Cairde
Challenging ethnic minority health inequalities

Improving Mental Health Engagement for Migrant & Ethnic Minority Women

CHUMS

HSE
Mental Health
Engagement
& Recovery

An Roinn Sláinte
Department of Health

Farahani, Z. T., Arora, Y., Matarutse, E., Bounekdja, D., Marchelewska, E., Villani, J., & Murphy, R. (2025). Creating a national mental health engagement infrastructure for migrant and ethnic minorities. Cairde.

Authors:
Zahra Tayer Farahani, Yukti Arora, Ethel Matarutse, Dallal Bounekdja, Emilia Marchelewska, Jacopo Villani, Rebecca Murphy

Design:
Julio A. Pérez Torres (j.a.perez.torres@gmail.com)

Published by Cairde, 2025
ISBN 0 9536304 0 4

Acknowledgments

Project Trainees	Alina Mielnik
	Jennifer Haru Chipa
	Justyna Maslanka
	Liljana Picari
	Nchang Akenji
	Marcia Megal
	Rawan Alzawadi_
	SY
	SP
	Sumona Begum
	JK
	Thembeka Mabaso
	TP
	Wafaa Abusharkh
Research Participants	Anonymus
Project Co-production:	Emilia Marchelewska, Cairde, Project Coordinator
	Dallal Boukidja, Cairde, Project Worker
	Jim Walsh, Peer Advocacy in Mental Health, Head of Training and Development
	Jennifer Haru Chipa, Lived Experience
	Justyna Maslanka, Lived Experience
	Rebecca Murphy, DCU / CHUMS Study
	Tonya Myles, Cairde, General Manager
Trainers & Contributors	Main trainer: Jim Walsh, Peer Advocacy in Mental Health
	Jacopo Viliani, HSE Mental Health Engagement
	Rebecca Murphy, DCU, CHUMS Study
	Doireann Crosson, Poushali Kundu, National Women Council
	Zeinab Abdi, Cairde/HSE Migrant Mobile Health Team
Research team	Rebecca Murphy, DCU / CHUMS Study
	Zahra Tayer Farahani
	Yukti Arora
	Ethel Matarutse
Peer Support & Counselling	Jennifer Haru Chipa
	Thembeka Mabaso
	Black Therapists Ireland
Project partner: HSE Mental Health Engagement	Jacopo Villiani, HSE Mental Health Engagement, Program Coordinator
	Una Twomey, HSE Mental Health Engagement, Senior Project Manager
	Michael Ryan, HSE Mental Health Engagement, Head of the Service
Project Funder:	Department of Health

About us

CAIRDE

Cairde is a national community health development organisation dedicated to reducing health inequalities among minority ethnic communities in Ireland. Our work focuses on providing information and advocacy, building the capacity of minority ethnic groups, and amplifying lived experience in research, policy and service delivery.

Cairde's Be Aware, Be Well – Migrant Mental Health Initiative

Be Aware, Be Well seeks to reduce mental health inequalities by strengthening mental health literacy, improving access to services, promoting wellbeing through community-based initiatives, and supporting the mental health services inclusivity.

Core Activities:

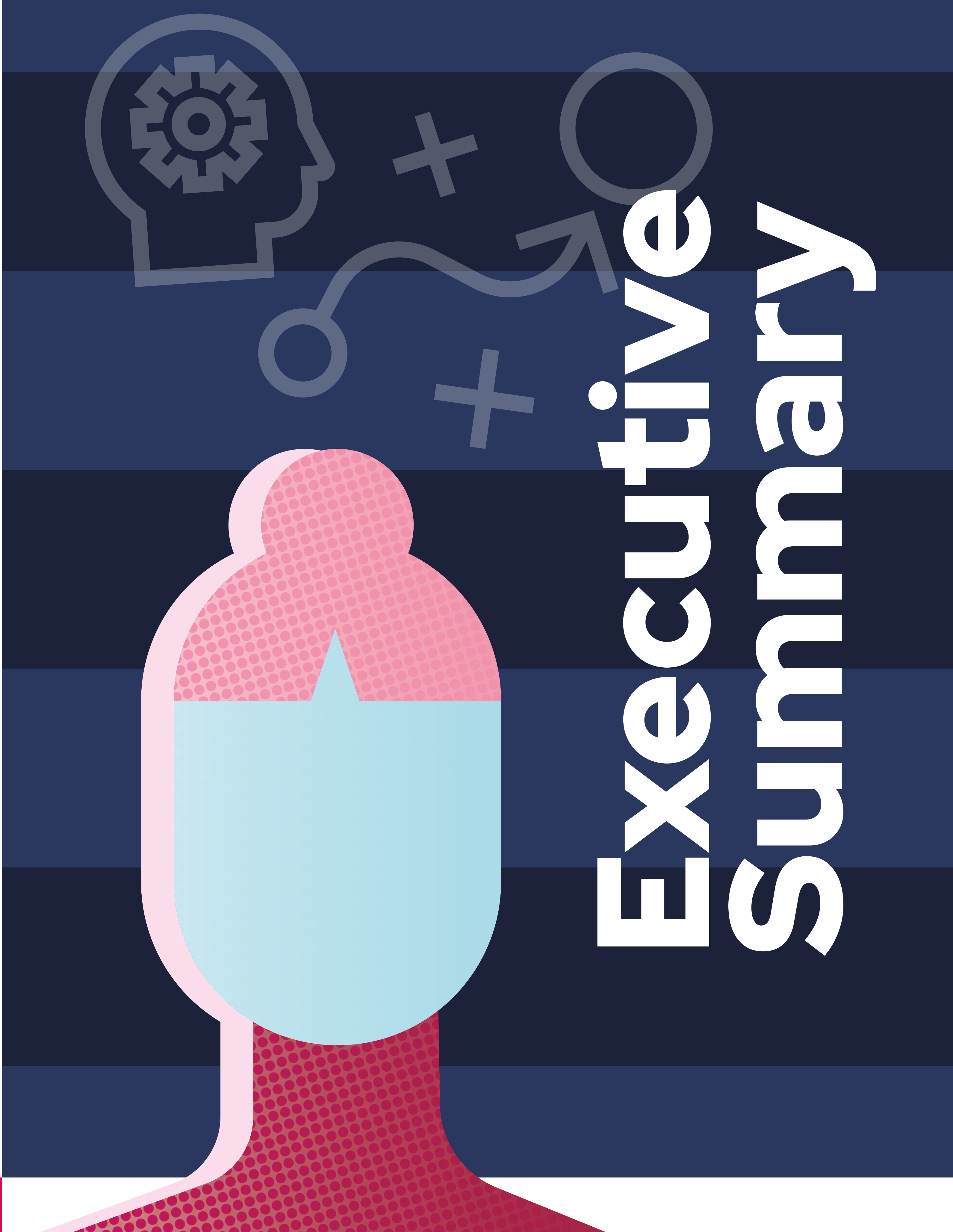
Support & Advocacy	Capacity Building, Education & Training	Service Improvement Facilitation
We provide peer-led support for migrants experiencing difficult times and mental health challenges.	We deliver evidence-based and bespoke training programs while creating safe spaces for migrants to connect, share experiences, and access supports. Our *Pathways to Being Well* offers a multilingual guide, workshops, and training specifically designed for migrants and peer supporters.	We strengthen migrant mental health engagement through capacity-building and partnerships. By contributing to policy, research, and advisory groups, and by engaging with service providers, we advocate for culturally humble mental health services for diverse communities.

Cultural HUmility in Mental health Services (CHUMS) Research Collective

Based in the Dublin City University's (DCU) School of Nursing and Psychotherapy, the CHUMS Study is a research collective that brings together academics, practitioners, and community partners to explore how cultural humility can be embedded within Irish mental health services. Our work focuses on co-producing research grounded in equity and inclusion, with a strong commitment to amplifying ethnic minority voices and generating evidence to inform practice and service development.

HSE Mental Health Engagement Office

The HSE Office of Mental Health Engagement and Recovery (MHER) works to ensure that the voices of people with lived experience inform service delivery and improvement. It aims to create recovery-oriented mental health services by incorporating lived experience perspectives. Our work focuses on mental health engagement, recovery education, individual placement and support, peer support, and the implementation of the *Sharing the Vision*.



Executive Summary

Executive Summary

The rationale

This initiative responds to persistent structural inequities that limit the participation and influence of migrant and ethnic minoritised women in shaping mental health systems.

Cairde's earlier work conceptualising a Mental Health Advocacy role for ethnic minority communities highlighted the need for an Amplifier function to support committee participation, system-level representation, and ongoing capacity building for migrants and ethnic minorities engaged in mental health advocacy. Building on this work, in collaboration with HSE Mental Health Engagement office, the National Migrant and Ethnic Minority Mental Health Engagement project was initiated to establish a formal engagement structure in Ireland. To address these gaps, the project integrated a capacity-building training with participatory research, ensuring that lived experience directly informed strategic design.

Building Capacity as a Foundation for Engagement

The first phase centred on a six-week Migrant & Ethnic Minority Mental Health Engagement Training Programme, delivered between October and November 2024. Fourteen participants, selected from seventy applicants, engaged in structured sessions focused on system literacy, advocacy skills, and confidence-building for effective participation in engagement structures.

The training functioned both as an empowerment mechanism and an entry point into structured engagement, enabling women—many previously excluded from formal decision-making spaces—to build capacity, voice their experiences, and form peer networks. Participants valued its trusted and safe environment and emphasised its importance for sustaining engagement over time. They also identified areas for improvement, including more flexible delivery formats, enhanced language accessibility, and structured follow-up.

