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MENTBEST
Protecting
mental health
in times of change.

MENTBEST

Protecting mental health in times of change

Selected Interventions Report

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MENTBEST Consortium

Full Name	Short Name	Beneficiary Number	Role
EUROPEAN ALLIANCE AGAINST DEPRESSION	EAAD	1	Coordinator
INSTITUTO DE SAUDE PUBLICA DA UNIVERSIDADE DO PORTO	ISPUP	2	Beneficiary
UNIVERSIDAD AUTONOMA DE MADRID	UAM	3	Beneficiary
NATIONAL SUICIDE RESEARCH FOUNDATION	**NSRF**	**4**	**Beneficiary**
REGION HOVEDSTADEN	PCC	5	Beneficiary
DET NATIONALE FORSKNINGSCENTER FOR ARBEJDSMILJØ	NFA	6	Beneficiary
EESTI-ROOTSI VAIMSE TERVISE JA SUITSIDOLOOGIA INSTITUUT	ERSI	7	Beneficiary
STIFTUNG DEUTSCHE DEPRESSIONSHILFE UND SUIZIDPRAEVENTION	GDF	8	Beneficiary
QENDRES SE SHENDETIT DHE MIREQENIES KOMUNITARE	CCHW	9	Beneficiary
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MONSENSO A/S	MSS	11	Beneficiary
PINTAIL LTD	PT	12	Beneficiary
KENTRO EREVNON NOTIOANATOLIKIS EVROPIS ASTIKI MI KERDOSKOPIKI ETAIREIA	SEERC	13	Beneficiary
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PROJECT DETAILS

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LIST OF WORK PACKAGES

Work Package No.	Work Package Name	Lead Beneficiary
WP1	Mental Health Epidemiology and Interventions	13 - SEERC
WP2	COMBINA Development	2 - ISPUP
WP3	COMBINA Study	14 - IMIM
WP4	COMBINA Evaluation	10 - LUCAS
WP5	MENTINA Development	8 - GDF
WP6	MENTINA Trial Delivery and Evaluation	5 - PCC
WP7	Participatory Action Approach	9 - CCHW
WP8	Communication, Dissemination and Future Implementation	3 - UAM
WP9	Project Management	1 - EAAD
WP10	Ethics requirements	1 - EAAD

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1. Executive summary

Deliverable 1.2 (D1.2) entitled "Selected Interventions Report" is the second deliverable from Work Package 1 (WP1). D1.2 is led by the National Suicide Research Foundation (NSRF) with input from the South-East European Research Centre (SEERC), the Institute of Public Health of the University of Porto (ISPUP) the European Alliance Against Depression (EAAD) and members of the co-creator network (WP7).

The objective of D1.2 is to identify and prioritise the best evidence-based interventions for mental disorders and sub-clinical mental health conditions, by consulting with stakeholders, including mental and public health experts and people with lived experience, who joined the WP7 co-creator network.

Given the overlap in the timeline between D7.1 (Report on Establishment of Co-Creator Network led by the Community Centre for Health and Wellbeing (CCHW)) and D1.2 – both of which required the organisation of online workshops with the co-creator network – the stakeholder consultation process relating to the objective of D1.2 was conducted in the form of a web-based survey. Following the first WP7 workshop organised on the 10th of November 2023, a survey was distributed to 25 stakeholders from seven countries, who were invited to share their input regarding successful interventions. The survey questions focused on obtaining a rating of interventions identified through the WP1 Scoping Review 2 (SR2) and on identifying additional, relevant interventions, based on the knowledge and experience of end-users and service providers.

SR2 aimed to identify and critically review existing interventions focused on improving and preventing mental disorders and sub-clinical mental health conditions. In addition, SR2 aimed to identify gaps, specifically regarding the application of the identified interventions to the prevention and mitigation of mental ill-health in five vulnerable groups: migrants and/or refugees, older people, younger people, long-term unemployed, people living with mental disorders.

D1.2 addresses the research gaps identified by SR2 and describes the approach and the results of the stakeholder consultation process, with a particular focus on the identification and the prioritisation of high-quality, innovative, cost-effective, and evidence-informed interventions for improving mental health challenges and preventing transition from sub-clinical to mental ill-health. The results from D1.2 will provide an evidence base to inform the structural and the theoretical development of WP2 Comprehensive Multifaceted Community-Based Intervention ("COMBINA").

2. Introduction and background

MENTBEST is a 5-year project, funded by the European Union, designed to support vulnerable groups in the general population, especially those at risk of being disadvantaged by dramatic societal change, experiencing stressors, and suffering (further) adverse impacts on their well-being, including mental health. The project proposes the use of proven community-based interventions and innovative technologies focusing on vulnerable groups. The European Alliance Against Depression (EAAD) leads this project with a multi-disciplinary consortium of 14 European partners.

Members of MENTBEST have researched, created, and delivered community-based interventions to reduce depression and suicidal behaviour. The EAAD 4-level model, which has been implemented in 120 communities across 17 EU countries and proven to be effective in reducing suicidal behaviour,

will be expanded to target wellbeing and anxiety in sub-clinical populations. This comprehensive community-based intervention will be named COMBINA and validated in five model regions in Albania, Estonia, Greece, Ireland and Spain.

The overall objective of MENTBEST is to enable vulnerable individuals, mental health practitioners, and communities across Europe to prevent and mitigate mental health problems (clinical and non-clinical) related to rapid changes in our societies. To achieve this, one of the Specific Objectives (SO2) of MENTBEST is to identify and synthesize high-quality interventions that address mental health challenges associated with rapid societal, economic, environmental, and other change in Europe, particularly for migrants/refugees, older people, younger people, long-term unemployed, and those living with mental disorders. The identified interventions will be combined with an adapted and expanded 4-level intervention programme designed and validated by the European Alliance Against Depression (EAAD), to create COMBINA, a community-based intervention programme focused on sub-clinical mental health conditions (for example, distress, anxiety syndromes, sub-diagnostic depressive symptoms), mental disorder prevention and well-being.

2.1. Overview of Task 1.2 "Selection of Interventions"

WP1 worked together with key stakeholders (public and mental health experts and people with lived experience of mental health conditions and their families), to identify and prioritise the best evidence-based interventions, in terms of outcomes, acceptability and value for money. Following completion of D1.1 Scoping Reviews, aimed to present a summary of findings to the co-creators, to prioritise the interventions identified in the SR2 and to gather information on additional interventions or key components of interventions, based on the experience and perceived needs of stakeholders, via an online consultation. The initial aim of the consultation was to develop a generalization framework and triangulate findings across the review of the literature and the stakeholder's input, by following an adapted and short version of the Nominal Group Technique (NGT).

The NGT is a group process for the establishment of priorities or the generation of creative solutions (Gorman and Clayton, 2005; Dunham, 1998). It consists of a structured, small group dynamic (5-12 participants) in which a facilitator presents a question or problem, and in which solutions are sought, one by one from each participant, after providing time for individual reflection and brainstorming. One key element of the NGT is the anonymity in the collection of responses – from participant to facilitator – and therefore takes advantage of pooled judgements from a variety of people with distinct knowledge and skills (Dunham, 1998).

