Sláintecare Healthy Communities

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Community perspectives on health needs and assets in Sláintecare Healthy Community Programme areas in Dublin

The FEABHAS project

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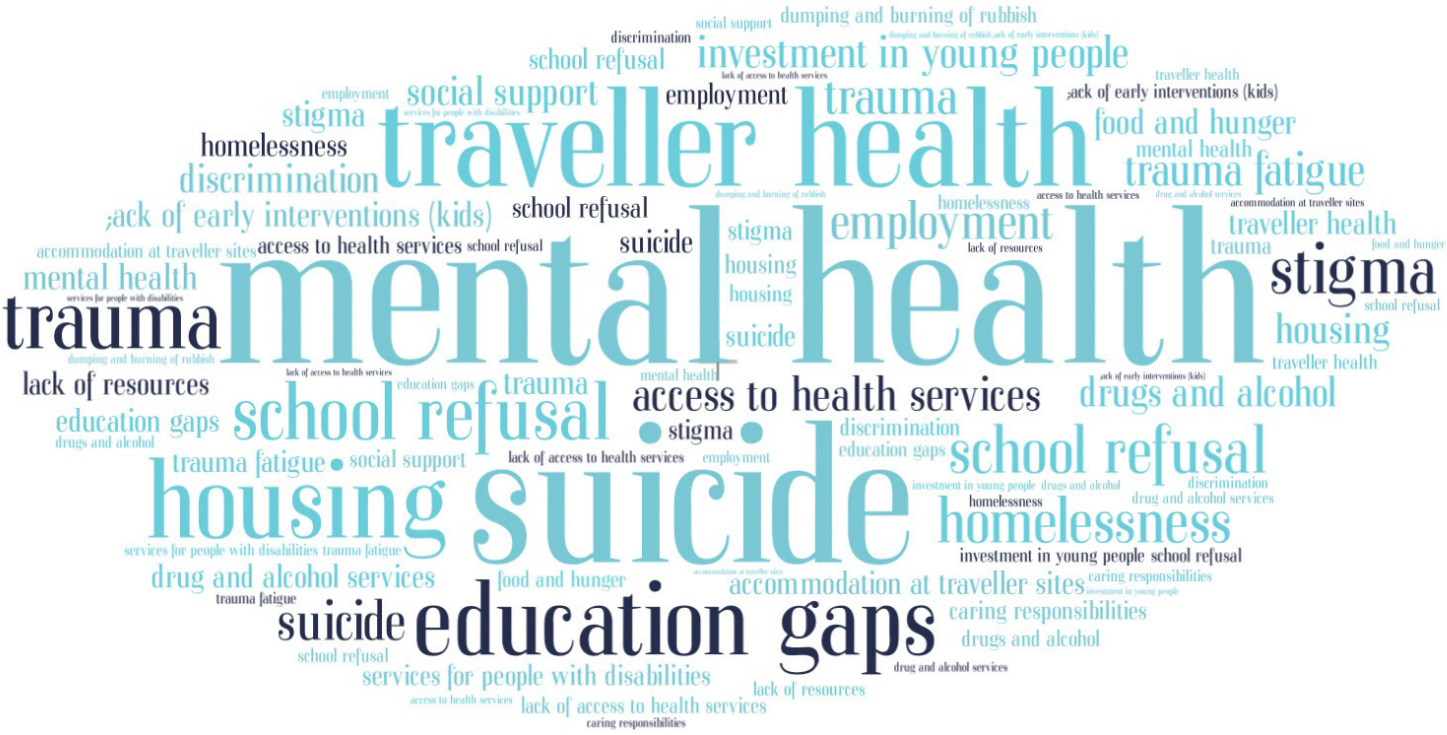

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Finally, the research team would like to thank all community members and workers who generously gave their time and trusted us with their lived experiences of health and wellbeing. Without your commitment, this research would not have been possible. We hope your valuable contributions will help bring about the changes you wish to see in your communities.

The study was led by Professor Debbi Stanistreet (Head of Department. Department of Public Health and Epidemiology, School of Population Health, RCSI) and the research team partnered with Dublin City Council Local Development Officers:

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FOREWORD

This study was commissioned by Dublin City Council using seed funding. The purpose of the commission was to establish a meaningful community engagement process and an evidence base for community engagement within the Sláintecare Healthy Community Programme (SHCP) in Dublin City. It sought to provide a structured approach to assessing and prioritising social determinants of health and health needs and assets in the four Sláintecare areas, and to inform the place-based approach being undertaken as part of the SHCP.