Research to Deepen Understanding and Shape Strategy

The second phase employed participatory qualitative research, delivered by CHUMS in collaboration with Cairde, to explore how ethnic minoritised women conceptualise engagement, experience barriers, and envision pathways for equitable participation. It also examined how the training could be strengthened as a strategic platform for engagement.

Between March and May 2025, six focus groups were conducted with thirty women, including training participants and other community members. The findings revealed that **mental health engagement is best understood as a continuum—from early awareness and literacy to meaningful participation in governance and decision-making structures**. Engagement is shaped by intersecting structural, cultural, and environmental factors: limited system literacy, language and cultural barriers, mistrust, practical constraints, and the marginalisation of lived experience expertise.

Community organisations emerged as essential actors in this landscape. Participants identified them as trusted intermediaries, capable of providing culturally safe spaces, facilitating first contact with engagement opportunities, and sustaining participation through capacity building over time. Their role is not peripheral but structural—a cornerstone in building equitable engagement pathways.

Participants also articulated a clear vision for future engagement structures: accessible, culturally responsive, and designed for genuine influence. They called for engagement spaces that are built on trust, supported by interpretation and cultural mediation, informed by diverse lived experiences, and meaningfully connected to community infrastructure.

A Strategic Pathway for Equitable Engagement

Drawing together the training and research components, the project co-produced a strategic pathway for embedding ethnic minority women's voices in mental health governance. This pathway prioritises:

Establishing a shared and culturally grounded understanding of engagement

Embedding responsive and flexible methodologies across the engagement spectrum

Institutionalising equity measures including fair recognition, remuneration, and anti-tokenism

Building durable partnerships between statutory services, community organisations, and lived-experience networks

Collaborative Implementation and Strategic Impact

The initiative was implemented through a collaboration between Health Service Executive Mental Health Engagement and Recovery, Cairde, and CHUMS. Wraparound supports—such as childcare, travel allowances, peer advocacy, and access to counselling—were central to enabling genuine participation.

By coupling a training programme that builds capacity and trust with research that generates strategic evidence, this initiative lays a strong foundation for the National Ethnic Minority Mental Health Engagement (infra)Structure. It demonstrates that meaningful engagement depends on intentional design, where language, trust, recognition, time, and community partnerships are operational cornerstones. This work represents a significant step toward rebalancing power within mental health governance, enabling ethnic minoritised women to shape—not merely access—mental health policy and engagement structures in Ireland.

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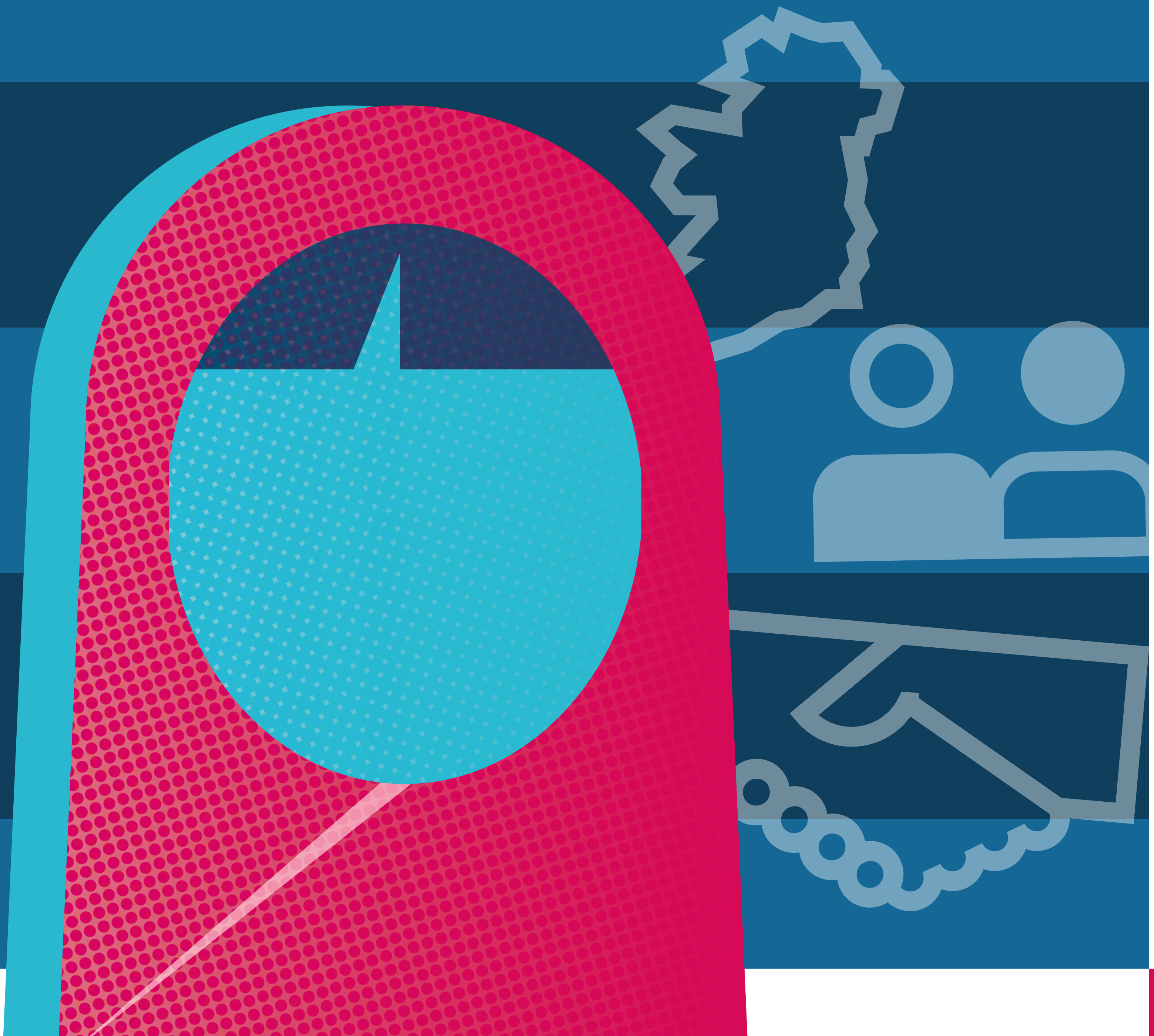
Abbreviation	Meaning
CHUMS	Cultural HUmility in Mental health Services
MHER	Mental Health Engagement and Recovery
DCU	Dublin City University
NAMI	National Alliance on Mental Illness
NWCI	National Women Council of Ireland
MISHSoC	Meaningful Involvement in Services in Health and Social Care
PAMH	Peer Advocacy In Mental Health
MHCT	Mental Health Capacity-Building Training

Introduction: Bridging the Gap in Mental Health Engagement



Introduction: Bridging the Gap in Mental Health Engagement

This introductory chapter outlines the global and national context for meaningful engagement of individuals with lived experience in mental health systems, with particular attention to Ireland's policy commitments and frameworks. It highlights the underrepresentation of ethnic minoritised women within mental health engagement structures and introduces a collaborative initiative by the National Office for MHER, Cairde, and the CHUMS Study at DCU. The initiative integrates training and participatory research to strengthen engagement pathways for ethnic minoritised women and advance more inclusive, culturally responsive mental health services in Ireland.

The Global Context for Lived Experience Engagement

The meaningful involvement of individuals with lived experience of mental health difficulties—empowering them with voice, choice, and influence across all aspects of the mental health care system, including design, implementation, and evaluation—is widely recognised as essential for the global transformation of mental health (WHO, 2022; 2025).

Individuals with lived experience are now rightly viewed as essential stakeholders in mental health service design and delivery, and their participation is deemed crucial for enhancing mental health systems, services, and service users' outcomes (Thornicroft and Tansella, 2005; Corrigan et al., 2014; Vojtila et al., 2021). Such participation encompasses full empowerment and engagement in mental health advocacy, policy formulation, planning, legislation, programme design, service delivery, monitoring, research, and evaluation (Human Rights Council, 2020; Murphy et al., 2021).

Defining Meaningful Mental Health Engagement

Meaningful mental health engagement has been defined as a respectful, dignified, and equitable process that incorporates individuals with lived experience into various processes and activities within a supportive environment that empowers individuals, recognises lived experience as a form of expertise, and utilises it to enhance health outcomes (HSE, 2024; WHO, 2023). The National Alliance on Mental Illness (NAMI) contends that enhancing the lives of mental health service users and their families necessitates a cultural shift that establishes engagement as the new standard of care. NAMI asserts that engagement is built and sustained on the principles of hope, mutual trust, respect, effective communication, and recognition of the expertise, strengths, and resources that individuals with mental illness bring to their recovery (NAMI, 2016).

Participation in engagement activities varies in degree, ranging from consultation to joint decision-making and from involvement in service delivery to user-led services. Regardless of the level of involvement, it is essential that participation is not tokenistic and that the perspectives of individuals with lived experience are thoroughly acknowledged and esteemed in policy and practice. To enhance health outcomes through meaningful engagement with individuals with lived experience, WHO recommends that Member States establish provisions to ensure individuals receive adequate support during the engagement process (WHO, 2022). This necessitates recognising power imbalances and creating supportive environments characterised by equitable power dynamics through dialogue, acknowledging the importance of amplifying individuals' voices, and establishing safe spaces for meaningful contributions from all (Institute for Global Health, 2020).

National Policy and Frameworks in Ireland

In recognition of the need to both explicitly acknowledge and proactively support meaningful mental health engagement, Ireland's mental health policy, *"Sharing the Vision – A Mental Health Policy for Everyone,"* strongly emphasises the necessity for individuals with lived experience to be integrally involved in the design, delivery, and transformation of mental health services (Department of Health and Children, 2020).