NGT, delivered in online environments, is effective for obtaining consensus on a single topic. Previous research groups have designed and tested NGT web-based platforms for resolving issues (Tseng et al, 2006, Lago et al, 2007). For example, Tseng et al designed an NGT platform to implement a web-based knowledge transfer process across a group of experts in information technology (IT). To achieve this, participants accessed the platform and were asked to explore and share their own solutions through online messaging. In addition, participants were asked to rank their solutions, based on online NGT discussions. This experimental study reported high satisfaction in the online NGT consultation process and showed agreement with previous research stating that NGT balances participation across members, inclusive of online environments.

WP1 undertook a series of discussions focused on the workplan and challenges. The discussions were held between WP1 and additional members of MENTBEST, such as the WP7 lead team, in meetings – including the Plenary meeting in Frankfurt – to gather expert input and to address possible challenges.

Among the challenges discussed, overburden of members of the co-creator network from invitations to participate in two workshops in a short period of time was seen as a major risk for D1.2.

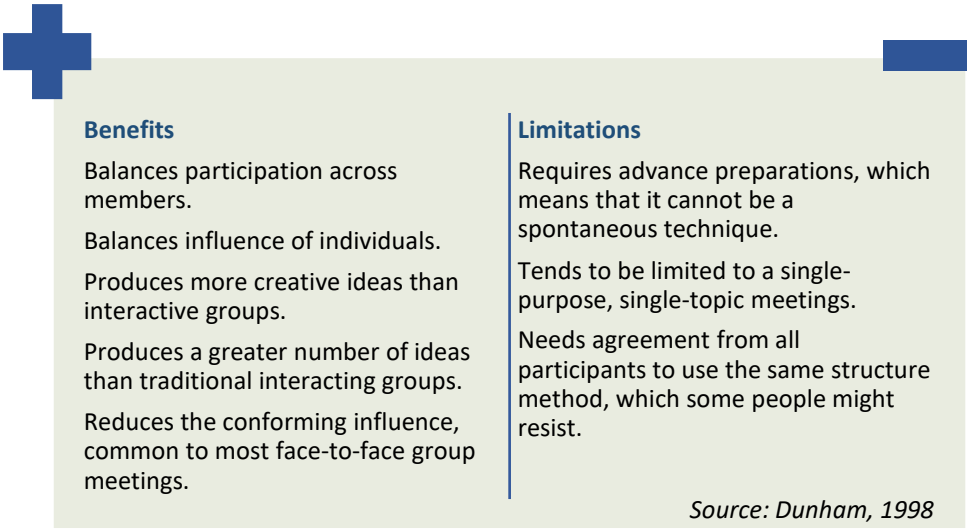

Figure 1. Benefits and limitations of the Nominal Group Technique in complex decision-making processes.

Considering stakeholder overburden and time as limitations, an adapted and short version of the NGT was delivered in the form of an online survey, which omitted the discussion of ideas between stakeholders. The survey questions focused on prioritising the interventions where there is strong evidence of effectiveness, as identified in the D1.1 SR2, and on brainstorming and generating a list of other interventions that have proven to work, particularly, in vulnerable populations for which the latest published evidence was not available: migrants and the long-term unemployed. It is important to note that there were no deviations from the Description of the Action, except from the one stated above.

2.2. Summary of findings from Deliverable 1.1 "Scoping Review No. 2"

Based on an extensive review of the most up-to-date published scientific literature, WP1 identified promising interventions that could be integrated into the community-based COMBINA intervention programme. The review of the literature followed a standardised approach to:

- conduct a systematic search of the literature in mental health-related journal databases,
- select the literature by using a set of inclusion and exclusion criteria, and
- present a synthesis of the findings from the identified studies.

The search of studies focused on depression, self-harm, anxiety, Post-Traumatic Stress Disorder (PTSD), stress and burnout, as well as on psychosocial and lifestyle mental health promotion and prevention interventions for the general and vulnerable populations in Europe.

The review identified 18 articles consisting of systematic reviews and meta-analysis published in the English language in 2021, 2022 and 2023. Although the articles were published in recent years, the interventions assessed by the reviews were implemented in a period spanning from 1980 to 2020. The studies described and summarised interventions or elements of interventions that could be used to promote mental health or prevent mental health disorders in non-clinical, sub-clinical and at-risk

populations by changing outcome measures associated with depression, self-harm and suicidality, anxiety, stress, and by improving wellbeing and resilience.

The findings from the literature review were classified based on the evidence of effectiveness of the intervention, following a RAG system: Red (R) there is evidence that the intervention is ineffective or harmful; Amber (A) there is some evidence of effectiveness, but the evidence is limited; Green (G) There is evidence of effectiveness; and Unclear, an added classification to denote where there is no evidence. The recommended (G) and not recommended interventions (R) from the SR2 shown in Table 1 were presented as preamble to the online survey.

Table 1. Recommended and not recommended mental health interventions based on a scoping review of reviews published in 2021, 2022 and 2023.

Recommended				
There is strong evidence to support the use of online, smartphone-based and telephone-facilitated interventions to reduce anxiety and depression **in children, adolescents, adults and older people.**	Active music therapy is a worthwhile intervention to tackle emotional difficulties and mood problems in **children living with depression or anxiety**.	A simulation of adverse circumstances, using virtual reality technologies, for skills training can improve self-efficacy by reducing anxiety, panic, and stress, associated with traumatic events**, in groups of children and adults from the general population**.	**For children and young people aged 10-19 years old**, active approaches, psychotherapy and routine care, are better than doing nothing (e.g., waiting list) for reducing self-harm, including suicide attempts and non-suicidal self-injury, as well as suicidal ideation.	Selective and indicated preventative interventions **for children aged 8-12 years**, such as parent education and cognitive behaviour therapy (CBT), are successful and cost-effective.

Not Recommended	
Mindfulness-based interventions delivered in schools settings to **adolescents (aged 12-18 years)** are not recommended for depression or anxiety.	Universal interventions (e.g., those targeting all children in a school) to prevent anxiety **in children and adolescents** are not cost-effective.

Source: Deliverable 1.1 Scoping Reviews.

For the purposes of this report, it is important to mention that in D1.1, two recommendations were provided relating to the gaps identified from the review of reviews:

1. Evidence on the effectiveness of interventions in migrants and long-term unemployed missing in the reviews published in 2021, 2022, and 2023, analysed by WP1. **Action suggested**: extend the literature search and/or review beyond 2021 to identify best evidence-based interventions in these two vulnerable groups.
2. Evidence on cost-effectiveness of interventions to protect mental health was insufficient, only 1 out of the 18 reviews included in the scoping review, mentioned cost-effectiveness. **Action**

suggested: extend the literature search and/or conduct a review of primary economic studies on specific interventions for mental health prevention or promotion.

In attention to these recommendations, the analysis of the survey data focused specifically on the recommended interventions in the context of target population for whom the intervention has proven to work and into the delivery setting.