This report summarises the communities' lived experience in relation to their health needs, and highlights the strengths and assets within these communities. The insight of the communities into the issues they are facing has been humbling. People living in disadvantaged areas do not need educating about the impact of social determinants of health on their lived health experience, because they live them every day.

I would personally like to acknowledge that the greatest asset these communities have, are the members who clearly want to see changes to the health experience of their community, particularly for the most vulnerable. There are many who work tirelessly to try and make this happen, but they believe this can only really come to fruition, if their voices can be heard by the policy and decision makers. I hope this report will provide a vehicle for those voices to be heard, so that actions can be taken across all sectors to address the growing inequalities we are experiencing in Ireland, and to ensure every member of society has the opportunity to live a fulfilling and healthy life.

I hope that this research report provides a useful step in recognising the wealth of knowledge the community brings to addressing health inequalities and the value of actively engaging them to co-create sustainable solutions going forward.

Professor Debbi Stanistreet
Department of Public Health and Epidemiology, School of Population Health, RCSI.

ABBREVIATIONS

CBPR	Community-based participatory research approach
DOH	Department of Health
DCC	Dublin City Council
FGD	Focus Group Discussion
HNA	Health Needs Assessment
HSE	Health Service Executive
LDOs	Local Development Officers
NGT	Nominal Group Technique
PBA	Placed-Based Approach
SDGs	Sustainable Development Goals
SDoH	Social Determinants of Health
SHCP	Sláintecare Healthy Communities Programme
TWs	Transect Walks
WHO	World Health Organization

GLOSSARY OF TERMS

Assets	Any factor or resource which improves the ability of individuals or communities to sustain their health and wellbeing and reduce health inequities.
Community	A group of people with diverse characteristics who are linked by social ties, share common perspectives, concerns or identities. They may or may not be occupying the same space.
Community-based participatory research	A research approach in which researchers, organisations, and community members collaborate on all aspects of research projects. It aims to empower the community to participate in decision-making processes about issues that pertain to them.
Environmental health	A branch of public health that focuses on how the environment, such as air, water, and living conditions, affects human health and aims to prevent and control environmental factors that can harm people's well-being.
Focus group discussion	A discussion with a group (usually 6-8 people) to talk about specific topics or issues of interest under the guidance of a facilitator.
Health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Health needs assessment	A systematic approach to identifying the health needs of a defined population, which can be everyone within a geographical area or people with particular characteristics, leading to agreed priorities and resource allocation to address these unmet needs, reduce inequalities, and improve health.
Health equity	Ensuring everyone has a fair and just opportunity to be as healthy as possible, regardless of their social, economic, or environmental circumstances. It may include removing or reducing barriers such as poverty, discrimination, and lack of access to healthcare.
Literature review	A summary or evaluation of previously published studies on a particular topic to provide an overview of the current understanding.
Methodology	A description of techniques used to identify, gather, and analyse information regarding a specific topic or issue.
Nominal group technique	A structured research method used to generate ideas, make decisions, and prioritise issues in a group setting.
Participant	A person who takes part in, or becomes involved in, a particular activity such as research.
Place-based approach	An approach that focuses on addressing issues within a specific geographical area or community, taking into account its unique social, economic, cultural, and environmental characteristics.
POBAL	A state-sponsored organisation in Ireland with responsibility for administering and managing government and EU funding aimed at supporting social inclusion and addressing social disadvantage in the country.
POBAL HP Index	A set of deprivation indices to identify areas of disadvantage and to target resource to schemes and initiatives which can support communities most in need. The Index is widely used across Government, state agencies and researchers on social inclusion and equality.
Purposive sample	Selecting people to participate in research who are best placed to provide information related to the research topic.
Research	A systematic approach undertaken to explore a specific question, increase knowledge and understanding and provide findings on a topic or issue.