The actual implementation of this is further supported, most notably, by the Health Service Executives' National Office of Mental Health Engagement and Recovery's *'Mental Health Engagement Framework 2024 – 2028'* (HSE, 2024), the '*Mental Health Engagement Methods Guide'* (HSE, 2024) and more globally by Mental Health Europe's Co-creation Toolkit (2022), and the WHO's most recent '*Roadmap for integrating lived and living experience practitioners into policy, services and community' (WHO, 2025).* All of which are co-produced pragmatic guidance documents which serve to improve mental health engagement within services by offering tools that enhance accountability, governance, and guidance for supporting genuine collaboration with individuals who have lived experience.

Mental health engagement aligns closely with key trauma-informed principles—safety, trust, empowerment, voice and choice, collaboration, and cultural, historical and gender responsiveness. These principles underpin actions within both Sharing the Vision and the Mental Health Engagement guides. Adopting a trauma-informed lens is essential, recognising that migrant communities face disproportionately high levels of trauma linked to pre-migration experiences and migration journeys. Further, cultural trauma—arising from the erosion of health-protective resources, contributes to mental health inequities. Consequently, trauma-informed approaches emphasise the need for capacity-building supports that restore these resources by empowering community to advocate for health promoting policy and service delivery changes (Sweeney et al., 2018; Subica and Link, 2022).

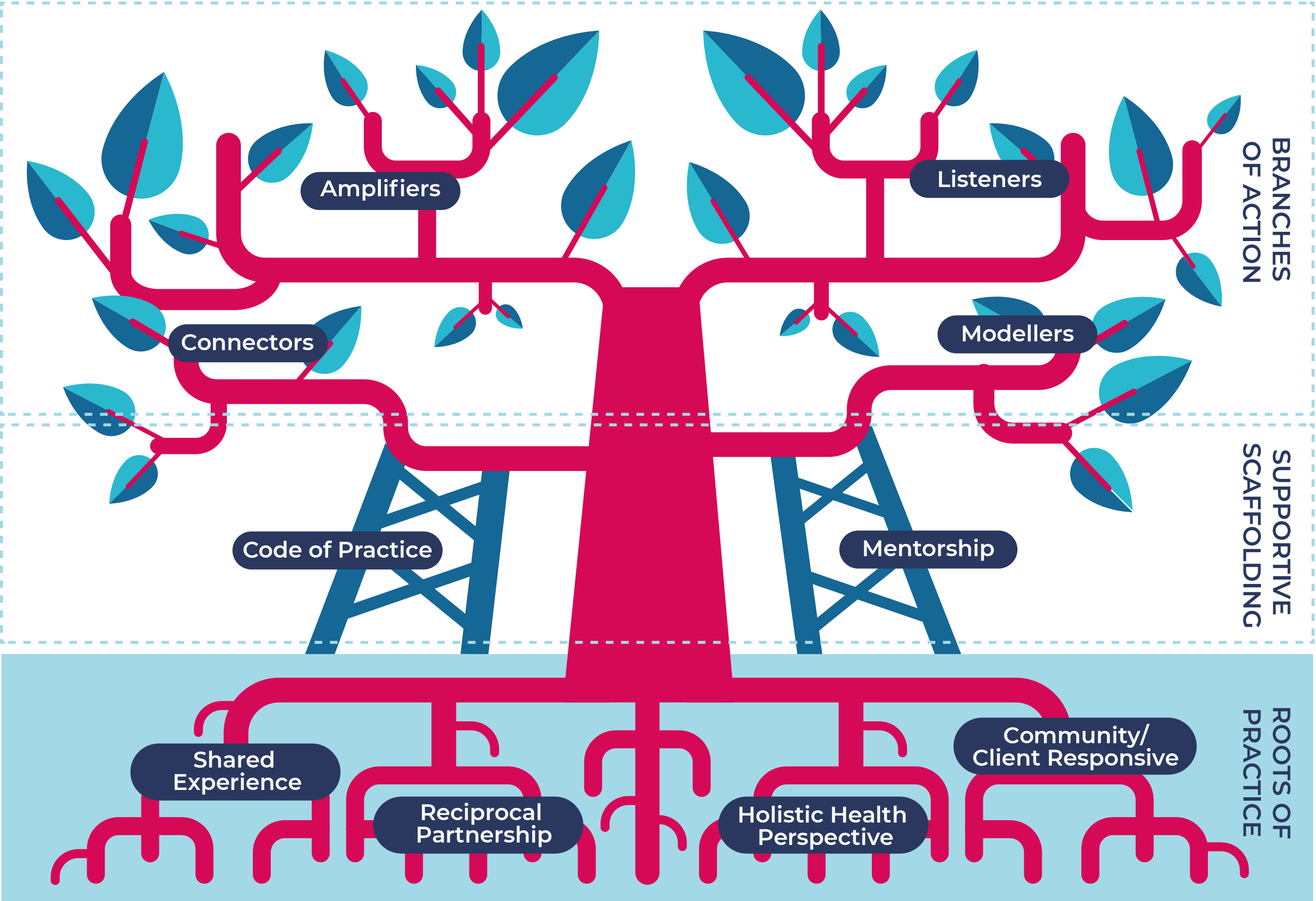
Mental Health Inequities Among Migrant Women

Migrant women in Ireland have been documented to experience considerable inequities in accessing and participating in mental health services (Akidwa, 2020; Health Service Executive, 2018; Mental Health Reform, 2021, NWCI, 2023; Bojarczuk et al., 2015). Multiple intersecting factors contribute to these inequities, such as language and cultural barriers, stigma related to mental health, insufficient awareness of mental health rights and services, and a widespread lack of trust in institutional structures, trauma (Memon et al., 2016; Shundi, 2021; Pederson et al., 2022).

These challenges highlight the necessity of developing culturally sensitive solutions in partnership with ethnic minority women. Yet to date, there remains a widespread absence and marginalisation of migrant women's voices within mental health service design, delivery, and evaluation (Huschke et al., 2020). A report on Meaningful Involvement in Services in Health and Social Care (MISHSoC) revealed that, despite considerable service involvement activities within health and social care, certain populations remain inadequately engaged. For instance, notably, migrant and ethnic minority women reported that they had rarely or never been approached for their opinions regarding the services they received (Carroll & Walsh, 2024). Arguably, the limited level of participation in mental health engagement structures by ethnic minority women serves to further reinforce the entrenched mental health inequalities they experience (Bojarczuk et al., 2015; Stapleton et al., 2022; Apers et al., 2023; Nyikavaranda et al., 2023).

While migrant women from ethnic minority backgrounds represent diverse nationalities, cultures, and experiences—constituting a heterogeneous group with subgroups rather than a single, uniform community—it is nevertheless understood that migrant women in general experience significant and diverse integration challenges (Stapleton et al.,2022). This, alongside their documented mental health inequities, underscores the strong need for institutional reform and the implementation of tailored support structures to facilitate their meaningful participation as agents of change in economic, political, and social spheres (Organization for Security and Co-operation in Europe, 2014).

Building on Cairde's Mental Health Advocacy



Conceptualisation

In response to these documented inequities, working with Maynooth University, Cairde undertook early conceptual work to develop a dedicated Mental Health Advocacy model for ethnic minority communities as a mechanism for strengthening representation, reducing systemic barriers, and bridging communities with mental health supports and service provision (Murphy et al., 2021).

This work conceptualised four interconnected components of an advocacy role—Amplifier, Listener, Connector, and Modeller—each reflecting a distinct function required to support ethnic minoritised individuals in both accessing services and shaping them. (Murphy et al., 2021)

Of particular relevance to the present initiative is the **Amplifier** component, which focuses on equipping ethnic minoritised individuals with the skills, confidence, and organisational scaffolding required for meaningful participation in committee work, co-design processes, and system-level representation across regional and national mental health structures. This role conceptualisation suggested that, with appropriate training, mentoring, and structural supports, migrant and ethnic minority lived experience advocates are positioned to play a substantive role in shaping policy and contributing to decision-making environments from which they have historically been excluded.

Although the advocacy role remains unfunded and not yet formally implemented, its conceptual foundations are directly aligned with the aims of the current project.

Bridging the gap

Against this backdrop, this report responds to the significant gap identified earlier—namely, the widespread absence and marginalisation of ethnic minority women's voices within mental health engagement structures in Ireland. While policy frameworks emphasise the importance of lived experience in shaping services, migrant and ethnic minoritised women remain underrepresented in decision-making processes and engagement mechanisms.

In recognition of this inequity, the National Office for MHER, Cairde, and the CHUMS Study at DCU established a collaborative initiative aimed at addressing this gap. The initiative combined two interlinked phases—training and research—to create pathways for more inclusive and culturally responsive engagement.

The first phase, led by MHER and Cairde, focused on the co-design and delivery of a mental health self-advocacy and committee skills training programme for ethnic minoritised women. The training sought to enhance participants' knowledge, confidence, and capacity to participate meaningfully in mental health structures at local and national levels.

The second phase employed participatory qualitative research, delivered by CHUMS in collaboration with Cairde, to explore how ethnic minoritised women conceptualise engagement, experience barriers, and envision pathways for equitable participation. This phase also examined how the training could be strengthened as a strategic platform for engagement.

