experienced benefits for the client as a result of engaging with the PSW; "Sometimes she calls me also, she feels more confident and happier, she is very thankful for the help and she even share that one of volunteer introduced her to his elderly relative, they became a good friends and chatting every single day by phone".

Exemplar 2

There are many people living in Ireland alone, geographically distanced from their established family and social networks, who may have no or very few people to talk to. In this exemplar, the PSW offered this assistance and employed their Listener role to emotionally support a client. The client expressed their feelings of loneliness, of missing their family members, and their anxiety about the C-19 pandemic. Support phone-calls with the PSW provided a space for the client to release her worries and concerns. The PSW listened and communicated to the client that she was not her own and had their support. The PSW also shared their knowledge of wellbeing tools they had learned about in the training to help the client manage her distress, including guiding her through the Emotional Freedom Tapping technique and later sending her a video of the technique which the client could continue to refer to later. The PSW appraised the outcome of their support phone-calls; "I think she needed to talk to someone because after talking to me, she started feeling well and she thanked me for listening to her and gave her a positive energy".

> *loneliness is a big issue. So, if you're coming to a country, maybe […] you're an EU migrant, but you're on your own, maybe you don't speak English. […] Maybe you know, you're in direct provision somewhere in the middle of nowhere and you have nobody to talk to […] very often these people are just left to their own resources and their stress levels are just booming, you know. And that shows as high anxiety, that shows as deepening depression, physical symptoms as everything is connected. […] so that kind of emotional support, in a form of showing: I have time for you, you're not by yourself. Maybe you're here by yourself, or maybe you don't trust anyone, but I'm here for you. I can give you a phone call every week or every two weeks and you know it has worked like magic to be honest (Trainer 1).*

> *[…] it's when somebody is under stress and we make a phone call or he wants to have a chat with someone, they feel lucky, you know... They feel, uh, they feel like their problem. They share with you and you can understand them. […] because some people, they are alone and this is very bad situation, like to have someone who is alone and who have a chat, to have a conversation with someone (FG1, Trainee 2).*

> *[…] there is people who suffer from mental health, they don't talk. But after talking to anyone, it just he need to someone to listen to them. And after that, they feel more relaxed and more better […] It just need someone who needs to listen to them and maybe they think that, that, that person he care of me and he listened to me. And after that he feel better and he feel, he feel good (FG1, Trainee 4).*

The trainee participants described their Listener role as active, rather than merely passive. They spoke of active listening as a space to firstly understand and acknowledge their client's experience but also of then utilising the knowledge garnered to offer responsive therapeutic strategies. These ranged from 'softer' approaches such as offering words of motivation and encouragement to more pragmatic approaches such as action planning.

> *When I take this training from Cairde, you know I learned many things how to deal […] to help them to support them because they, because they are human beings, you want to be equal. You want to speak to him and to encourage him because everyone in the life have mental health, but in the different ways, you know […]. You can support and encourage the people to do something positive, the people, […] they feel happy and they pleased to do something […] (FG1, Trainee 1).*

> *The role I play, […] cheer up the person I'm working with, makes them feel that this is normal, and that's OK. It's temporary. It's not gonna be forever and they are doing very well and like support them, encourage them. And it doesn't have to be all the time, like just an advice like. Just talk to them as a human being and maybe play with them. Talk to them about what they like, make them remember how they used to be and they could be better. And like they are in this situation now, because this situation will help them move forward to what they want to be in the future […] (FG1, Trainee 3)*

> *[…] so being in the hospital as a patient, make you kind of think again about the whole of your life and try to think forward, what you wanna do for the next step. So we might help them of thinking as well what they are gonna do or put the plan for themselves. (FG1, Trainee 3)*

4. Modellers

In the course of employing the 'Amplifier' and 'Listener' roles, some of the trainers and trainees indicated that a 'Modeller' branch of action could also be integrated into their work. Such Modeller work, as envisaged by the participants, would teach and model wellbeing strategies that clients could utilise to enhance their self-care and manage their well-being. Participants identified that the integrity of such Modeller work is dependent on them first learning about and practise managing their own wellbeing. It is this experiential knowledge that will enable the MHWA workers to then authentically share or 'Model' these skills with clients on a one-to-one basis or in the course of their Amplifier work.

> *information sessions and with a nice element of evidence-based self-care techniques or even sharing own issues could be incorporated in that […] (Trainer 1).*

> *That's why we are here. I think that's why we are here because we could talk from our experience by working with only patients, so we know what, what's the next step […] So training was designed to give trainees more information and skills to manage own mental well-being and therefore they will be able to share those skills with their community members. […] (FG1, Trainee 3).*

Modeller role is often integrated in the course of MHWAs employing the 'Amplifier' and 'Listener' roles. It encompasses peer modelling of wellbeing tools and strategies that clients could utilise to enhance their self-care and manage their well-being.