Research data	Information collected, observed, generated, or created to generate research findings.
Research team	A group of people working to carry out and successfully complete a research project.
Social determinants of health	Non-medical factors that influence the health outcomes of individuals or groups. They include conditions in the environment where people are born, grow, live, work, and play, as well as factors such as income, wealth, education, social resources, and the environment.
Sustainable development goals	The Sustainable Development Goals (SDGs) are a set of 17 global goals created by the United Nations to tackle issues like poverty, inequality, and climate change by 2030. They provide a shared blueprint for peace and prosperity for people and the planet, aiming to improve lives and protect the environment.
Sláintecare Healthy Communities Programme	A cross-government initiative to improve the long-term health and wellbeing of 19 identified disadvantaged communities across Ireland. The programme uses a place-based approach to tackling health inequalities.
Stigma	A set of negative beliefs that are associated with a particular characteristic a person or a community. It is often associated with adverse mental health outcomes in the affected individuals.
Transect walk	A group exercise often done with a researcher and people who are familiar with the community, such as community members. It entails walking between two geographical points, asking, listening, and looking, to identify and describe the community issues and assets.
TUSLA	The independent statutory regulator of early years services in Ireland.
Universal Health Care	A healthcare system that provides promotive, preventative, primary, curative, rehabilitative and palliative health and social care services to the entire population ensuring timely access to quality, effective, integrated services on the basis of clinical need, and free at the point of access.
Wellbeing	A positive state experienced by individuals and communities determined by social, economic and environmental conditions.

FIGURES AND TABLES

1 EXECUTIVE SUMMARY

INTRODUCTION

Health inequalities are closely linked to the broader social determinants of health (SDoH), which include the conditions in which people are born, grow, live, work, and age [1]. These determinants, - such as unemployment, inadequate housing, unsafe workplaces, and limited access to health services, arise from a wider set of economic and social policies, the built environment, and political systems, all of which significantly impact health outcomes [2,3]. The World Health Organization estimates that SDoH factors account for 30-55% of health disparities, contributing to widening health inequities between affluent and disadvantaged populations [3].

In Ireland, despite the high proportion of the population reporting good health, significant health inequalities persist, disproportionately affecting people in disadvantaged communities who experience poorer health outcomes and higher rates of premature death [4,5].

To address these gaps, the Sláintecare Healthy Communities Programme (SHCP) was launched in 2021 as a cross-government initiative to reduce health inequalities and improve the health and wellbeing of the 19 most disadvantaged communities in Ireland [6]. The SHCP employs a place-based approach to address local needs by focusing on SDoH [4,7]. Place-based approaches (PBA) offer the opportunity to address the root causes of health disparities, including poverty, homelessness, and low educational attainment within disadvantaged areas [8,9], by delivering locally tailored interventions that meet the needs of the community. Delivering interventions that meet community need requires meaningful community engagement, where communities can be actively involved in the decision making about the health and social issues that they face on a day-to-day basis.

This research explores community perspectives on health and wellbeing, as well as community assets, in The Dublin SHCP areas of Ballyfermot/Cherry Orchard, Priorswood/Kilmore West, and Finglas/Cabra, to begin to inform a broader health needs assessment process. We employed a community-based participatory research (CBPR) approach and interpretive methods, to understand the unique health needs and assets of different groups within these communities.

METHODS

In partnership with Local Development Officers (LDOs) serving as community enablers, participants were recruited from various community groups. Data were collected using a variety of qualitative methods, including transect walks (TWs) and mapping, nominal group technique (NGT) workshops, and focus group discussions (FGDs).

Photovoice was initially planned as a method to capture community perspectives through visual storytelling [10]. However, safety concerns related to gang activity and drug dealing, and concerns about the capacity of the older population to engage with this method, led us to adjust our approach. We adapted our method to ensure comprehensive participation of the community in a safe and accessible manner. These methodological adaptations underscore the need for flexibility in CBPR and also reflect the challenges faced by people who live and work in these communities. Thematic analysis was used to analyse the data, informed by Braun and Clarke. Nvivo version 12 was used to organise and analyse the data for each individual community dataset, followed by triangulation across the different datasets firstly by area, and then across the different community areas. Community assets were also identified and collated during the TWs, NGT workshops, and FGDs.

RESULTS

Six main categories of health and social need were identified in the study, each with mental health as a significant component: environmental issues, illicit drug use, access to health care amenities and social networks, sense of safety, and family structure. Underpinning these categories, are three consistent themes running throughout; community disempowerment and lack of involvement in decision making; mistrust and lack of confidence in authority; and interventions offered which do not correspond with the health needs identified by the communities. These three themes stem from several factors described by participants as unresolved for generations, without regard for their health and wellbeing.