Between March and May 2025, six focus groups were conducted with thirty women, including training participants and other community members. The specific objectives of the research were to:

- Understand ethnic minoritised women's views of current mental health engagement structures in Ireland, as well as the proposed *National Ethnic Minority Mental Health Engagement Structure 2025*;
- Identify barriers and facilitators influencing their engagement and explore new ways to enhance participation;
- Evaluate the mental health engagement [EM14.1]training programme delivered by Cairde; and
- Capture women's perspectives on how mental health services could be improved for them and their communities.

Together, these two phases form a comprehensive response to the equity gap in engagement—empowering ethnic minoritised women to act as agents of change while generating evidence to inform national policy and service development.

As the introductory chapter, this section outlines the context, rationale, and collaborative framework underpinning the initiative. The remainder of this report is structured as follows:

- Chapter 2 examines the training phase, detailing its design, recruitment, and delivery;
- Chapter 3 presents the research methodology and findings; and
- Chapter 4 offers recommendations for strengthening the engagement of ethnic minoritised women in Irish mental health systems, informed by insights from both the training and research phases.

Implementation of the Capacity-Building Training Programme

Implementation of the Capacity-Building Training Programme

This chapter outlines the implementation of the capacity-building training programme developed to enhance the meaningful participation of migrant and ethnic minoritised women in mental health engagement structures in Ireland. It describes the programme's aims, objectives, delivery framework, and key components, including training content, participant supports, and follow-up activities designed to sustain impact.

Project Aims and Objectives

While the overall aim of this project was to enhance meaningful mental health engagement among migrant and ethnic minoritised women in Ireland, addressing their underrepresentation within existing engagement structures, it also sought in the longer term to reduce mental health inequities and promote greater inclusion within Ireland's mental health systems. This chapter focuses on the implementation of the capacity-building training programme developed to support that goal.

The training was designed as a practical intervention to empower participants to advocate for improved access to mental health services, build confidence and skills for active participation in service improvement processes, and strengthen their mental health literacy, wellbeing, and recovery. It also sought to generate insights to inform the development of more inclusive and culturally responsive engagement practices across mental health services.

Expected outcomes of the training phase included the development of a cohort of lived-experience advocates, the establishment of a supportive learning model for future engagement initiatives, and the generation of evidence to inform the creation of a National Ethnic Minority Mental Health Engagement structure.

Implementation Framework

The project was supported and implemented through a collaborative partnership. The HSE MHER team provided funding and oversight, while Cairde led coordination and delivery. Implementation followed a co-production model, with input from multiple stakeholders.

Table : Implementation Framework

Component	Description
Co-production Group	▪ Guiding programme design, delivery, and findings dissemination ▪ Included Cairde, P[GU15.1]eer Advocacy in Mental Health (PAMH), DCU CHUMS, and migrant women with lived experience.
Key Deliverables	▪ Capacity-building training programme ▪ Research report
Wraparound Supports	▪ A supportive environment was provided based on mutual respect, non-judgment, and confidentiality. ▪ Supports included travel and childcare allowances, refreshments and lunch, peer support and advocacy, referrals to counselling. ▪ A dedicated project worker as the main point of contact throughout the programme.
Learning Dissemination & Sustainability	▪ The report will be shared with the key stakeholders, support advocacy efforts, contribute to research ▪ Guided by the research findings a National Ethnic Minority Mental Health Engagement structure will be proposed

A six-week *Migrant & Ethnic Minority Mental Health Engagement Training Programme* was delivered between October and November 2024 to empower participants to engage meaningfully in mental health processes.

Recruitment

Participants were recruited from among Cairde clients and through migrant organisations and mental health networks. Fourteen women were selected from seventy expressions of interest. Selection criteria included personal or family experience of mental health difficulties, community involvement or advocacy interest, and previous participation in engagement structures. Participants represented diverse groups, including EU migrants, International Protection Applicants, and Beneficiaries of the Temporary Protection Directive from Ukraine.

The programme aimed to:

- Increase understanding of Ireland's mental health system and access pathways;
- Develop advocacy and communication skills;
- Foster confidence to participate in engagement structures;
- Promote culturally sensitive and inclusive approaches to care; and
- Support participants in sharing lived experiences safely and effectively.

Training Structure and Content

The training comprised six half-day sessions, each focusing on a core theme.

Table 2: Overview of Training Sessions

Session	Focus Area	Facilitation
1. Introduction & Lived Experience	Value of lived experience in transforming mental health services; use of personal stories to influence systems and support peers; introduction to HSE mental health engagement structures	PAMH, Cairde, HSE Mental Health Engagement
2. Communication & Advocacy Skills	Developing effective communication, self-esteem, and assertiveness; practicing refusal skills; exploring advocacy strategies; representing self and others	PAMH
3. Mental Health Literacy	Understanding mental health services in Ireland and pathways to care; overview of common mental health conditions; introduction to women's mental health	PAMH, NWCI
4. Cultural Inclusivity & Policy	Challenges for migrant and ethnic minority communities, including stigma and discrimination; equality versus equity in care; applying a culturally inclusive lens to policy analysis	CHUMS
5. Policies & Rights	Overview of Irish mental health governance and legislation; reviewing policy documents; advocating for systemic improvements; introduction to migrant mobile teams	PAMH, Cairde / HSE Migrant Mobile Teams
6. Empowerment & Resilience	Building leadership skills and resilience; group work strategies; tools for committee and decision-making participation; addressing advocacy fatigue	PAMH

Participatory Research on Ethnic Minoritised Women's Mental Health Engagement

Participatory Research on Ethnic Minoritised Women's Mental Health Engagement

This chapter focuses on the research element of the initiative. It first describes the methodological approach, outlining the study's aims and objectives, qualitative design, participant recruitment, data collection, and analysis procedures used to explore mental health engagement among ethnic minoritised women in Ireland. It then presents the findings, which reveal how participants conceptualise engagement and identify key barriers, enablers, and strategies for improvement. The findings provide an evidence base for the recommendations presented in the final chapter.

Methods

Study Objectives

The specific objectives were to:

- Understand ethnic minoritised women's views of current mental health engagement structures in Ireland, as well as the proposed *National Ethnic Minority Mental Health Engagement Structure 2025;*
- Identify the barriers and facilitators influencing their mental health engagement and explore new ways of enhancing participation;
- Evaluate the mental health advocacy training programme offered to ethnic minoritised women by Cairde; and
- Explore ethnic minoritised women's perspectives on how mental health services could be improved for them and their communities.

Research Design and Data Collection Methods

This research was conducted in collaboration with Cairde, a community health development organisation operating across Ireland. Cairde was actively involved in multiple stages of the research process, from design to dissemination.

To gain a deeper understanding of mental health engagement among migrant and ethnic minoritised women, a qualitative approach was employed using focus groups. Focus groups are increasingly utilised in health and mental health research involving minority populations as a culturally responsive method that empowers participants and amplifies their voices (Hall et al., 2023).

Participant recruitment was primarily facilitated through Cairde. Invitations were extended to women who had recently participated in the organisation's Mental Health Capacity-Building Training (MHCT), as well as to those engaged with Cairde through other initiatives. Additionally, a social media campaign was launched to promote the study and reach a broader audience.

In total, six semi-structured focus groups were conducted with participants (n = 33) between March and May 2025. Two focus groups were held online via Zoom, while the remaining four were conducted in person at Cairde's offices. Two focus groups (n = 8) included participants from Cairde's recent MHCT; three groups (n = 21) comprised other migrant and ethnic minoritised women; and one group (n = 4) included Cairde employees who also identified as migrant and ethnic minoritised women.

Table 3: Focus Group Details

Focus Group	Number of participants	Delivery Mode	Participants
Focus Group 1	5	In-person	MHCT participants
Focus Group 2	3	In-person	MHCT participants
Focus Group 3	7	In-person	Non MHCT participants
Focus Group 4	6	In-person	Non MHCT participants
Focus Group 5	8	Online	Non MHCT participants
Focus Group 6	4	Online	Cairde employees

Informed by existing literature on the topic and the specific objectives of the study, a topic guide (Appendix 1) was developed to structure the focus group discussions. Participants were also encouraged to contribute any additional information they considered relevant to the research aims.

The focus groups ranged in duration from 30 to 90 minutes. Each session was co-facilitated by two members of the research team using a semi-structured interview schedule. Discussions were guided by questions exploring participants' understandings of mental health engagement, their experiences with engagement initiatives, perceived barriers, and strategies for overcoming these barriers.

Participants

The participants in this study were migrant and ethnic minoritised women residing in Ireland. The sample comprised 33 women aged between 25 and 64 years (M = 44.34, SD = 10.40). Participants represented a diverse range of countries, including Nigeria, Angola, Bangladesh, Libya, Algeria, Palestine, Ukraine, Brazil, Poland, Romania, Albania, Uganda, Syria, Hungary, and Iran. Approximately 90.9% reported lived experience of mental health challenges, either personally or within their families. A detailed overview of participant demographics is presented in Table 4.

Table 4: Participants' Demographic Information

Characteristics	Category	Frequency	Percentage
Gender (missing: 2)	Female	31	93.93
Age (missing: 2)	25- 34 years	8	25.8
	35-44 years	5	16.1
	45-54 years	13	41.9
	55-64 years	5	16.1
Education level (missing: 2)	Elementary or some high school	2	6.1
	Complete high school	3	9.1
	Post-secondary certificate	4	12.1
	Bachelor's degree	12	36.4
	Master's degree	10	30.3
Employment status (missing: 2)	Employed full time	8	25.8
	Employed part-time	7	22.6
	Unemployed	9	29

English Proficiency (missing: 2)	Fair	1	3
	Well	6	18.2
	Very well	11	33.3
	Competent	13	39.4
Years in Ireland (missing: 2)	0-5 years	8	24.2
	6-10 years	5	15.2
	11-15 years	6	18.2
	16-20 years	6	18.2
	21-25 years	4	12.1
	25+ years	2	6.1

Ethics

Ethical approval for the study was obtained from the DCU Research Ethics Committee [DCUREC/2024/202]. All participants received an information sheet outlining the purpose and procedures of the study and were given the opportunity to contact the research team with any questions or concerns. Prior to the focus groups, participants were contacted individually to confirm eligibility, explain the study's aims and objectives, and address any queries. Informed consent was obtained from all participants through signed consent forms before participation. All data were anonymised, and any identifiable information, including names of individuals and locations, was removed to protect participant confidentiality.