3. Approach

The stakeholder consultation was conducted by applying a descriptive study design using an online survey. A 7-item survey was designed using the web-based tool *QualtricsXM* (Qualtrics, Provo, UT), with license for academic research by University College Cork, in Ireland. The core focus of the survey was twofold:

(1) establishment of priorities, from the list of recommended interventions identified in SR2; and
(2) identification of additional, relevant interventions, particularly in migrants and the long-term unemployed.

In addition, the survey included questions to identify digital tools (e.g., apps and websites) for self-management of mental health symptoms, expected implementation barriers in schools and migrant communities, and resources or training needed by the participant or a colleague to implement a new intervention in their community. The survey is shown in the Appendices.

The stakeholders were selected from a list of members of the WP7 co-creator network who attended the first co-creator workshop organised online on the 10th of November, led by CCHW. This workshop aimed to introduce co-creators to the research project. Participants MENTBEST teams presented an overview of the COMBINA and MENTINA interventions, and importantly, the objectives of the network were defined. In addition, provided an interactive introduction to the co-creator web-based platform. A total of 25 stakeholders were invited via email to complete the survey on the 17th of November. The stakeholders included end-users and service providers of interventions to improve mental health and illness within the five model regions for implementing COMBINA (Albania, Estonia, Greece, Ireland and Spain), as well as Germany and Denmark (MENTINA). All participants gave their permission to participate in the online consultation and made an informed consent before completing the survey.

The quality of the survey questions was assessed by using Qualtrics' 'ExpertReview' function which provided suggestions for improvement and a *Fair* overall score – highlighting the use of 3 or more open-ended questions which could affect completion rates. To increase the response rate, the survey was kept short (less than 12 minutes) and two separate reminder emails were sent to the stakeholders using a refreshed and customised message each time.

The survey data analysis followed a qualitative and descriptive approach. The descriptive analysis was suitable for this report as it identifies the 'who, what and where of events and experiences' and it is also a flexible and explorative method employed in qualitative research (Doyle et al, 2020). Where applicable, quotations from the survey answers are provided by using pseudonyms to preserve the anonymity of the stakeholders.

4. Results

The web-based survey was completed by 15 members of the WP7 co-creator network. The descriptive characteristics of the stakeholders are shown in Table 2. The stakeholders were living in Albania (n=2),

Denmark (n=1), Estonia (n=1), Germany (n=2), Greece (n=3), Ireland (n=1) and Spain (n=5). They self-identified as end-users (n=7), service providers (n=6), or both (n=2). Fourteen stakeholders had a high educational level and one participant completed upper secondary level (data not shown in Table 2). The co-creators represented a diverse range of age groups.

Table 2. Descriptive characteristics of stakeholders who completed the online survey consultation.

Country	***n***	***Gender***	***n***	***Age group***	***n***
Albania	2	Female	9	18-24 years old	1
Denmark	1	Male	6	25-34 years old	4
Estonia	1			35-44 years old	3
Germany	2	***Role***	***n***	45-54 years old	3
Greece	3	End User	7	55-64 years old	3
Ireland	1	Service provider	6	65+ years old	1
Spain	5	Both	2		

4.1. Establishment of priorities

From the list of recommended interventions identified by SR2, **online smartphone-based, telephone facilitated interventions** and **selective and indicated prevention interventions** were both rated as the most important by most of the stakeholders, with 7 votes each. **Simulation of adverse conditions** was rated as the least important intervention (Ranking 4) by most of the stakeholders, with 6 votes in total (Figure 2).

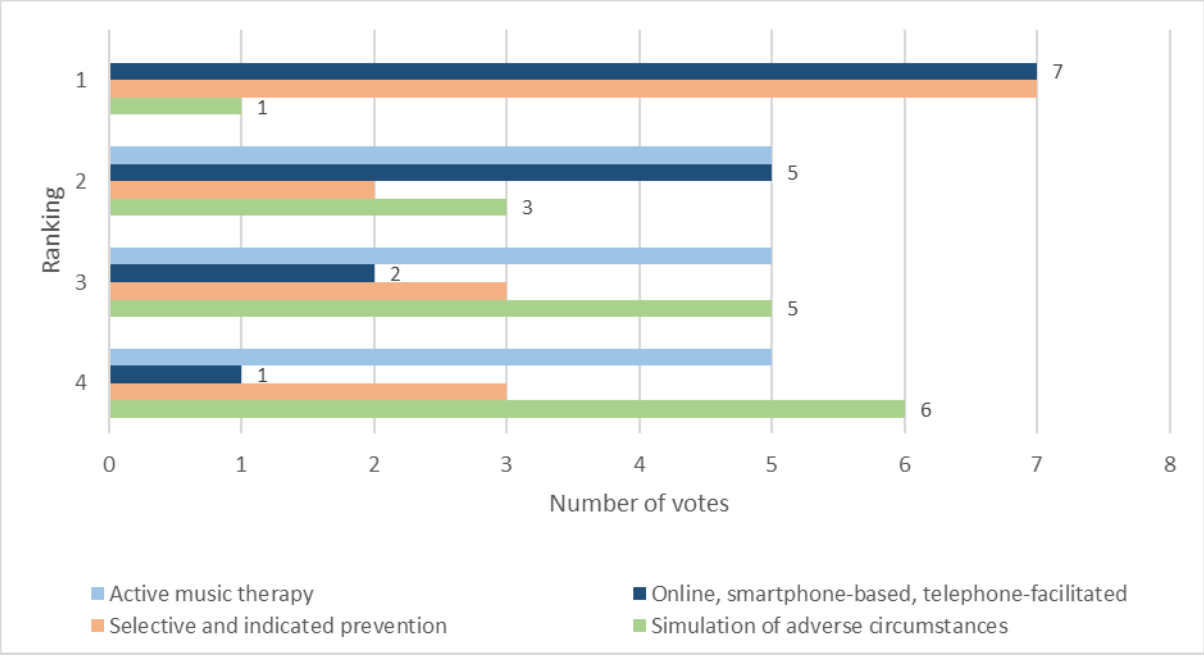

Figure 2. Ranking of interventions in terms of importance, most important (Rating 1) versus least important (Rating 4).

4.2. Identification of additional interventions

Stakeholders were asked to recommend relevant interventions, other than those identified in SR2, with a particular focus on vulnerable groups such as migrants, the long-term unemployed and people with a history of mental health disorders. The stakeholders identified 17 interventions encompassing distinct categories: psychotherapy, health promotion, education, social support, clinical practice, and included a theoretical paradigm (recovery model) (Table 3).

Psychotherapy was mentioned as a general treatment that may be conducted in individuals, at the primary care level, and in groups of people facing similar mental health issues, at the community level. Specific types of psychotherapy suitable at individual or group levels in primary care settings included Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) therapy and Cognitive Restructuring (CR). Overall, psychotherapy, in all its types and techniques, was referred to by 8 different stakeholders.

Table 3. Interventions identified by stakeholders ordered by level of implementation (Primary care, Broader Community, Community-based, and Special needs).