Mental health emerged as a critical concern, across all communities and age groups, with high levels of anxiety, depression, self-harm, and suicide frequently linked to the pervasive drug-related violence and many other issues. Participants report that mental health issues are exacerbated by the cycle of poverty perpetuated by factors such as inadequate support for parents who want to return to the workforce or education and a lack of adequate welfare support for dual-parent households compared to single-parent homes, which promotes fracture of the family.

Community members highlighted intergenerational trauma, especially among children, young people, and the Traveller community, as well as the impact of living in areas plagued by crime, gun violence, and drugs. Other challenges include discrimination and stigma, fragmented services for addiction and mental health, insufficient support for carers, and social isolation among the elderly. This isolation is worsened by a lack of nearby facilities age-related activities, transportation, and gang intimidation, which discourages access to social services.

Several environmental health concerns across the communities, including illegal dumping, open burning, rat infestations, and exposure to waste, were highlighted as longstanding issues ongoing for many years. In particular, the Traveller communities raised concerns about exposure to air pollution and factory waste, mould in living areas, sub-standard electricity provision, and lack of green spaces. The unresolved nature of these issues has left the communities feeling neglected. In communities where parks exist, access is limited for people with disabilities and the elderly due to poor designs like zig-zag gates, uneven inclines and constant flooding due to a malfunctioning pump. Additionally, the risk of needle stick injuries from discarded needles, coupled with inadequate pavement and park lighting, particularly in high-crime areas, heighten residents' feelings of insecurity.

Relations with Gardaí were described as difficult and some communities reported indiscriminate and disproportionate arrest of youths. Security issues relating to drugs and addiction such as intimidation and threats to life, were viewed as highly disruptive to a sense of security and overall well-being.

Participants viewed the normalisation of drug use as a societal failure which requires an urgent solution. The affluent lifestyle and the gangs' promise to protect, make it a natural progression in life for vulnerable children who are groomed at an early age. Secondary education is viewed as not working alongside home and life challenges that exist in a child's life, such as poverty and bullying, which significantly affect their wellbeing and school attendance. Concerns were also raised about the secondary school system's harsh punishment of such children, often labelling them as disruptive or non-compliant with school rules, such as dress code violations. The reported punishments which include reduced school hours or, in some cases, dismissal from school, were viewed as increasing the risk of these children being drawn into drug use and other anti-social behaviours.

Further, the study highlighted significant challenges in accessing healthcare services. Long waiting times for GP and specialist services and referrals to distant hospitals result in high travel costs, especially where public transport is unavailable. Additionally, a complicated referral system and extremely long waiting lists for assessment of children with special needs, was viewed as exacerbating health issues, negatively impacting academic performance, and adding stress to carers.

Despite these issues, significant assets were identified within the communities, particularly in relation to community members and workers' commitment to improve the lived experience for the most disadvantaged groups. In this respect, several local organisations and community groups were reported as playing a significant role in reducing the impact of health inequities. However, there is a strong feeling of a generalised systemic disregard of the community voice in relation to the wider social determinants of health. This disregard is seen as a major factor in the continuing state of economic and social disadvantage, the lack of sense of community, and the burden of poor mental and physical health compared to their counterparts in more affluent areas of Dublin.

DISCUSSION

This study identified six main categories of health and social need, underpinned by recurring themes of community disempowerment, mistrust in authority, and interventions that do not align with identified community health needs. Participants offered rich insights into the issues they face, demonstrating the value of community involvement in health needs assessment.

POSITIONING THE FINDINGS WITHIN A PLACE-BASED APPROACH

The health and social needs raised cannot be resolved with short-term behavioural interventions alone, but rather, require a multi-sectoral approach [11,12]. Place-based approaches offer a valuable framework for multi-sectoral approaches. Developing local engagement plans and strengthening collaboration between communities and stakeholders would foster community empowerment, trust-building, and active participation in addressing health needs [13,14]. Future interventions should also identify and cater to the specific needs of different groups within the SHCP areas.

To support this work, there needs to be a clear long-term commitment to funding. Uncertainty in funding, leads to short-term planning, staff retention issues, and risks to key community projects. In addition, success of the SHCP should be measured using mid to long-term indicators that reflect improvements in social determinants of health and health outcomes [13,15].