Analysis

Audio recordings of the focus groups were transcribed verbatim and coded using NVivo. During the process of familiarisation with the data, detailed notes were taken for each focus group. Data were analysed using experiential thematic analysis, following the six-phase approach outlined by Braun and Clarke (2013):

1. Data transcription and familiarisation;
2. Initial coding;
3. Reviewing and refining codes;
4. Generating sub-themes and overarching themes;
5. Defining and naming themes; and
6. Producing the report.

Credibility

Member checking (Braun & Clarke, 2013; Candela, 2019; McKim, 2023) was used to enhance the credibility of the findings, in line with Braun and Clarke's recommendations for research involving members of vulnerable groups. A summary report of the study's findings was sent to participants via WhatsApp, inviting them to review the content and indicate whether their views had been accurately represented in the manuscript.

Findings

The focus groups aimed to explore participants' views and experiences of mental health engagement among migrant and ethnic minoritised women in Ireland. Each discussion began with an open question about how participants understood the concept of *mental health engagement* and what it meant within their personal and cultural contexts. The conversations then evolved to examine key factors influencing engagement—such as awareness, access, trust, and inclusion—and to identify practical strategies for strengthening participation and representation within mental health systems.

Theme 1: Mental Health Engagement

This theme explores how participants understood and experienced mental health engagement within their personal, cultural, and social contexts. Two interrelated sub-themes emerged: conceptualising mental health engagement, which examines participants' definitions and perceptions of what engagement means; and important factors and strategies, which considers the key influences shaping women's engagement and the approaches they proposed to address existing barriers.

Conceptualising Mental Health Engagement

Our first finding centred on how migrant and ethnic minoritised women define 'mental health engagement'. For many of the participants, mental health engagement was not simply understood as participation in the existing mental health engagement structures. Instead, it emerged as a layered and nuanced concept that reflected their personal and collective journeys of navigating the mental health system in Ireland.

For some women, the first step was developing an understanding of the term "mental health" and integrating it into their language and vocabulary:

For myself as a mental advocate for ethnic minorities and refugees and asylum seekers, ..., we come from different backgrounds. The people, they don't know what is exactly ... mental health. So, they need an education to be educated, what is mental health. Some they are going through it, but they don't know, this ... mental health. (Maria, Respondent 4, Focus group 5)

For some participants, the next step was learning about the mental health support available and figuring out how to use it. One participant described mental health engagement as the ability to take the steps needed to help herself and her family with mental health problems:

"It's when … I have some problem with my mental health … I can help myself and for my family, and I know how I need to, … steps, what I need to use to get this result". (Hazel, Respondent 1, Focus group 5)

Another participant described mental health engagement as engagement with mental health services:

From my own point of view, mental health engagement is when individuals engage with … mental health services could be their own team as well, like the nurse or, … social worker or … art therapy, outreach… (Zara, Respondent 1, Focus group 1)

Some women had experience of participating in the existing mental health engagement structures and articulated their experience as having a voice in the delivery of mental health services:

I'm actually have the opportunity to use my voice in campaign of mental health in national implementation project, at sharing the vision as reference group speaking … as a representative person of people with living experience and ethnic and minorities group, especially women… my voice is important. (Ali, Respondent 2, Focus Group 1)

Others, emphasised on the significance of engagement that led to positive and meaningful change in mental health services:

it means being able to speak your mind, share your views, be heard and not just to be heard because once you say this thing, it means it is bothering you. So… The expectation is there will be some change. So, it's not just making noise. But it is voicing out your opinions and getting them to be heard, meaning implemented, not all of them, of course, but at least to show that there is some consideration. (Hazel, Respondent 1, Focus group 5)

As one of our experienced participants in mental health advocacy noted, mental health engagement exists on a spectrum with individuals engaging at different levels:

I think it's, it's very difficult to bring people to that level because usually… very few, …, would be … prepared to go and advocate on their own behalf or on behalf of their community at the … more abstract level … usually … they don't identify their activity with mental engagement. (Maya, Respondent 1, Focus group 6)

To summarise, mental health engagement for our participants was a journey that began with awareness about mental health and integrating it into their language, gaining knowledge about available supports, learning strategies to care for their mental health, engaging with mental health services, and ultimately, having a voice in the delivery of those services and contributing to meaningful change.

Important Factors in Mental Health Engagement

Participants identified important factors influencing the mental health engagement of migrant and ethnic minoritised women including awareness about and understanding of the mental health system in Ireland, time and resources, culture and language, trust, social and psychological determinants of mental health, and equality.

Understanding the Mental Health System

Awareness about mental health problems, having information about available services, and understanding the mental health system were noted as an important factor by participants:

I don't understand the full picture of … mental health services in Ireland… it's a … real challenge there, … because for some cultures, … mental health doesn't exist. It's, .. all the physical representation exists. So, it's a kind of very long way to make these connections. (Mina, Respondent 3, Focus group 6)

As one participant experienced in mental health advocacy noted, the challenge for women from ethnic minority background is to go beyond their own personal and lived experience and understand the whole mental health system:

for people who are …real actors, you know, like people who have experience of the services and people who are affected by the issue, it's also very hard to disentangle this from their own personal experience … because people kind of build their own understanding about the whole system based on their own experience (Mina, Respondent 3, Focus group 6)

Strategies for enhanced understanding of mental health system

Participants suggested various strategies to enhance understanding of the mental health system among migrant and ethnic minoritised women. These included mental health awareness campaigns, training sessions and workshops, and the creation of social media content tailored to the needs of ethnic minority communities. One participant shared their experience of using social media platforms to raise mental health awareness within their own community:

We mentioned about the women's … we have a meeting or something, and you speak to encourage them so that's why we open a Facebook page for our community. Even maybe you don't want to talk with me, but I share. You can read everything, and we share in other groups as well for the social community (Ella, Cairde 1, Focus Group 1)

The need for long-term and sustained initiatives was a recurring theme emphasised by many participants:

So, I feel like the long-term sessions … and if the people need more time, is OK, this kind of policy, if the people doesn't came second and finish or we need maybe more to ask or to do something to come back. (Natasha, Respondent 2, Focus group 2)

Culture and Language

Cultural and linguistic differences were identified by participants as factors that could hinder the mental health engagement of migrant and ethnic minoritised women at different levels. Participants noted that no or little proficiency in English will lead to lack of communication and isolation of migrant and ethnic minoritised women:

I always had this idea that education is something nobody's gonna take from you. And when you feel like you have this language barrier, you cannot communicate what you want… I couldn't adapt to the places, I couldn't talk, and that was the problem. (Nika, Respondent 3, Focus group 4)

According to our participants, this language barrier often discourages women to participate in social activities and leads to self-isolation:

Sometimes it's not the community, it's ourselves … we try to close ourselves, sometimes there's event to go, but we don't go, we just stay at home. So, I know language barrier, for me language barrier. My first language is [native language], but there are so many events that we don't go and it's for free …but we prefer to stay at home. (Dana, Respondent 5, Focus group 3)

Talking about their mental health experiences and sharing emotions and feelings in a second language was another aspect noted by participants:

the language is a big challenge for the migrant and uh living here in Ireland, especially for those not fluent in English because they not express their emotions, you know, and uh, trauma in in a second language, you know, it's very difficult, so it's hard for them, you know, to express all of those things. So, this is a big barrier for them (Sofia, Respondent 4, Focus group 6)

Another cultural factor mentioned by participants was the use of the term "mental health," which does not exist in some cultures and languages, and carries very negative connotations in others.

On another note, participants highlighted the role of gender expectations in some cultures, where women may be required to consult with—or seek permission from—male family members before engaging in discussions about mental health:

You know, some women are not allowed to join all the groups because the family restrictions or cultural restrictions, so they want … to join in a secret place (Asma, Respondent 5, Focus group 1)

Strategies for addressing cultural and linguistic barriers

Participants suggested various strategies to address cultural and linguistic barriers. These included translating materials into multiple languages, providing interpretation services, and employing ethnic minoritised staff who speak additional languages within the mental health system.