Level name	***Category***	***Intervention***
Primary care	Psychotherapy	Psychotherapy in general
Primary care	Psychotherapy	Cognitive Behavioural Therapy (CBT)
Primary care	Psychotherapy	Dialectical Behavioural Therapy (DBT)
Primary care	Psychotherapy	Eye Movement Desensitization and Reprocessing (EMDR) Therapy
Primary care	Psychotherapy	Cognitive Restructuring (CR)
Broader community	Health Promotion	Sport
Broader community	Health Promotion	Art
Broader community	Health Promotion	Social media and/or television advertisements
Broader community	Perspective	Recovery model with people with first-hand experience
Community-based	Education	Discussion forums for like-minded people
Community-based	Education	Face-to-face prevention and education talks
Community-based	Psychotherapy	Group therapy / Mutual support groups
Community-based	Social support	Peer-to-peer support / Peer mediation
Community-based	Social support	Teacher education
Community-based	Social support	Regular talks with trained or instructed social workers or similar
Community-based	Social Support	Weekly meetups with old and new friends
Special needs	Clinical practice	Biological treatment

At the community-based level, group therapy and mutual support groups were mentioned by five different individual stakeholders, followed by peer-to-peer support and peer mediation with four mentions from different individuals. This finding demonstrates a high level of agreement among the

stakeholders on the effectiveness of psychological interventions consisting of social support in the form of structured interactions between two or more people who connect at an emotional and a cognitive level which may include the presence of one or more psychotherapists serving as facilitators (APA, 2018). The remaining interventions at this level were each mentioned one time.

Stakeholders identified the populations for which the interventions have proven to work and the context of delivery (Table 4 and Table 5, respectively). Group therapy and mutual support groups were indicated for treatment and prevention of mental health conditions in adolescents, migrants, the long-term unemployed and adults from the general population, suggesting the possibility of applying this intervention in diverse groups of the population. For the vulnerable populations for which there is insufficient scientific evidence published in the last three years, psychotherapy, digital communication strategies, discussion forums, group therapy, peer-to-peer support, and regular talks with community health professionals were recognised as effective.

With reference to the context of delivery of mental health interventions, community centres, schools and digital media were mentioned by seven, six, and five different stakeholders, respectively. Digital media includes messaging through mobile phone apps, as well as web-based videoconferencing tools. For the broader community and general population, structured leisure activities, such as sport and art, and digital communications were perceived to be effective for the promotion of mental health.

Interestingly, the recovery model was referred to be effective for the general population in different areas of society, suggesting that emphasis on resilience and personal control over life circumstances should be adopted as the philosophical framework.

Table 4. Interventions perceived to be effective on specific population groups.

Intervention	*Children*	*Migrants*	*Unemployed*	*People with a history of mental health conditions*	*Adults*	*General population*	*People with mental health conditions*
Psychotherapy			X	X		X	
Cognitive Behavioural Therapy (CBT)		X					X
Dialectical Behavioural Therapy (DBT)		X					X
Eye Movement Desensitization and Reprocessing (EMDR)		X					
Cognitive Restructuring (CR)		X	X				X
Sport						X	
Art						X	
Social media and/or television advertisements	X		X			X	
Recovery model with people with first-hand experience						X	
Discussion forums for like-minded people		X	X	X			
Face-to-face talks to prevent and educate	X						
Group therapy / Mutual support groups	X	X	X		X		
Peer-to-peer support / Peer mediation	X	X			X		
Teacher education	X						
Regular talks with trained or instructed social workers		X	X				
Weekly meetups with old and new friends		X		X			
Biological treatment							X

Table 5. Recommended interventions organised by context of delivery.

Intervention	*Primary care*	*Community centre*	*Schools*	*Workplace*	*Telephone*	*Digital media*	*Broadcast media*	*Dedicated space**	*At home*
Psychotherapy	o	o	o		o	o			
Cognitive Behavioural Therapy (CBT)								o	
Dialectical Behavioural Therapy (DBT)		o							
Eye Movement Desensitization and Reprocessing (EMDR)	o							o	
Cognitive Restructuring (CR)	o							o	
Sport		o	o					o	
Art								o	o
Social media and/or television advertisements						o	o		
Recovery model with people with first-hand experience								o	
Discussion forums for like-minded people		o	o	o		o			
Face-to-face talks to prevent and educate			o						
Group therapy / Mutual support groups		o				o			
Peer-to-peer support / Peer mediation			o			o		o	
Teacher education			o						
Regular talks with trained or instructed social workers		o							
Weekly meetups with old and new friends		o						o	
Biological treatment								o	

*Dedicated spaces include mental health centres, rehabilitation centres, and leisure facilities.

4.3. Digital tools

The stakeholders were asked to identify digital tools (e.g., mobile apps or websites) that are useful for mental health. The *iFightDepression* (iFD) web-based tool was mentioned by two different participants residing in Germany, suggesting exposure to initiatives of the German Depression Foundation leading the implementation the iFD tool developed by the European Alliance Against Depression (EAAD). Additional digital resources are shown in Figure 3 and described briefly below:

- Mobile apps designed for productivity, meditation or management of sleep hygiene, such as **Forest**, **Insight Timer**, and **Headspace**, and an online counselling platform for young people entitled **Live Without Bullying**,
- Social media apps designed to stay connected with friends, family and communities, such as **WhatsApp** and **Facebook**, and
- Websites for young people dealing with relationship problems: the **Cool Not Cool** (http://www.coolnotcoolquiz.org), component of the broader United States government-funded initiative **That's Not Cool** (https://thatsnotcool.com); and EAAD-Best free online self-management tool for depression, **iFightDepression** (https://tool.ifightdepression.com).