METHODOLOGICAL CONSIDERATIONS

Flexibility in research methods is key to researching community needs. However, while flexibility is critical, it is also resource-intensive. Simpler methodologies and community worker training may be beneficial, reducing the reliance on external experts. Additionally, the role of the LDO, or an equivalent community enabler, should be considered vital in building engagement with community members and organisations so that participants are comfortable to engage openly with the research process.

IMPLICATIONS FOR NATIONAL POLICY

Whilst this study has emphasised the importance of the community voice in articulating health needs and highlighting inequalities, national policy changes are also required to effectively address inequalities. International evidence underlines how disparities in health outcomes are largely driven by the unequal distribution of power, income, and services. Marmot asserts that such disparities are the result of flawed social policies, unfair economic systems, and inadequate governance [16], a view well supported in the literature [17-19]. Given this robust evidence, we advocate for a National Inequalities Strategy to offer a co-ordinated framework for collaboration among stakeholders, supported by national and local task forces. This would foster synergy between top-down policies and community-led efforts.

FUTURE RESEARCH

Finally, the study also highlights the need for further research to explore the value of the community voice and the impact of place-based approaches (PBAs) on health; to assess which interventions are most appropriate in terms of Reach, Effectiveness, Availability, Implementation, and Maintenance or Sustainability (REAIM) [20,21] within the context of a place-based approach.

CONCLUSION

Community engagement is an important component of assessing health need to enable a better understanding of community lived experience of their needs and priorities [18]. Meaningful community engagement in health needs assessment involves co-creating knowledge and solutions to the health issues. Community and empowerment is an outcome of active engagement. Currently there is no formal mechanism for engagement with communities as part of the SHCP. Strengthening the role of the community voice in shaping how health and wellbeing needs are addressed, and building on local assets to build local capacity is key to addressing health inequalities. However, local actions alone, are not sufficient. Meaningful policy change is needed at a national level and requires a focused all-of-government commitment. Reducing inequalities nationally is not just a matter of health and social justice, but will benefit the economy by enabling a fairer distribution of health and opportunities, so that every child and adult in Ireland has the opportunity to reach their full potential.

RECOMMENDATIONS

This research has raised a significant number of complex issues relating to health experience among the communities in question. The majority of issues do not exist in isolation of each other and recommendations have therefore focused on actions that will address the root causes of the issues that communities face. There is clarity required at a national level to identify where governance and accountability lie between Government departments, The HSE, and Local Authorities with regards to the actions identified below.

KEY NATIONAL LEVEL RECOMMENDATIONS

1. All public bodies in Ireland have a statutory responsibility to promote equality, prevent discrimination and protect the human rights of their employees, customers, service users and everyone affected by their policies and plans. In order to promote HSE compliance with this duty, our primary recommendation is to declare a National Health Inequalities Emergency in conjunction with the National Director of Health Improvement, and to set up national and local health inequalities task forces that bring together key stakeholders. This will enable a joined-up approach to addressing community issues and provide a vehicle through which stakeholders can work together to deliver tailored services to meet community needs. Such an approach will also ensure clear leadership, governance and accountability for specific actions on a national scale.
2. Community engagement plans should be developed for all SHCP areas across the country, tailored to individual area need. Building on existing community assets, the SHCP has an opportunity to ensure structures are in place to enable meaningful collaboration between the community and stakeholders that address health and social issues and support local capacity building. These plans should have clear outcome measures in terms of level and type of engagement, and be subject to annual monitoring.
3. There is a need to address waiting times and the requirement to travel long distances to access primary care services. We recommend the new national and local inequalities task forces give due consideration to the inverse care law, which identifies how availability of health care varies inversely with health need in the population served. This should also be a strand of the population based planning and health needs assessments processes being developed to inform resource allocation in the newly identified health regions.
4. Investment in children and young people should be a priority in any national inequalities strategy. An overall increased allocation of funding is required to spend on childhood early years at a national level, with proportionately more funding being made available for the most disadvantaged areas. In particular, there is a very urgent need to address long waiting lists and convoluted referral systems leading to delayed diagnosis of children with special needs. This has been a long-standing issue nationally and needs to be resolved as a matter of urgency.
5. Long term SHCP outcome indicators are needed that reflect the broader health and social needs of the communities. The Government of Ireland Wellbeing Framework [22] offers a useful framework for identifying measures most closely aligned with community experience and wellbeing. Measures should also be used as a tool to promote cross-sectional collaboration among the different stakeholder organisations.