Exemplar 1

I gave her some posters with Yoga poses for stress release and sleep, she put them on her fridge and she was going to practice in the evening. I asked her if she wished to practice breathing techniques with me. She was happy to do that. I explained to her to sit comfortable, put her hands in her lap, and close her eyes. I instructed her how to breath for 7 seconds, hold for 4 and exhale for 8 seconds. We did it three times. When she finished, she felt sleepy as she was without a good sleep from last night. She felt relaxed when she opened her eyes, and she was happy about that. Her back was a bit free of pain. She was happy to practice these techniques every evening. Our second meeting was like a victory.

Exemplar 2

I did some videos, sharing some information related to the Life Skills Online Program to share it with asylum seekers living in different direct provisions. I was happy for that opportunity to share my experience with the Life Skills Program. I have learned many practices to maintain a better mental health. These tools to release stress which I liked are Mindful walking, feel the heart beats (self- compassion), breathing technique.

> *It's between emotional support and giving people evidence-based tools to mind own mental health […] Clients could be taught how to implement them in their lives, maybe with some you know, behavioural tools how to implement new, new habits. […] by giving people tools and by having more structure and more support for some groups we can achieve, for those groups we can achieve bigger, more prominent results and prevent the difficulties from escalating (Trainer 1).*

SUPPORTIVE SCAFFOLDING – UNDERSTANDING & SUPPORTING OUR PROFESSIONAL BOUNDARIES

As the MHWA are only at the beginning of their journey, Trainers identified the need for future training and continuing professional development, particularly in relation to professional boundaries. The sensitive nature of mental health distress requires critical consideration of legal and ethical issues such a GDPR, human rights legislation, in addition to the potential for vicarious stress and/or traumatization.

Understanding scope of MHWA role

Trainers identified that it is important that MHWA have a strong understanding of the scope of their role, their skill-set, and any associated limitations to these. In their work, MHWA s will need to be cognisant and further trained to adequately identify when a client's difficulties or concerns are outside of their remit and/or skill set as a MHWA and to refer on as appropriate to other specialities such as the GP, or counselling/psychological support services.

> *[…] there were people jumping in saying I would almost advise the person. […] I said, well, we don't do that really […] they need to be careful of that, because you're putting yourself, possibly in the role of an expert and peer to peer, from my perspective anyway, there is no expert here. It is just us and there's what's best for you, but you know, I try to enable you to make choices. I might signpost you, which doesn't face the same thing: could you consider doing this considered unless you can gently, ...kind of put people into that space and direct them that way, as opposed to any advising […] We have the conversation and we get the person to consider go and see and come back to their doctor 'cause we can't advise on those kind of high expertise levels if you want to call it that. And it may come back to you as well, because if you start advising someone and it doesn't work out for them because you have no expertise to do this, then you know you may find yourself in deep water here. you're not a therapist there, not a counsellor […] takes a while to kind of get that […] (Trainer 2).*

It will also be integral that MHWAs understand their duty of care to clients and differentiate between what their role as a MHWA requires them to do and what they may normally do in the role of a friend. One trainer highlighted this is a particularly crucial distinction to make in the field of mental health when the safety of the person and/or other people may be at risk.

> *We have the conversation, and we get the person to consider go and see and come back to their doctor cause we can't advise on those kind of high expertise levels if you want to call it that. And it may come back to you as well, because if you start advising someone and it doesn't work out for them because you have no expertise to do this, then you know you may find yourself in deep water here (Training Placement Host 2).*

Mentoring and supervision

The Trainers noted that duty of care boundaries can be effectively managed through further Continuing Professional Development training and most importantly through close supervision and mentoring from senior colleagues and embedded organisational policy and procedure infrastructures.

> *[…] going forward that they would need to be very aware of boundary issues and all you know, and maybe that's where we could work on down the line, because that could happen to one of our advocates, even the most junior advocate, they would know what to do what to do right away. There would be no grey area there. They would have their phone there and if it was one of my advocates, they would ring me immediately and say; listen, this has come up, I'm doing the right thing here. As Cairde could have somebody to do that within their organization, I'm sure... I'm sure they have like... (Training Placement Host 2).*

Exemplar 1

In terms of client support, *we worked together on more complex cases. For example, an Arabic speaking client has contacted Cairde following an outreach campaign. One of the trainees took a lead on the case. I reminded them about the code of practice etc. After they had an initial conversation and identified issues, we reflected on the support provided, we discussed options available to a client, including access pathways and agreed an action plan for the support team. It included PSW providing emotional support in the Arabic language and signposting client to appropriate external supports, explaining what services they offer, and I guided them through some advocacy actions. A senior advocacy officer and myself followed up on more complex advocacy issues.*

In this vein, mentoring was a core component of the training programme. During the training placement phase, senior staff members in Cairde and IAN provided structured supervision to the trainees. This included guiding the trainee's through rigorous decision making process, in addition to supporting their interactions with external stakeholders, adherence to the roots of their practice and ensuring the quality of their 'branches of action' work.