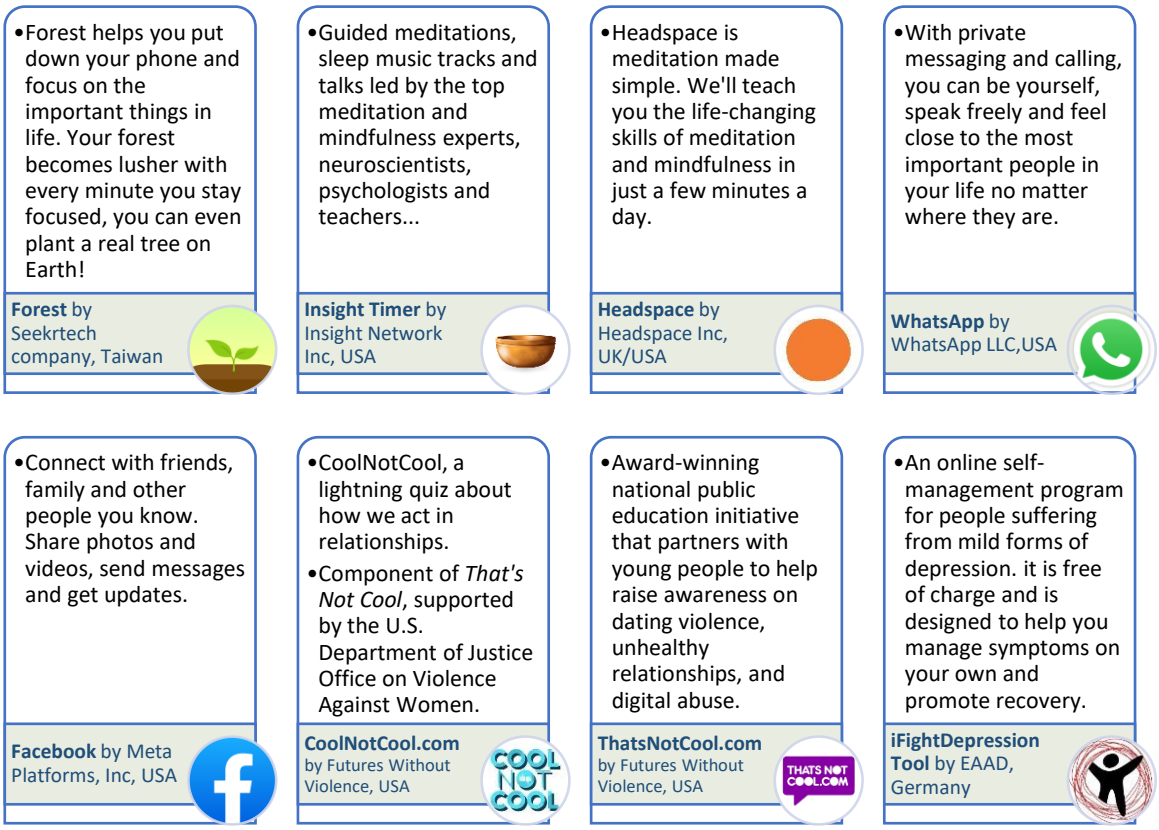

Figure 3. Description of mobile apps and websites used to manage mental health symptoms.

Although digital tools were identified briefly, one of the stakeholders expanded on his answer: "*Apps such as WhatsApp are the most common and day-to-day used app for migrants within camps. Dissemination via the app within a group chat has shown to be easily accessible for most people of*

concern and provide direct communication, limiting misinformation and direct updates. There are no applications used for mental health. However, apps such as WhatsApp are used to inform regarding site activities that anyone residing in site can participate. Hence, using these tools to gather the population together for activities reinforcing positive movements and behaviour."

4.4. Barriers and resources

Perceived barriers, in accordance with published literature on global implementation challenges (Wainberg et al, 2017; Qureshi et al, 2021), included limited funding, lack of skilled mental health human resources and inadequate training of personnel (or the need to increase capacity building) (Table 6). In relation to migrants, language barriers which could be affected by the translation of materials into the language of the members of migrant communities, was perceived as a challenge. There were context-specific barriers, for example, in the case of Spain, any plan of implementing a complementary school activity must receive approval from the Ministry of Education.

Table 6. Perceived implementation barriers in the effective delivery of mental health interventions by a group of 15 stakeholders residing in Albania, Denmark, Estonia, Germany, Greece, Ireland and Spain.

Implementation barriers	*n*
Limited funding	13
Lack of skilled mental health human resources	11
Inadequate training of available personnel	9
Language barriers	2
Lack of political will or interest	1
Required to liaise with high level officials to obtain permission to operate in schools (Spain)	1
Lack of monitoring	1
Low uptake/engagement by target population	1
Scepticism	1
Stigma and self-stigma	1

Priority actions to address these barriers included raising awareness on mental health conditions in all areas of society, by disseminating educational information and materials through workshops, podcasts, and brochures. A focus on capacity building of professionals and carers, as well as increasing – financial – resources by campaigning for funding, were suggested as solutions by the stakeholders.

Regarding the 'lack of monitoring', a stakeholder – Jim – said: "*We can create an app for building a network, so that psychologists who work in education can address to each other for any problems they have during the implementation of the intervention (maybe we could do the same for teachers). In relation to teachers' perception of their professional role, they usually connect their role only with providing knowledge and they usually don't pay attention to students' emotions, thoughts and problems outside the classroom. In Greece, there is a new role which is assigned to one or two teachers in every school which is called "school life's counsellor". This role is usually undertaken by teachers who express an interest in psychology and how students' emotions, thoughts and other life difficulties affect their learning. So, we could target only those teachers in every school*."

Another stakeholder – Mary – suggested: "*Focusing on easily available interventions instead of those requiring a lot of personal monitoring and establishing a way for people to use the intervention themselves, with minimal guidance."*

In addition, the stakeholders expressed the need for resources and training in their communities in the following areas:

- Resources
    - Information and materials for workers and patients.
    - Funding for human resources and materials.
    - Improved psychotherapeutic methods.
- Community-building by
    - Providing a safe and adequate setting.
    - Rewarding the community members.
    - Creating digital spaces to network and stay connected.
    - Scheduling meetings to discuss implementations challenges – if applicable.
- Training and technical support in
    - Diversity and experience of mental health challenges specific to vulnerable groups, e.g., migrants.
    - Regional availability and accessibility to mental health support and care.
    - Learning how to communicate effectively with target groups.
    - Learning basic code of conduct, in relation to diversity and inclusion.
    - Learning topics of psychology and neuro-linguistic programming.
    - Implementation guidance for COMBINA – if applicable.
- Dissemination activities
    - Launching an advertising campaign in digital media channels.
    - Raising awareness and reducing stigma surrounding mental health problems.
- International cooperation

5. Recommendations and conclusion

The prioritisation of evidence-based interventions favours digital- and telephone-facilitated interventions and interventions targeted at individuals or subgroups of populations whose risk of developing mental health conditions is significantly higher than average. This risk is assessed through an initial screening of risk factors, signs and symptoms (Compton and Shim, 2020).

Furthermore, selective and indicated interventions, such as psychotherapy, were perceived to be effective for the detection and treatment of ill-mental health in vulnerable groups, including migrants, the long-term unemployed and people with pre-existing mental health problems.

Relating to priority actions in the communities of interest for implementing COMBINA, the establishment of mutual support groups and/or peer-to/peer support networks was often referenced by the stakeholders. Added to this, the creation of safe spaces for participants of COMBINA to connect with other members of society who have experienced similar challenges, as well as with professionals who can provide support to these groups and networks, were perceived as important elements of successful interventions.

Finally, it is important to consider context-specific characteristics and conditions which can affect the outcomes of the COMBINA intervention in vulnerable populations. As an example, SEERC conducted a consultation with three experts in Greece (a report prepared by Ana Vivas and Lina Gega, SEERC, was included in the Appendices). The experts presented lived experience of mental health conditions and work with two vulnerable groups (young people and migrants). Regarding interventions that have proven to work for children and young people living in Greece, the experts recommended the use of interactive activities and digital resources, as well as peer mediation and access to technical support from professionals. For migrant populations, the use of digital tools was highlighted, including the use of WhatsApp to diffuse messages among members of communities, in agreement with the findings from the online survey consultation. In addition, the establishment of safe spaces for groups of the population with unique characteristics and needs – e.g., migrant women – was perceived as a need that could be addressed in the design of a mental health intervention.

The findings from the consultation performed in Greece shed light into the difficulties faced by migrant populations living in the Southeastern region of Europe, which has not been reported in the scientific literature, addressing an important gap. Therefore, an initial and comprehensive assessment focused on epidemiological, behavioural, social and environmental factors, as well as administrative and policy, may need to be conducted with specific populations in some model regions for MENTBEST to identify priority needs, enablers and/or barriers preceding the implementation of the COMBINA and MENTINA interventions.