They also suggested adopting a more flexible approach—one that acknowledges cultural differences across communities and accommodates individuals according to their preferences:

There is a very strong cultural dimension to engagement because different cultures respond to different things and for some cultures, community organising is like a water to dried up plant. …and for some cultures it's not. Some cultures are very individualistic. … I think it's important to use various methodologies and various ways how we don't leave behind people who … I'm talking about … particularly vulnerable groups, … kind of people who might organise only on the basis of their um ethnicity, but they might not be in mixed groups. It's a very kind of unpaterned field. So, uh, we have just to be mindful about different methodologies, making sure that they are equally employed in this process of engagement. (Mina, Respondent 3, Focus group 6)

Environmental Factors

Environmental factors, including limited time, childcare responsibilities, work commitments, and travel constraints, were identified by some women as barriers to mental health engagement. One of the participants who recently coordinated a mental health capacity building for migrant women summarised these factors::

There are some barriers, … there is people starting a new job, or having to work in the same day of the training … starting college …childcare responsibility, … the distance travel. … they are looking for online …one participant requested for accommodation (Sofia, Respondent 4, Focus group 6)

There was a perception among participants that these environmental factors are often not being sufficiently acknowledged:

Those people who are activists, they're in a particular circumstances as well, because it's not everyone who has time and capacity to engage on ongoing basis for years in these processes and very often it's like a job really, because it's taking time, you have to have money to travel as well because they don't always reimburse. And I think it's sometimes not really understood by people who advocate for lived experience to be part of service delivery. (Maya, Respondent 1, Focus group 6)

Strategies for addressing environmental factors

Participants suggested strategies for addressing environmental barriers at two key levels. The first involved recognising the value of lived experience by offering appropriate compensation, as well as facilitating migrant women's participation by covering childcare and travel expenses. The second level focused on adequately funding migrant community organisations and equipping them with the necessary resources to support mental health engagement within their communities:

One of the biggest thing is resources. We've looked up into that. And I think it has to be taught because we're struggling with resources, to enable us to do our work very well. You know, and that's something that really I think will be important, it's top of the agenda, top of the recommendations. Without resources, we can't do anything. We're limited. (Nadia, Respondent 2, Focus group 6)

Social factors (social determinants of mental health)

Social factors including housing, living conditions, employment, and immigration status, and racism were identified by participants as social determinants influencing both mental health outcomes and engagement:

when I came in the country, I got interviewed and within 6 months, I got rejected. I cannot work. I have no access to the labour market. I cannot work and I have 2 kids. My husband is here. Both of us, we can't work. We are only relying on this, um allowances, which is €37 each person. The kids are going to … need clothes. The kids are not used to this life of staying in a hotel. … We are just in this one room with one small window. It's not, it's not only me as a parent that is going to be depressed, the kids too. (Lili, Respondent 2, Focus group 4)

For some communities being subject to racism on a daily basis hindered their engagement significantly and lead to their extreme isolation and exclusion:

you don't feel good in the street. It's a lot of racist, myself, when I come here, I don't believe that, but all the year passes more is more any shop, any place. When you use the traditional clothes, somebody she needs to be go two hours with a [participant's' ethnicity] woman in the street and you will see that. So … she don't go to, she needs to be very sick to go to the hospital. So imagine to go to make therapy or something like that (Zoya, Respondent 5, Focus group 4)

There was recognition among participants that these social factors constrain individuals' ability for full and meaningful mental health engagement:

We, kind of strive towards people participating meaningfully, which means that it's not fair to take somebody out of direct provision centre, a person who arrived a few weeks ago, and experienced lots of issues around mental health and maybe access the mental health services and put them in the panel discussing policy developments, mental health in Ireland. (Maya, Respondent 1, Focus group 6)

Strategies for addressing social determinants of mental health

The primary recommendation from participants for addressing the social determinants of mental health and engagement was to adopt an individualised approach—one that supports migrant women by responding to their specific needs and circumstances:

I suppose mental health, it's even more difficult than other spheres of public health policies, because it's very emotive subject. It's something that, people have to be supported throughout the process as well, and the work that happens behind the screen, like the advocacy, dealing with people issues because people will always kind of need their basic needs addressed first before they can kind of meaningfully participate. (Mina, Respondent 3, Focus group 6)

They also emphasized on the reciprocal nature of engagement:

It's kind of daily work and it's a work that has to be reciprocal. So basically … you work with them to give their voice, but sometimes they come to you with their issues and that's how you build this trust and engagement. (Maya, Respondent 1, Focus group 6)

Trust

Trust in the mental health system was noted as another important factor by participants. They mentioned that migrant and ethnic minoritised women sometimes don't trust the system and therefore are not willing to engage. This lack of trust is often due to fear of consequences for example break of confidentiality, impact on their immigration status, or custody of their children:

They are scared, especially people with kids because the law here says if the mother is unfit or unstable, they are going to take your kids away from you. So they are scared of all those things… because you are scared that, oh, I have a 3-year-old, they will take him away from me because I think I'm mad, you know. (Lili, Respondent 2, Focus group 4)

Participants also identified mental health stigma—along with negative stereotypes and attitudes toward individuals with mental health problems—as a significant barrier to trust and subsequently engagement for migrant and ethnic minoritised women. This stigma could be experienced within their own communities, in the wider society, or as internalised beliefs:

Someone in our culture …has mental health problem. Maybe (s)he shame to marriage, to go to the work, something like that because … it's not good, it is not a good person. … because it is something … en route …the family. Especially sometimes the family when they know one of her family, one person like sometimes they encourage him. They said to sit here, don't go, don't speak like that. (Miriam, Respondent 3, Focus group 1)

Participants also shared experiences of prejudice and discrimination when they spoke about their lived experiences of mental health:

Even if at times we try to express our mental health problem, the trauma that we have gone through, you see the reaction from the crowd. It will just, it will increase your mental health. Yes, it increase your mental health. You will not even know how to talk next time you, you know, in short, you know how that they already killed your spirit. You don't know how to talk. You are just stigmatised, you are afraid. (Sara, Respondent 4, Focus group 1)

Strategies for creating a safe space and building trust

From our participants' point of view one of the best ways to build trust is through community organisations:

The key contacts to the communities are those organisations are those, you know, if you're lucky to have a worker in an organisation that works through your language or specific service for a particular community (Ari, Cairde, Focus group 2)

They also reminded that building trust requires time and will not happen immediately:

they don't trust easily, especially the mental health, you know, it's about our culture is really sensitive. So, you know, if, if you want to trust to anyone, … maybe it takes time. (Ella, Cairde 1, Focus group 1)

Using social and cultural gatherings as a platform for mental health engagement was strongly recommended by participants. They believed that involving women in meaningful activities that allow self-expression, creativity, and joy creates a safe space and paves the way for mental health engagement:

I think is very important to everybody loves to talk about the country, the food, the clothes, they do. So if you give the opportunity for the people to show their work, their craft, the cooking, useful … and everybody participating in that, so this give agency and also brings the opportunity the person to bring the culture to the group. … I think all those things are kind of excuses to talk, to communicate, and meanwhile if there is someone that they could take notes or could uh, look closer to what each one is talking about some profession of mental health that could (Nika, Respondent 3, Focus group 4)

Using the existing platforms which already gained trust within the community was also suggested:

There was like women breakfast, … I attended a few times even though my English was like not great, but actually it helped me. Like just to see people and everyone, if you like to bring your whatever from your own culture and people start to um know about other people's cultures and … that was really helpful … I'm thinking about it is in those events you can go and talk about this (Zara, Respondent 1, Focus group 1)

A key theme that emerged from participants' responses was the need for a person-centred approach to mental health engagement. Participants highlighted the value of being heard, respected, and treated as individuals:

So is, uh, to listen, you know, because even if you don't understand what someone is telling you, when you listen to the person, you understand there's no way you're not going to understand, but you know, people, they don't like to listen…so the only thing that can solve the problem is listening. (Dana, Respondent 5, Focus group 3)

Equality and Inclusion

Some of the experiences shared by participants during the focus groups highlighted equality and inclusion as key factors influencing mental health engagement. Some of their experiences centred on the lack of recognition of lived experience as equally valuable expertise:

For some they want to build it as a career as well and if they can't, it's a source of frustration, because they can't understand why everyone else on the panel is paid and I can't be even reimbursed for my travel. (Maya, Respondent 1, Focus group 6)

One participant believed that the voice of migrant and ethnic minoritised women are sometimes *"diminished and as not as of the same value as psychiatrists or those working in in organisations"*.

Participants noted that while migrant and ethnic minoritized women are often welcome to share their personal stories their opinions about policy and practice are not sufficiently sought:

the kind of the background feeling I get is just like what can you know about how policy is developed in Ireland? You don't understand the language? You don't understand how it all fits together, the budget, the programme, everything else, therefore you're here to give us this kind of feeling of that we did our job or feeling of goodwill and that's where your engagement ends. (Mina, Respondent 3, Focus group 6)

Participants also expressed frustration about tokenism and the lack of genuine willingness to listen to the voices of migrant and ethnic minoritised women:

I sit on many different forums or boards or whatever call them committees. And that loneliness is real, can be very traumatic at times, even walking into that space. You feel is this tokenism that you you're being invited there. Do they really need to hear your voice? …and when you're asked to say something, … its they really hearing you? Because you're saying the same thing. You're saying something and it's not heard. But if somebody else says it… it's being picked up. (Nadia, Respondent 2, Focus group 6)

Strategies for promoting an equitable and inclusive approach

The first strategy recommended by participants was capacity building through the development of skills, knowledge, and access to resources. They mentioned the critical role of community organisations in this process:

It's really years of working with them on various projects, us and them engaging with different organisations, learning about the systems, learning the vocabulary, learning all the structures that are there and building their confidence and building their ability, … to formulate their opinions that are wider than just their own particular experience. (Maya, Respondent 1, Focus group 6)

They also emphasized on the importance of ongoing support as migrant women go along and engage and *"going with them to these opportunities or making sure that they're ready for being challenged"*.

The second recommendation was promoting more representation of migrant and ethnic minoritised women in mental health engagement initiatives. They believed that this can create allyship and strengthen peer support.