KEY LOCAL LEVEL RECOMMENDATIONS

6. The Local Authority is well placed to be a key architect in championing existing community assets. As part of the SHCP, all local level action can build effectively on existing community assets and active local community partnerships through the Local Authority function.
7. Interventions addressing mental health should be put in place as one of the key pillars of the SHCP. Mental health services need to be evaluated and where necessary expanded, in all communities, including promotion of mental health, access to early intervention and rapid response for people in crisis.
8. A review is needed of policy and response to 'threat-to-life' situations, to increase protection from harassment and intimidation, especially among households at higher risk of being targeted in SHCP areas.
9. Additional support and resource are required for local addiction services, including outreach services. Education and training in trauma informed practice should be provided to all local healthcare workers to reduce addiction stigma, for those attending services. Such services should also employ community members with lived experience who are in recovery, as key participants in service planning and as local peer support workers. The HSE Dual diagnoses clinical lead should advise on how mental health and addiction issues can be addressed concurrently.
10. Investment in children and young people needs to be a clear priority at local as well as national level including; pre-school education, addressing issues relating to primary and secondary school experience including school attendance; and increasing funding for existing youth services to ensure sustainable employment of talented local youth workers. The role of schools should be extended to take a 'whole child approach'.
11. More education is required for children and young people on addiction and mental health. This can be provided through schools and youth centres using local role models, with young people being taught strategies for managing and promoting their mental health.
12. The Government should ensure the development of a multi–agency plan to address the trust relationship with Gardaí , ensuring a co-design approach is utilised, and placing the community at the centre of the plan.
13. High quality affordable childcare services need to be available within communities, from pre-school through to wrap around and holiday care. If parents can return to work or education, they will have an opportunity to break the cycle of poverty and enable families to improve living standards.
14. Dublin City Council should review the use of derelict buildings in the communities for possible community use as recreational centres or other local amenity.

15. Actions that lead to 'small wins' at SHCP level, will help rebuild trust and facilitate a better relationship between authorities and the SHCP communities. Thus, they are extremely important in the short term;

Potential actions include:

- Address lack of postal services for the Labre Traveller community in Ballyfermot
- Resolve specific environmental issues raised by community members including large scale dumping and littering
- Support the elderly population's engagement with community activities and reduce social isolation through improving access to public transport
- Address electrical hazards on halting sites and improve living conditions
- Repair pavements to ensure safe mobility for the elderly and people living with disabilities.

16. Finally, we recommend that the DOH explore with other SHCP areas, whether the findings of this study are transferable nationally and whether the local recommendations from this study might inform the wider SHCP programme.

2 BACKGROUND

Inequalities in health are linked to wider social determinants of health (SDoH) that are related to conditions in which people are born, grow, live, work, and age [1]. The social determinants are non-medical and often stem from factors such as inadequate income, unfit housing, unsafe workplaces, and lack of access to health and wellbeing services [2]. These factors arise out of a wider set of economic and social policies, development agendas, social norms, built environment, and political systems, and greatly impact health outcomes [3].

According to the World Health Organization, SDoH account for 30-55% of the variations in health and are responsible for widening health inequities (unfair, and avoidable differences in status) between people in affluent areas and their counterparts in disadvantaged communities [3]. In Ireland, despite the high proportion (80%) of the population reported to be in good health [23], significant health inequalities exist, especially for those in disadvantaged communities. People living in disadvantaged communities suffer a disproportionate burden of poor health outcomes and premature death compared to those with a higher socio-economic status [4].

THE SLÁINTECARE HEALTHY COMMUNITIES PROGRAMME

To bridge this health equity gap, the Department of Health (DOH) launched the Sláintecare Healthy Communities Programme (SHCP), in 2022. The programme, a Healthy Ireland initiative, aims to reduce health inequalities and improve the health and wellbeing of the 19 most disadvantaged communities in Ireland [6], four of which are in The Dublin City Council area (Figure 1).

The SHCP is a cross-government initiative implemented at a local level by local authorities, the HSE, and a wide range of community organisations, to deliver initiatives designed to improve health outcomes and reduce health inequalities in these areas [6]. The SHCP vision for health equity sits within an essential component of the Healthy Ireland Strategic Action Plan 2021-2025, which aims to improve population health and reduce inequalities through people and community empowerment.