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7. Appendices

7.1. MENTBEST Survey on Interventions and Strategies

Welcome.

We welcome you to this survey. The purpose of this survey is to identify mental health promotion interventions for a community-based programme.

Thank you for collaborating with **MENTBEST**.

At the conclusion of this survey, we will have mapped potential strategies for dealing with depression, self-harm, anxiety, post-traumatic stress disorder (PSTD), stress and burnout in the following vulnerable groups of the general population:

1. Children and adolescents (people up to 18 years of age)
2. Older people (people aged 65 years and older)
3. Migrants and refugees
4. Long-term unemployed
5. People with existing mental health conditions

MENTBEST partners have reviewed research globally and have identified the following interventions that are recommended and those that are not recommended (please see box below). From this survey, the interventions, treatments and strategies identified with your input, will be assessed and combined and integrated in COMBINA, a community-based intervention programme focused on strengthening resilience, sub-clinical mental health (for example, distress, anxiety syndromes, sub-clinical depression), and the prevention of mental disorders.

Recommended ✓

- There is strong evidence to support the use of online, smartphone-based and telephone-facilitated interventions to reduce anxiety and depression in **children, adolescents, adults and older people**.
- Creating, listening or playing music, known as active music therapy, is a worthwhile intervention to tackle emotional difficulties and mood problems in **children living with depression or anxiety**.
- A simulation of adverse circumstances, using virtual reality technologies, for skills training can improve self-efficacy by reducing anxiety, panic, and stress, associated with traumatic events, in groups of **children and adults from the general population**.
- For **children and young people aged 10-19 years old**, active approaches, psychotherapy and routine care, are better than doing nothing (e.g., waiting list) for reducing self-harm, including suicide attempts and non-suicidal self-injury, as well as suicidal ideation.
- Selective and indicated preventative interventions for **children aged 8-12 years**, such as parent education and cognitive behaviour therapy (CBT), are successful and cost-effective. Selective and indicative prevention is targeted at individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average, and it involves screening/assessment of risk factors, signs and symptoms.

Not recommended ✗

- Mindfulness-based interventions delivered in schools settings to **adolescents (aged 12-18 years)** are not recommended for depression or anxiety.
- Universal interventions (e.g., those targeting all children in a school) to prevent anxiety **in children and adolescents** are not cost-effective.

Consent form. Before we begin, please see the consent form below.

This consent form relates to contributions of the MENTBEST Co-Creators for the Selection of Interventions Task.

If you agree with the details provided in this survey and you are happy to consent to become a consulting stakeholder, please type your full name - First name and Surname(s).

Q1. What is your role in MENTBEST?

- End User
- Service Provider

Survey questions. *Before you answer the next questions, please take 5 minutes to reflect and list your ideas regarding effective interventions for promoting mental health and mitigating mental disorders. Take a piece of paper and describe each idea in a brief phrase or a few words. Since this is an opportunity for you to prepare contributions to the survey, we would appreciate your genuine effort and concentration during this time.*

Q2. Considering the interventions identified by MENTBEST, rate each intervention from 4 to 1 in terms of importance: 1 being the most important (highest value) and 4 being the least important (lowest value). *Drag and drop and select box.*

- *Online, smartphone-based, telephone facilitated interventions*
- *Active music therapy*
- *Simulation of adverse circumstances using virtual reality technology*
- *Selective and indicated prevention such as parent education*

Q3. Based on your experience, can you recommend a relevant intervention, treatment or strategy that you are aware of other than the ones already mentioned and **preferably for vulnerable groups such as migrants, the long-term unemployed or people with a history of mental health conditions?** *Please specify the target population and the setting (community health centre, school, workplace, digital, etc.) for this intervention that you think is the most important in your community.*

Recommended intervention

Population(s) for which this intervention is effective

Setting

Q4. Can you recommend an additional intervention, treatment or strategy, that has not been mentioned?

- Yes
- Nothing to add

If the answer is yes, please provide details of a relevant intervention, treatment or strategy:

Recommended intervention

Population(s) for which this intervention is effective

Setting

Q5. Are you aware of any digital tools, e.g. existing apps or websites, that you find useful for your work with the populations above or for your mental health?

Q6. What do you expect the barriers would be if we were to implement a new intervention or a new system in schools and migrant communities?

- Lack of skilled mental health human resources

- ☐ Poor funding
- ☐ Inadequate training of available personnel
- ☐ Other

Q7. How can we overcome these barriers?

Q8. What resources or training would you and other people (colleagues, community members) need to be able to implement a new intervention or mental health promotion system?

End of survey. Where do you live?

- Albania
- Estonia
- Greece
- Ireland
- Spain
- Other

Q24. How old are you?

- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

Q25. How do you identify?

- Male
- Female
- Prefer not to say

Q26. What is the highest level of education you have completed?

- Primary
- Lower secondary
- Upper secondary
- 3rd level – no degree
- 3rd level – degree or higher
- Not stated

We thank you for your time spent taking this survey.

7.2. Consultation with stakeholders to inform MENTBEST deliverables

Completed by Ana Vivas and Lina Gega, SEERC, on 31 October 2023

Aims

1. To understand the **needs and priorities** of 5 vulnerable populations* in relation to their mental health and wellbeing, from the perspectives of stakeholders who may be experts-by-experience as members of these vulnerable populations and/or professionals who support these populations in different roles.
2. To identify **interventions, strategies and resources (including digital)** that can protect the mental health of vulnerable populations, from the perspectives of both experts-by-experience and professionals who support them.
3. To **compare stakeholder reflections** based on their experiences **with published evidence** based on reviews of reviews, in relation to vulnerable population needs and potentially helpful interventions to protect their mental health.
4. To use the findings of consultations with experts-by-experience and professionals, along with the findings of systematic reviews and the existing resources and clinical expertise of the MENTBEST team, **to inform the selection and development of interventions** and other deliverables for the MENTBEST programme.

*children and adolescents, older people, unemployed people, migrants, people with a history of mental health problems

Consultation process

- In three separate **one-to-one online** consultations – each lasting 1 hour – two researchers (Ana Vivas and Lina Gega) used **5 questions (see boxes below)** to guide a conversation with 3 experts.
- Two of the participating experts had a **dual perspective** as members of a vulnerable population and as professionals working with a vulnerable population.
- The researchers took **contemporaneous notes**, which they then summarised under each question across all 3 experts.
- Each statement is **grounded in the experts' narratives**, indicated as Expert 1 (E1), Expert 2 (E2), Expert 3 (E3).
- **Personal information – i.e. gender, ethnicity, religion, country of origin, city of residence – are concealed** in the summaries to protect the anonymity of the experts.
- This summary was **shared with the experts** asking them for any corrections or additions to their own narratives, or any reflections to other experts' narratives.

1. Could you tell us about your **background and your life/work experiences** as a migrant/a professional working with migrants/professional working with children and young people?
- What does your current role involve?