The third recommendation was to openly discuss these experiences, name them, and advocate for them to be acknowledged and addressed:

We need to say it… even if it's about using the racism card or whatever they want to call it, just say it … why am I saying things and you're not taking them into consideration, but if somebody else is saying it …. it's a difficult one. (Nadia, Respondent 2, Focus group 6)

Theme 2: Service Improvement

This theme focuses on participants' perspectives on how mental health services could be improved to better meet the needs of migrant and ethnic minoritised women. Discussions highlighted the importance of person-centred, culturally responsive, and accessible care. Participants reflected on their experiences within existing services and offered practical suggestions for building trust, continuity, and inclusivity in mental health provision.

Person-centred care

Participants described significant challenges with building trust and maintaining continuity in their interactions with mental health services. One participant explained:

"And trust is also difficulty when the doctor is changeable, for example, every 6 months is a different doctor... especially because ethnic and minority people, especially women, different cultures, different religions, we are very, there is sensitivity... different emotions, different understanding of that." (Mary, Respondent 1, Focus group 2)

The lack of consistent providers was described as undermining the development of sustained, person-centred therapeutic relationships. Participants shared experiences of being stereotyped or dismissed by professionals who failed to understand their personal histories or cultural backgrounds. They described feeling stigmatized in ways that undermined their ability to express legitimate emotional distress: One participant expressed:

"If you are not ready to listen to how I'm feeling, then how do you come in to help? This is another problem and sometimes they stigmatise you... and it's getting worse because they wouldn't give me a chance to like express myself....Because you have past history, you shouldn't judge me with my past history. First, listen to me, maybe I'm reasonable." (Nora, Respondent 3, Focus group 3)

These experiences reinforced a sense that services are not designed to meet the complex and varied needs of minority communities.

Culturally responsive care

Language barriers were described as a major obstacle to effective engagement with mental health services. Participants highlighted the absence of professional interpreters and culturally sensitive mediators as a persistent gap. Many expressed frustrations at not being able to fully articulate their emotional and psychological experiences in English, explaining that certain feelings are difficult to express in another language:

"It's very difficult sometimes to translate feelings or situations in another language." (Respondent 3, Focus group 4)

Participants advocated for the recruitment of community-based advocates who could act as cultural and linguistic bridges between services and communities. Without this kind of support, participants felt communication was strained, contributing to mistrust and disengagement. Participants also called for greater representation of ethnic minority communities within the mental health workforce, particularly people with lived experience who could understand the cultural and social realities faced by service users. One participant stated:

"They must also employ... advocate from the mental from the ethnic minorities and also from the lived experience." (Maria, Respondent 4, Focus group 5)

This was seen as essential not only for improving communication but also for making services more relevant and responsive to the communities they aim to serve.

Accessible care

Participants identified several structural barriers that made it difficult to access mental health services. These included complex referral pathways, long waiting times, a shortage of professionals and inconsistent follow-up.

"Imagine a person who's going through emotional breakdown and they're made to wait for over 6 months because there's no specialists." (Julie, Respondent 3, Focus group 5)

The bureaucratic nature of the system was described as overwhelming, especially for those unfamiliar with how health services operate in Ireland. Participants reported that even when they managed to secure appointments, the consultations were often rushed, limiting their ability to fully explain their concerns. One participant shared:

"You are given 10 minutes. OK, explain what's wrong with you, and if you want to explain more, the doctor will be telling you, oh, they got outside, so you need to be quick... they just want to prescribe medication." (Lili, Respondent 2, Focus group 4)

These complicated processes, combined with worries about the cost of care, especially for those with temporary protection status or limited financial resources, left some participants feeling excluded or forced to seek care elsewhere or disengage completely. As one participants explained during the focus group:

"I start to look for for counselling, but because I couldn't afford in Ireland, I look for counselling in [name of the country where the respondent is from]." (Nika, Respondent 3, Focus group 4)

Participants proposed several practical improvements to make services more accessible and responsive. These included expanding community-based outreach, offering walk-in services without appointments, and providing low-cost or free counselling. Participants also stressed on the need for continuity, noting that trust and openness take time to build. One participant explained:

"So I feel like, um, the service has to provide like a long term to people that really need it because people that have mental health problems, they don't tend to open up at the 1st, the 2nd, the 3rd sessions. They tend to open up the more they feel like this person is there, this person is willing. So I feel like there has to be a long term for those that particularly need it." (Nina, Respondent 3, Focus group 2)

Participants also recommended raising public awareness about mental health services and introducing crisis helplines, suggesting that better information and immediate access to support could prevent harm and encourage earlier engagement:

"They should give the number, contact number. Maybe they do the... sticker to place at home, you know, that's in case you have seen somebody going through mental health, call this number... Like now if you have accidents you know, 999, if you have something 112, you know, there should be something you call when you determine and they, they should call." (Hana, Respondent 1, Focus group 3)

Theme 3: Reflections on the Mental Health Engagement Training

This theme captures participants' reflections on the mental health engagement training, highlighting what they found most valuable, the challenges they encountered, and their recommendations for future delivery. Participants discussed the relevance of the training content, facilitation style, and accessibility, offering constructive insights to strengthen future capacity-building programmes for migrant and ethnic minoritised women.

What was helpful?

Participants consistently articulated a high regard for the Cairde mental health engagement training, emphasising its role in raising mental health awareness among communities often underrepresented in mainstream services. The training was particularly valued for its relevance to the lived realities of those who are unfamiliar with how to access mental health support. As one participant shared:

"Um, I found it so helpful because, um, it gave me more knowledge about um mental health, one. two, it gave me more knowledge of how and where I can seek for mental health, or even advise someone to go to." (Nina, Respondent 3, Focus group 2)

The training also provided participants with a platform to reflect on their own experiences and contribute to collective learning. One participant described it as:

"And it was very helpful to understand how you can protect yourself, how you can care of yourself, that you're important as well, and you listen to your voice, somebody will listen to your voice, somebody is interesting of you and they're giving you the opportunity, the chance to speak, to be here with other people. You're not alone. That was the message for people, I think, as well." (Natasha, Respondent 2, Focus group 2)

Some participants noted that the training gave them useful tools they could apply in their current volunteer or professional roles:

"I only have done previously as well, but after course, of course, I have more tools to understand my role and how to do better and more consistently, more professionally, to do more professionally." (Natasha, Respondent 2, Focus group 2)

Participants appreciated the safe and inclusive atmosphere created during the sessions, which encouraged sharing and connection. The trusted relationship many participants already had with Cairde was described as a key factor in enabling participation, with one noting that:

"everyone whom we know... we thought that would be good for the training, said yes."

There was also enthusiasm for more such sessions, with participants calling for the training to be expanded to reach a wider range of people.

What was less helpful?

While the training was well-received overall, participants identified several aspects that limited their engagement and learning experience. A common reflection was that the content felt rushed, with too much information covered in too little time. One participant remarked:

"I think it's the time and the training because everything, um, is just too many to learn in a very short period of time." (Nina, Respondent 3, Focus group 2)

suggesting the need for a more spaced-out programme to allow participants more time to process and reflect on the material.
Although the facilitators were described as open and engaging, creating a positive learning environment, some participants highlighted language and communication challenges. Despite the facilitator's approachable style, a few noted difficulties understanding certain accents, particularly Irish accents. As one participant shared:

"sometimes even English speakers, we can't understand.....sometimes we don't understand, especially Irish speakers, like native Irish." (Mary, Respondent 1, Focus group 2)

This suggests that, while the delivery was positively received, clearer communication could help make future training sessions even more accessible to all participants.

In addition to these content and communication challenges, some participants noted that the in-person format limited accessibility for those managing travel, childcare, or work commitments. A few suggested that offering online or hybrid delivery options could help overcome these barriers and make future sessions more accessible to a wider range of participants.

Recommendations for future training

Participants provided several practical suggestions to strengthen future training delivery. First, they recommended extending the training over multiple sessions or offering follow-up workshops to allow participants more time to engage with the material. There was also a strong desire for more interactive and practical learning, such as group exercises or hands-on activities. One participant recommended:

"So I think in in the future when we have training like that will be great to um have a workshop." (Ali, Respondent 2, Focus group 1)

Participants also highlighted the importance of ongoing support and follow-up after training completion. One participant proposed regular check-ins:

"Keep checking up on them to know how far they're going because even we that are volunteering also go through mental health sometimes. So we also need help. So I feel like, yeah, the follow up will also help you." (Ali, Respondent 2, Focus group 1)

Finally, several participants suggested offering the training online or in a hybrid format to improve accessibility. Participants also recommended that future sessions include content on Irish systems, laws, and cultural integration, as well as strategies for working across different cultural groups:

"We should add a little bit of studying on Irish culture...Even though that, um, as we're trying to help um immigrants with mental health issues, we can also educate them more based on the knowledge of the Irish culture and the Irish laws because, um, it's not only about mental health, but, um, helping these people to integrate.". (Nina, Respondent 3, Focus group 2)

These additions were seen as essential for enabling participants to support others in navigating mental health services within Ireland's diverse communities.

Conclusion and Recommendations: Pathway to Equitable Mental Health Engagement

Conclusion and Recommendations: Pathway to Equitable Mental Health Engagement

The acknowledgement of and commitment to equitable mental health engagement is clearly delineated in the policy documents of *"Sharing the Vision – A Mental Health Policy for Everyone,"* and in the complementary and continued work of The National Office for Mental Health Engagement and Recovery. This programme of work, led by Cairde and outlined in this report, firstly platforms the lived expertise knowledge of ethnic minoritised women and subsequently informs a strategic pathway, formulated by them, to support their strengthened equitable and meaningful participation in 'mental health engagement' in Ireland. The following section provides an overview of the core 'take home' messages evidenced by the research data.

To ensure their meaningful involvement in mental health engagement an engagement infrastructure (not just a structure) is needed.