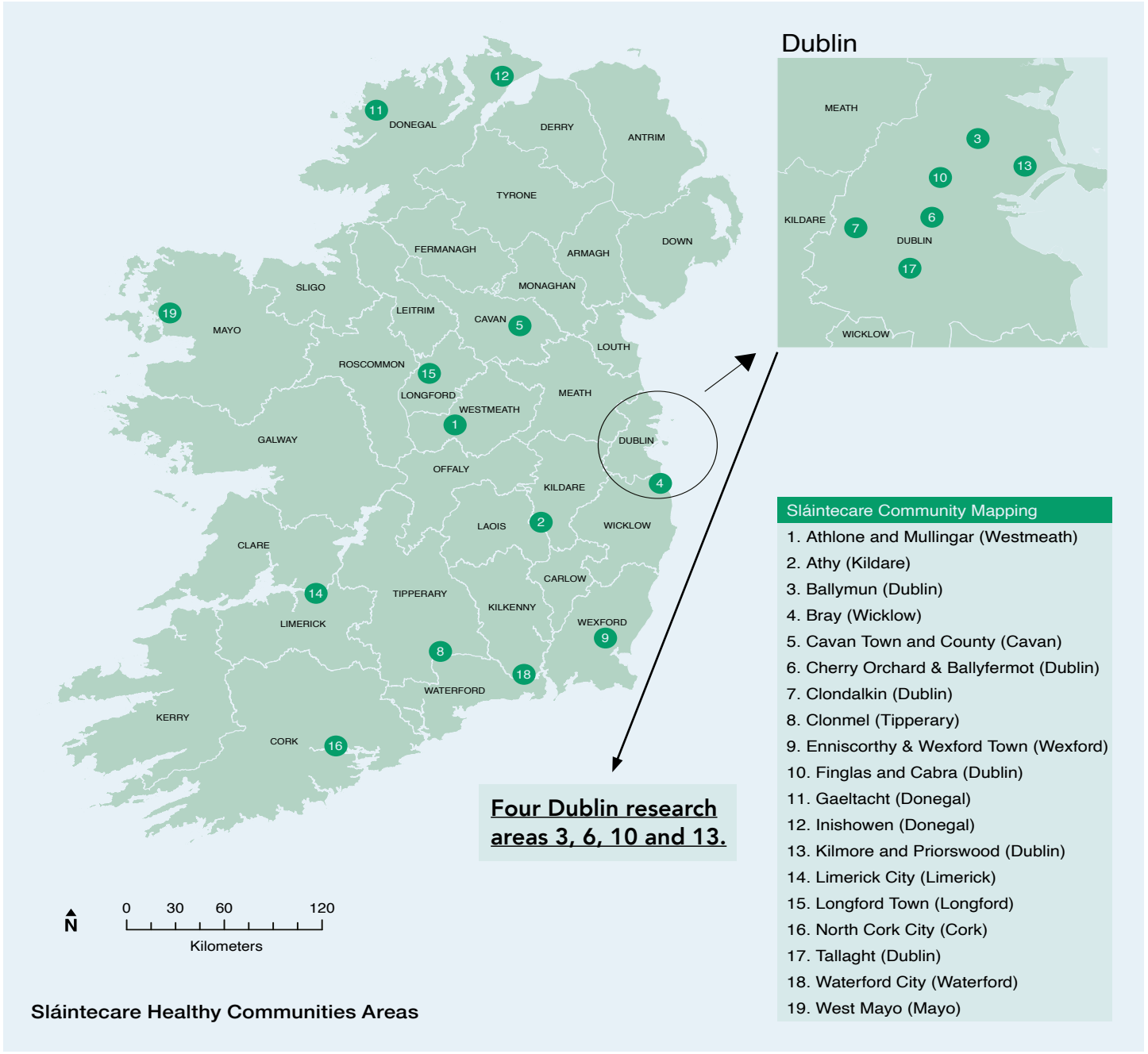

Figure 1 Sláintecare Healthy Communities Areas in Ireland.

Accessed from Sláintecare Care Healthy Communities: Progress Report 2022 September 1st, 2024. Available at https://www.gov.ie/en/publication/ef5f2-slaintecare-healthy-communities/

The Sláintecare Healthy Communities 2022 progress report states that SHCP takes a life course and place-based approach to address local needs, addressing the social determinants where they are created. SHCP creates a platform for multiple agencies and government departments to work together at a local level to improve the long-term health and wellbeing of communities, creating communities where everyone can thrive [4,7].