Expert 1 (E1):

- Native to Greece – University educated.
- Graduate psychologist working in schools with children and adolescents, from pre-school (4 years old) up to 18 years old (high school).
- In schools, their work enables them to understand not only the needs of the pupils, but also the needs of mothers (gender is important) who have mental health problems and the challenges for older people who look after their grandchildren, or of migrants who are parents, or of unemployed parents who struggle in the face of a limited welfare system.
- The psychologists in schools play different roles, from identifying learning difficulties and making an onwards referral for a formal diagnosis, to working with parents and teachers for prevention of problems, or for intervention when problems occur. For example, including conflict resolution when there are problems such as bullying.

Expert 2 (E2):

- Second generation migrant from a family of political refugees from the Middle East.
- University educated, counselling and psychology background, currently working as an information specialist for a government organisation, collecting and analysing data from refugee camps, also working for the European support office for refugees in the country dealing with information flow.
- Has a network of other migrant who live in the country and who also serve in supportive roles for refugees in the community.
- Own experience of bureaucracy as a big source of stress, unfairness and insecurity, even for them as a migrant born and bred in the adopted country, living in it for nearly 30 years and working for the Greek government, there is no extended visa while applying for citizenship, and this makes it very hard to travel and plan a life in the country.
- They speak the language of the migrants so when they are in the field they deal with many other issues and provide help to refugees by frequently mediating communication (translation) with other employees who are native to the host country.

Expert 3 (E3):

- First generation migrant from a specific community – University educated in both their native and adopted country, now teaching the children of migrants from the same community their native language (started with funding from the native country) and ways to reconnect with their roots.
- Believes that integration of migrants in their adopted country can happen without losing one's own heritage and identity.
- Works as social caregiver in a 24-hour residential setting (temporary accommodation) for children and adolescents who are removed from their families by court order because of abuse, and for children and adolescents who are unaccompanied migrants. The role involves teaching the children life skills, offering day-to-day activities and emotional support, like a parent would do. The role does not involve offering therapeutic advice. At any given time, they have under their care about 23 children and adolescents who may stay from a few weeks to 9 years.
- Has a leadership role in an NGO that focuses on women's issues and is involved in the support of women from her migrant community who can be more vulnerable compared to (or because of) men from the same community.

Summary of expertise

- **3 experts** through lived experiences and work with 2 key vulnerable populations: **children/young people** and **migrants** (both adult migrants and children migrants).
- Additional insights into 3 other vulnerable populations interfacing with migration and children/young people: **unemployed** migrants, **parents** with mental health problems, and **older adults** who are migrants, older adults who are carers of children.
- Two experts had **dual perspectives**: both as migrants and as professionals working with migrant communities in different settings (camps and wider community). One of these experts also works in a residential setting with abused children and young people. The third expert is a professional working with children and young people, and with parents, in schools.

2. In your experience, what are the main **priorities and difficulties** that children and adolescents/migrants currently face in relation to their mental health?

For children and young people:

- The "digital world" and social media is behind many mental health problems; children do not have free-time activities other than spending time with screens, they need constant stimulation with technology. Parents are not educated to deal with this and do not often even see it as a problem. (E1)
- Sexting and sex-related bullying and its consequences (posting photos, spreading rumours etc) in adolescents (high school). (E1)

- Something which is new this year (triggered by cost-of-living crisis) is related to financial problems, which are typically linked to additions problems, mostly online gambling, betting and drug trafficking as a way of making money. (E1)
- Violence (physical and digital), and stigmatization (by educators and peers) in relation to diversity. Schools are not as inclusive and diverse as they should be, and there is a lot of discrimination and victimisation for gay and trans young people. (E1)
- Mothers with mental health problems: stigmatisation in schools as some teachers and many parents may view such mothers as indifferent or as bad mothers without consideration of their needs and vulnerabilities because of their mental health or addiction problems. (E1)

For migrants:

- When they arrive in the host country, the main challenges related to meeting their basic needs, such as shelter, food and sanitation. These necessities are often not provided at reasonable standards, e.g., living in a metal container, with mould and cockroaches, bitten by insects, no mattresses to sleep. (E2)
- Safety and protection from gender-based violence is also a big issue for women and young mothers. (E2)
- Stigma against certain religions can be also a source of stress; they have experienced discrimination when disclosing their religion (e.g., when seeking rental accommodation, the landlady asked whether they belonged to that specific religion, and she did not call them back).
- PTSD following violent events. (E2)
- Migrant women face two main challenges: first, poor working conditions as the majority work as house cleaners without insurance, and with low income; second, family violence, usually from their husbands/partners. This could be related to the specific characteristics of this migrant population, which is generally of low socio-economic status, who could not get further into Europe by plane that could just cross the land borders on foot. (E3)
- The second-generation of migrant women, have different challenges from the first generation (and the third generation), which is mainly related to self-confidence and identity since many families did not maintain their cultural heritage (language), and told their children not to talk to avoid discrimination. (E3)
- There is a new wave of very young women migrants, who come to their host country to marry men from their native country. These men have been living in the host country for many years and want to marry women from their native country, but these young women do not know the language of the host country, they are isolated in their homes, depend on their husbands and accept abuse/violence within the marriage as normal. (E3)

3. What do you do in **day-to-day life/practice** to protect your mental health/the mental health of children and young people/migrants whom you support?
- What **specific interventions, strategies or resources** do you use?
- Are you aware of any digital tools, e.g. existing apps or websites, that you find useful for your work with children and young people/migrants or for your mental health?

Children and young people:

- Using quizzes, videos, and other digital means to grasp the attention of the children and adolescents in the class. It is also important to use non-digital means to reinforce the human connection and go more into depth with discussion. (E1)
- Peer mediation e.g., when there is conflict or bullying between 2 students. This mediation is facilitated by elected pupils (e.g., in the school student council) plus teachers. (E1)
- Advice from other team members and professionals, attending seminars online and in person individually and in groups, to allow for skills development in dealing with complex presentations. (E3)
- When I have a problem and I need support/information I ask my colleagues (psychologist etc). The most important resource were the training seminars offered by the government that give knowledge and skills. Some of them are face to face and some digital. I do not know of any relevant online resources. (E3)

Migrants:

- From own experience, the best way to deal with a controversial topic is comedy/humour and to be open about pointing out the "elephant" in the room. For example, they originate from a country that is considered "hostile" and even more so at present because of the war in the Middle East, so humour is usually a good way to diffuse a "climate". (E3)
- WhatsApp group used by adults and adolescents to signpost them to resources, create a community and offer information on different services and opportunities. This worked really well when organised by the government, but they stopped it. (E3)
- Empathy and listening, being mindful of the context – e.g., mother with kids. Give hope and help migrants to stay strong even with difficult circumstances, understand their predicament without judging, being in the present with them. (E2)
- Create friendly female spaces so that they can talk and share similar interests and stories, because social connection between people who face difficulties is very important. (E2)
- Help the employees who work with the refugees to remain compassionate and positive. (E2)
- There are no apps or any other digital tools for promotion of educational activities for kids or adults, or activities for women, no app for mental health or to enable referrals for child protection. (E2)
- The best example of digital resources is that of the Danish Refugee Council. (E2)

4. Do you have a **"vision" of an ideal** intervention, or care pathway, or system to help children and young people/migrants in schools/the community?
- If you had a **magic wand**, what would you wish for, to make a difference to the mental health of children and young people/migrants?