> *[…] this role does require a little bit more sensitivity than advocating in a general health situation. I put loads of mentoring hours in this, we briefed people, we de-briefed them, especially those who interacted with clients. […] I assisted in drafting needs assessment survey, designing trauma and mental health awareness campaign, stress management workshop. I ensured quality and safety of information provided, helped with technical matters and group facilitation (Trainer 1).*

Code of practice

Alongside Mentoring, the trainee participants work is also supported by a rigorous code of practice. During the training, the trainees were taught about their code of practice and subsequently their placements afforded a learning opportunity to apply/adhere to it in real world settings and interactions with stakeholders and clients. Trainer participants specifically highlighted that the combination of the code of practice and mentoring would ensure the safe and ethical practice of the MHWA role.

> *[…] we went through the code of practice, so they're aware of the do's and don'ts, the role boundaries and limits to their own capacity…I'm happy with their level of understanding and actually adhering to it, also minding their privacy, minding themselves, the way they interacted with clients […] (Trainer 1).*

> *[…] having appropriate policies and procedures, like code of practice and having regular mentoring, supervision to ensure the safety of the client and the safety of the peer worker […] (Trainer 1).*

PATHWAY TO IMPLEMENTATION

PATHWAY TO IMPLEMENTATION

Through the research phase of this project, the role scope of the mental health & wellbeing support and advocacy worker was thoroughly conceptualised. As such, the mental health & wellbeing support and advocacy worker primary occupational practices are now envisioned as four core 'Branches of Action' (Amplifiers, Listeners, Connectors and Modellers), strongly underpinned by four anchoring 'Roots of Practice' (shared lived experience, reciprocal partnership, holistic perspective to wellbeing, a community responsive approach). Further, in support of continuing professional development and in line with required quality and safety considerations, the MHWSAW role is guided by supportive scaffolding mechanisms, including a code of practice, mentoring, and supervision. Table 5 provides a comprehensive role summary of the Mental Health and Wellbeing Support & Advocacy Worker.

With this conceptualisation of the role achieved, the next envisioned stage of this work is to progress towards sustained implementation of the MHWSAW role. There are many influencing factors which can facilitate the successful and sustainable implementation of the MHWSAW role, including:

1. Alignment with policy priorities: The Mental Health and Wellbeing Support and Advocacy Service for Ethnic Minorities thematically aligns with current policy priorities in Ireland[1], including the provision of psychosocial support, which is community based, peer-led, culturally responsive, and partnership brokering, in addition to being holistic, preventative, and recovery enhancing in orientation.

2. Alignment with globally recognised practices: Globally, there is consensus that the provision of culturally responsive care and resolution of the inequitable access to and quality of mental healthcare experienced by ethnic minorities, is dependent upon mental health services working in partnership with ethnic minority communities, and through roles such as mental health advocates, peer support workers, and cultural brokers.

3. Alignment with community needs: The disproportionate rates of mental health difficulties, alongside the inequitable access to and quality of mental healthcare, experienced by ethnic minority populations is well documented. The core occupational practices or 'Branches of Action' of the MHWSAW directly map onto key mechanisms evidenced to help facilitate enhanced mental and wellbeing and improve pathways to and quality of mental health care.

4. Alignment with Cairde competencies: The scope and goal of the Mental Health and Wellbeing Support and Advocacy Service for Ethnic Minorities is consistent with Cairde's well established corpus of work in the field of health advocacy. Cairde's competency and reputation in this field, alongside the trusted relationships the organisation has fostered with the communities it serves, provide the optimal platform from which this new MHWSAW role can succeed.

1 Outlined in 'Sharing the Vision; A Mental Health Policy for Everyone' 'Connecting for Life'; 'Sláintecare' 'Healthy Ireland 2013-2025' and 'Intercultural Health Strategy 2018-2023'.

With a view to optimising these alignment opportunities, the pathway to sustained and effective implementation of the MHWA will focus on five strategic actions.

1. Financing: Implementation of the MHWSAW role on a voluntary basis is unsustainable, belies the need to afford monetary value to the work of lived expertise, and could introduce precarity to the reliability and quality of support provided by the service. For these reasons, a secure funding source needs to be identified to facilitate the sustained and effective implementation of the MHWSAW role.

2. Streamlining: The MHWA role builds on Cairde's extensive corpus of work in this field. To optimize integration and cohesion of the role with Cairde's existing work streams, a revision and refinement of all existing in-house informational resources, toolkits, and promotional materials will be undertaken.