The core research findings can be categorised under three thematic areas:

Conceptualization of 'Mental Health Engagement'

The strongest research finding relates to the language of 'mental health engagement' and the diverse understandings and conceptualisations of this term amongst the participant cohort. The findings demonstrated that very few of the participating women were even aware of and/or understood the existing mental health engagement structures. It was clear from participant narratives that, dependent on each person's current positionality, their understanding of the terminology of 'mental health engagement' was very nuanced and reflective of their personal journey of navigating the mental health system in Ireland.

Appraising across participant narratives, it was then notable that mental health engagement should be viewed as a journey that begin with awareness about mental health and integrating it into their language, gaining knowledge about available supports, learning strategies to care for their mental health, engaging with mental health services, and ultimately, having a voice in the delivery of those services and contributing to meaningful change.

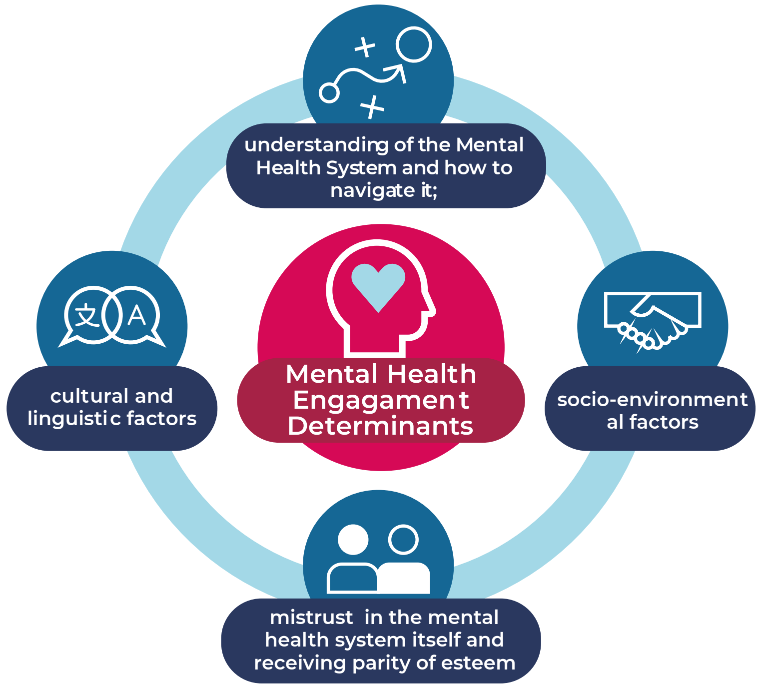
The varying conceptualisations of ‘mental health engagement’ has significant implications for the communication approaches required to attract and support strengthened involvement of ethnic minoritised women within mental health engagement structures as they current exist. It also encourages us to lean into this understanding of ‘mental health engagement’ existing on a spectrum along which individuals engage at different levels and to subsequently design and adapt our strategic approaches for equitable meaningful involvement of ethnic minoritised women along each stage of the journey.

Determinants to ‘Mental Health Engagement’

The research findings clearly evidence that determinants to meaningful ‘mental health engagement’ of ethnic minoritised women are expansive and diverse ranging from:

- understandings of the mental health system and how to navigate it;
- cultural and linguistic differences;
- socio-environmental factors; and
- mistrust — both of the mental health system itself and of the probability of receiving parity of esteem as a minority lived experience voice within the existing mental health structures.

These deeply felt and systemically entrenched determinants to mental health engagement will require significant commitment and sustained resources to meaningfully respond to and mitigate. The first step in working with this evidenced complexity is to actively listen to the strategies the women themselves propose as the pathway to their strengthened involvement in mental health engagement structures.



Strategies to ‘Mental Health Engagement’

The participating ethnic minoritised women adeptly communicated the strategies and methodologies required to meet the needs of their people and communities. We listened carefully to them and categorised their thoughtful and considered perspectives into four overarching strategic themes to strengthen their communicative impact. The pathway to strengthened participation of ethnic minoritised women in mental health engagement in Ireland includes strategies:

1. to reach a shared understanding of mental health engagement;
2. to implement responsive methodologies for mental health engagement;
3. to enact positive actions for equitable mental health engagement; and
4. to invest in sustained mental health engagement partnerships.

A full elaboration of each of these strategic thematic areas is provided in the table below.

Table 5: Strategies for Mental Health Engagement of Ethnic Minoritised Women

CORE NEED IDENTIFIED	STRATEGIC ACTIONS
Shared Understanding of ‘Mental Health Engagement”	▪ Culturally responsive awareness campaigns o Use community-led social media campaigns in native languages. o Integrate mental health content into community events and faith-based gatherings. ▪ Develop culturally appropriate mental health education and literacy workshops for Ethnic Minority Women o Delivery & Format: prolonged duration, hybrid, interactive, reflective & collective learning pedagogies, appropriate facilitators. o Topics: Build capacity for ‘mental health engagement’ by developing a deeper understanding of the mental health system, develop self & group advocacy tools o Establish mentorship and training opportunities for women to build policy literacy and leadership skills. o Evaluate participation practices regularly for inclusion and impact, not just attendance. ▪ Training for Mental Health Practitioners & Policy Makers o Awareness to the lived realities of ethnic minoritized communities in Ireland o Capacity strengthening in community responsive methodologies of ‘mental health engagement’ o Knowledge of inequitable approach and impact of WEIRD mental health systems (Western, Educated, Industrialized, Rich, and Democratic) o Cultural Humility training

Responsive Methodologies for 'Mental Health Engagement'	**'One Size Does <u>NOT</u> fit all'** o Discuss & proactively respond to the barriers of 'mental health engagement' for ethnic minoritised women o Work closely with trusted community organizations & groups o Outreach: Partner with non-mental health events, existing initiatives, and safe community spaces o Person-centred, responsive methods: Listen to people's needs and adapt 'mental health engagement' approach accordingly o Build in time: Understand and resource the time required to build trusting and safe partnerships for meaningful mental health engagement with ethnic minoritised women o Employ diverse methodologies: peer-to-peer support, storytelling, visual arts, and drama therapy. o Support both group and individual engagement models
Positive Actions for Equitable 'Mental Health Engagement'	■ **Address language & cultural factors** o Translate materials into multiple languages o Provide interpretation services during sessions and service access o Hire culturally competent, multilingual staff from ethnic minority backgrounds o Give opportunities to speak in own language, in culture/ issue/ religion specific groups (activities targeting communities, language/ community/issue specific break out rooms/group work) o Allocate sufficient time for participants to speak o Tailor engagement approaches to reflect specific cultural norms (e.g. women-only spaces, flexible group formats) ■ **Address participation barriers** o Cover travel, childcare & accommodation o Offer compensation for lived experience contributions o Respond to emerging individual needs (housing, living cond., racism, immigration status) o Support wider needs with provision of information, advocacy, counselling, peer support o Resourced to providing ongoing support to the participants
Commitment to Sustained 'Mental Health Engagement' Partnerships	■ Adequately resourced community organisations to lead long-term, continuing engagement efforts ■ Promote value of and demonstrate investment and long-term commitment to minority participation ■ Provide adequate financial compensation for lived experience contributions ■ Invest in long-term and sustained programmes to build people's trust & capacity over time ■ Secure sustainable funding for grassroots migrant and refugee-led organisations. ■ Invest in capacity-building and infrastructure (e.g. digital tools, staffing, space). ■ Strengthen partnerships between statutory services and community groups through clear communication mechanisms and structures.

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Appendix

Appendix 1

Focus Group Schedule

Thank you so much for coming here today and agreeing to share your views about participating in HSE mental health engagement structures and services in Ireland.

As you know, the voice of service users and families and cares is very important in the improvement of mental health services and there are several structures across HSE mental health services to strengthen mental health engagement among service users and people with lived experience of mental health. Some examples are lived experience panels and forums, service user surveys, engagement events and newsletters, and engagement networks. Although these structures provide a platform for the voice of service users and experts by experience to be heard, women from ethnic minority communities are rarely represented as part of them and their voice is almost absent. This is despite the fact that ethnic minority communities experience higher levels of mental health challenges, and have less access to services, and when they do have access, they are less satisfied with the service received.

Today, we are here to explore together the reasons for this lack of representation and engagement and ways to increase it.

I am going to propose some questions, and I would like to invite everyone to share their views and experiences with the group.

1. What does mental health engagement mean to you? How do you define it? Please feel free to use examples to explain it.

2. Have you ever become aware of any mental health engagement events or activities? How did you become aware of them? Did you participate? If yes, let us know about your experience. If no, what was the reason?

3. Do you think the mental health engagement structures that we talked about are suitable ways to engage women from your community or other ethnic minority communities? What other ways do you think HSE should use to engage women from ethnic minority communities?

4. In your opinion, what are the reasons for the lack of engagement of women from ethnic minority communities with mental health services? (For example, language or cultural factors, access to information, community factors, or systemic factors) How do you think their engagement could be improved?

5. If you get involved in one or some of the mental health engagement structures (for example a meeting or survey), what do you say about mental health services for women of ethnic minorities? What ways would you suggest for improving the mental health services for women from your community?

(***Only for participants who attended the training) Do you think the training supported you in terms of advocating for yourself and your community and engaging with mental health services? Please feel free to share your feedback on the format, content, and delivery of the training. Do you think the training is a useful way to increase the mental health engagement of women in your community?

Cairde
Challenging ethnic minority health inequalities

19 Belvedere Place
Dublin 1
Ireland (01)8552111
info@cairde.ie
cairde.ie