- Instead of cancelling the digital technology we need to raise awareness – instead of removing digital media, we need to teach children and adolescents how to approach them with a critical mind. (E1)
- We need to design interventions and safe spaces – both physical and digital – through a gender lens. (E1, E2, E3)
- It would be very useful to have something like COMBINA, but it would be best if this tool is promoted by official government organisations so that there is better acceptance by health professionals in schools. (E1)
- For any issues – legal, financial or health related - to be able to signpost people (migrants or young people who are victims of sex-related bullying) to the right help. (E1, E2)
- Create a community of practice, and resources to train the trainers, since a support network and feedback about a psychologist's day-to-day practice is missing from schools. If we are to implement a new tool, this kind of support is very important. (E1)
- Include intervention materials not only for children & adolescents but also for educators, it is important to train educators as well. (E1)
- Incentives and training for teachers to be able to see that if we can protect and improve the mental health and wellbeing of pupils, we can improve educational outcomes, behaviour and engagement, therefore making the teachers' work easier, more effective and more rewarding. (E1)
- Offering support to the family so that the family is enabled to make a difference for the child. Also, family to be educated about the use of digital media. Young people know digital media well, so educators can be the young people themselves (some sort of peer-supported education programme about mental health and digital media). (E1)
- For the migrant community to be able to express their emotions and to trust people who offer them help. (E3)
- I would teach the people to give love and positive feelings. Within the professional boundaries – to say a good word to everyone without suspicion. (E3)
- Connect with someone when departing for another country. Not judging. (E2)
- Better conditions for migrants to live, more opportunities, fairer administrative systems e.g., having to wait for 6 months before migrants are able to work. (E2)
- Flexibility and common sense e.g., getting a mattress from the storage room to the campsite for a kid to sleep on when the only barrier is bureaucracy. (E2)

5. What do you expect the **barriers** would be if we were to implement a new intervention or a new system in schools/migrant communities?

- How can we overcome these barriers?
- What **resources or training** would you and other people (colleagues, community members) need to be able to implement a new intervention or system?

For children and young people:

- Barriers in asking teachers to support interventions for children and young people's mental health (E1):
  - they do not consider this as part of their role, but rather think that this is the job of a psychologist.
  - they consider it as an additional administrative burden in an already pressured and under-appreciated job.
  - as a statutory requirement, they may not want to do it, or they may only do it in name as a paper exercise, to protest against the burdensome bureaucracy imposed by the government that saps away meaning from the teachers' work.
  - as a voluntary contribution, they may feel a sense of injustice (e.g., teachers are taken for granted), or they may feel a sense of entitlement (e.g., teachers should be paid for doing something additional).
- Not cooperation from parents and not being able to enforce it like in healthcare (E1).
- There are no standardized protocols or guidelines to help professionals deal with mental health problems in schools in a consistent way, similar to the ones in the UK or from the USA. Currently, it all depends on the individual psychologist/counsellor. There is oversight and governance which is heavy handed and bureaucratic rather than supportive – so professionals do not develop but they feel imposed upon, frustrated and demoralised by the government. (E1)
- There is gender bias – mothers with mental health problems are treated with contempt or as lazy or bad mothers. There may also be mothers who work e.g., two kids with ADHD – one mother was interested and the other was not interested – the mother was working. We emphasise the role of the mothers as the main carers without considering that the welfare of the child is a collective responsibility – fathers, teachers, etc. (E1)
- Secondary/high schools are based on punishment when adolescents are troublesome, and educators do not have the training/skills to deal with behavioural/mental health problems and resolve conflicts. (E1)

For migrants:

- Admitting to having a mental health problem and asking for help are taboo in certain cultures and there is stigma associated to mental health problems, so people may not ask for help. This is particularly the case for men (gender is a big factor here). (E2)
- Treating the first host country as a stopgap before going somewhere better, so no matter what the conditions or provisions are, there is disengagement and dissatisfaction; an example given of children migrants who grow up in supported accommodation in the first host country, arrive to their final country as adults and then contact their social caregiver to say that they wished they had made the most of their stay in the first country. (E3)
- Thinking that they need to hide or dilute their own identity and language to be able to integrate in a community (e.g., by changing their name, speaking the new language rather than their native language) which may be the result of misperceptions (e.g., advising mothers not to talk to their babies in multiple languages) or from fear of stigma (e.g., if speaking their language in public). (E3)
- Migrants are moving constantly; they may stay in a place temporarily and move to another shelter, even country, so it is difficult to provide long-term support and interventions and there is no continuity of care. "*Do not open a wound if you cannot close*" it, it is the mentality in mental health services provided to refugees. (E2)
- Mental health is often seen as a luxury by the refugees themselves: "*I don't have work, I cannot feed my family, what can a psychologist or a counsellor do*?" (E2)
- Therapeutic nihilism when all these things are happening how can you start an intervention to promote mental health when there are so many other problems with food, shelter and violence. (E2)
- Language barriers, especially for women migrants who arrive in the country to marry fellow countrymen who keep them isolated and dependent on them – unless these women can reach out for support in their own language, they won't be able to alert the authorities to the violence and abuse they experience, and even if they do, the system in the country requires them to physically go to a police station rather than the police going to their home. (E3)

- There is lack of cohesion within specific migrant communities and deliberately moving away from their own compatriots, e.g., not wanting to have them as neighbours or their children as classmates. This may be due to misperception that they will assimilate better in their adopted country if they are not surrounded by people from their native country, or because of fear and internalised stigma, or because of prejudice against people from their native country who are, for example, from rural areas and of lower socioeconomic status. (E3)
- Migrant camps are closed sites where only governmental employees can access the refugee populations, so everything needs to go through bureaucratic channels, which are not currently concerned with mental health but with legal issues regarding status of refugees. Barriers with different pathways to reach the refugees: a) government to promote an intervention. This will come up against bureaucracy and potentially lack of funding to promote this – people may also have different expectations or fears if the government is involved with an intervention. B) Direct communication with refugees through national organisations that deliver health services within each camp. C) International organisations within sites such as the Danish Refugee Council. D) Flyers on the wall explaining what this is about and a QR code for getting more information. Perhaps the best solution is to promote and offer interventions to migrant populations through NGOs that work with refugees outside camps. It is important that the materials and tools are accessible (user friendly and in the migrants' native languages). (E2)
- The main barrier is not with organisations or other professionals, the main problem is the resistance from the migrant community themselves which even if you offer them free resources, they may not accept them because they do not trust others or have no confidence in the system or the professionals even from within their own ethnic community. (E3)
- Having to keep boundaries e.g., "*how much money are you getting paid, you are getting paid because of me*", even if people have not eaten for days, you cannot buy them a sandwich because you will be automatically dismissed for unprofessional behaviour and there will be thousands more who are hungry. (E3)
- A potential barrier for digital tools to facilitate interventions for migrants is digital literacy specially for older adults, and language. (E2)