3. Upskilling: While the MHWSAWs have received initial training, the nature of the work requires consistent engagement with continuing professional development (e.g. accredited courses in coaching, motivational interviewing, crisis management, advocacy, peer support). This will be particularly important as the role strives to responsively evolve in line with the needs of the communities over time and as opportunities to scale the service emerge. A consistent horizon scan of training opportunities will be employed, not least to fulfil a moral duty to help facilitate a pathway of career progression for the MHWSAWs.

4. Promoting: The MHWA role is an optimal mechanism to help harmoniously bridge ethnic minority populations with required supports and service provision. Cairde's established relationships with the communities it services and with service provision at primary, secondary and tertiary levels will facilitate a strengthened efficaciousness of this required collaborative work. However, as the MHWA role is new, a targeted promotional drive is required at both the community and service provider level. Educating about the role, its value, functions, and parameters, will serve to support engagement and uptake while simultaneously managing expectations of all stakeholders.

5. Monitoring & Evaluating: An important mechanism to facilitate effective and sustained implementation is an embedded monitoring and evaluation strategy. An iterative monitoring tool will facilitate timely and responsive data capture on; 1) the activities, efficacy, and associated cost of the MHWSAW role; and 2) patterns of engagement and needs of the people availing of the service. This iterative monitoring will enable timely review and responsive adaptability of the role. After three years of implementation, it is envisaged that a methodologically rigorous evaluation of the role will be conducted.

Table 5: Summary of the role of Mental Health and Wellbeing Support & Advocacy Worker

The study resulted in conceptualisation of the MHWA role which encompasses 1) Roots of Practise; 2) Branches of Actions; and 3) Supportive Scaffolding.

Branches of Action – 'Reaching In & Reaching Out'			
Amplifiers	**Connector**	**Listeners**	**Modeller**
▪ Outreach awareness activities about Mental Health (MH) with minoritized communities ▪ In-reach awareness activities with MH support services and staff about the MH needs of minoritized communities and the role of the MHWSAW ▪ Regional/national awareness activities at community development and policy platforms	▪ An informal signposting ▪ A formal facilitation of client's meaningful access to appropriate support service ▪ Providing advice and guidance to service provide	▪ Providing emotion support: listen to client's difficulties, provide the time and space for them to share their worries and concerns. Offer validation, comfort, motivation and encouragement ▪ Action planning - helping to formulate appropriate pathways of support	Teaching and modelling evidence based culturally appropriate well-being strategies
This action branch aims to • Address mental health literacy[1] issues • Address language and cultural barrier • Reduce stigma • Increase cultural competency of service providers	**This action branch aims to** ▪ Address the service provision gap ▪ Address information barrier- about available support services and/or how to negotiate access to them, rights and entitlements, feedback and complaint procedures	**This action branch aims to** • Address issues of loneliness, difficulty in establishing supportive social networks, sharing experiences with other people due to language and cultural barriers, stigma, trust • Encourage self-awareness • Empower to make choices with regards to their mental well-being and health	**This action branch aims to** • support a client to make health-enhancing behaviour changes - self-care, self-regulation, self-management

Roots of Practice represent Foundational Occupational Values:			
Shared lived experience ▪ As either/both minority community member and mental health service user ▪ Building trust as primary component	**Reciprocal Partnership** ▪ Aligned with co-production ▪ Power balance and client centred approach ▪ Working in partnerships with other support services	**Holistic approach to wellbeing** ▪ Responding to interconnected, psychosocial determinants of mental health and wellbeing including the physical, social, and psychological needs of their clients; and incorporated culturally appropriate mind, body, and social practices ▪ Engaging with a person along the entire continuum from prevention, early intervention and management	**Community Responsive** ▪ Designing and adapting the core focus of MHWSAW's work in accordance with a need's responsive assessment of the primary social-cultural, socio-political environments determinants of a specific community's wellbeing
This Root of Practice aims to ▪ Alleviate the trust barrier between service provider and a client	**This Root of Practice aims to** ▪ Recognise the value of bilingual / bicultural workers in reducing health disparities and inequalities in service provision ▪ Address power imbalances	**This Root of Practice aims to** ▪ Apply the bio-psycho-social model of mental health ▪ Align with emerging trends in healthcare ▪ Embed cultural understanding of mental health	**This Root of Practice aims to** ▪ Apply the population approach ▪ Apply Positive Organisational Research

Supportive Scaffolding		
Understanding the scope of the role ▪ Role scope and limitations ▪ Workers skills set ▪ Understanding duty of care to clients ▪ Health and safety considerations	**Mentoring and supervision** ▪ Continuous professional development ▪ Individual and group supervision ▪ Policy and procedure infrastructure	**Code of Practice** ▪ Be aware, apply and adhere to agreed Code of Practice

(Footnotes)

1 The term "Mental Health Literacy" was coined in 1997 by Jorm et al. It refers to knowledge, beliefs and abilities that support the recognition, management or prevention of mental health problems.

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