PLACE-BASED APPROACHES

Place and health are intimately intertwined [24-27]. Place has significant impact on people's health, wellbeing and quality. It is indicated in the five Social Determinants of Health (SDoH) domains namely, economic stability, education access and quality, healthcare access and quality, neighbourhood and built environment, and social and community context [28]. Macintyre et al., identified four physical features of place that would affect health outcomes, including air and water quality, socio-cultural features of the area, provision of services including health, welfare and education, and finally the reputation of the area, which may impact self-esteem [24]. In addition to the differences of individuals living in particular place (compositional factors), differences in health also occur due to the differences in characteristics of the places where people live (contextual factors) [29].

In Ireland, the contextual impact is seen in the 2022 POBAL HP deprivation index report. The POBAL HP deprivation index is a social gradient tool which analyses measures of an area's level of disadvantage using three categories: demographics, social class, and labour market situation based on census data [30]. While the report shows national improvement in deprivation measures such as employment and population growth, the same level of improvement was not seen in many disadvantaged communities. Rather, the number of people in areas classed as very or extremely disadvantaged has increased by almost 37% from 143,506 to 195,992 individuals [30] with significant health inequalities. In these most disadvantaged areas, people are four and a half times more likely to report not having good health, and twice as likely to report having a disability compared to those in affluent areas [5]. Likewise, the disability rate in children growing up in extremely disadvantaged areas mirrors the rates only observed among people nearing retirement age in affluent areas [5].

Place-based approaches (PBA) offer the opportunity to target interventions that could address the contextual factors relating to characteristic differences in the places where people live to improve the health and wellbeing of these disadvantaged communities, thus enabling them to reach parity with their counterparts in affluent areas.

Place-based approaches also provide a collaborative means to address complex social, economic and environmental challenges at a defined, specific geographic scale [31]. The approaches aim to foster sustainable development, improve overall health and wellbeing by targeting the root causes of SDoH, in communities with entrenched disadvantage or deprivation [8,9]. These may include structural actions (i.e. changing the built environment), social actions (promoting group activities) or personal actions (promoting good health behaviours) and do so with an integrated, interagency and interdepartmental approaches [13,32].

Importantly, PBA recognise that each community is unique in terms of local assets, needs, social context and circumstances and that 'one-size fits all' approaches are not effective. Therefore, interventions are aimed to deliver locally tailored solutions to SDoH issues including poverty, housing, limited education etc. to improve health outcomes. Health inequalities and social disadvantage arise from complex, multi-faceted social problems which are often interlinked and mutually reinforcing, and therefore are often unchanged by singular interventions [8,9]. Addressing one social issue (e.g. education) in a community, can be easily undermined by neglecting another (e g. health) [8,9].

Existing literature generally suggests a positive health impact of PBA [13,29,32-34] However, it takes time, therefore medium to long-term funding and commitment is required for project success [13]. This allows for building relationships, partnerships and trust with community members, enhancing the long-term sustainability of the project. It requires strong leadership and firm political support backing these projects [13]. It requires the approaches that facilitate and support community engagement and active listening of communities voices.

COMMUNITY BASED PARTICIPATORY RESEARCH

More recently, recognition of the communities' voice in matters that affect them has become integral to the research process and community development. Community engagement is part of the Ottawa charter [35] and provides the opportunity for communities to share views of their health and wellbeing and how they interact with the SDoH in their specific community context.

Community participatory approaches in health research use methods which enhance the collaboration between communities, academic partners and other relevant stakeholders, to co-create knowledge that is beneficial to the community [36]. The approaches identify the community as a unit of identity, placing any research question in the community context. A broad range of terms such as participatory action research and as Community-Based Participatory Research (CBPR) can be used to describe participatory health research, depending on the research setting, the field of study and the authors' preference [37,38]. The main aim of participatory research is the importance of equitable participation in all research processes through active engagement of communities in effective decision-making about matters affecting them and their communities [39,40].

CBPR is well suited to engaging cross-cultural and disadvantaged communities and directly addressing issues of inclusion and equity by underscoring fair, equitable community participation in all research processes [36,41,42]. Involving the community in decision-making is linked to community empowerment and enhances their capacity to take ownership of matters of concern to them [2,42]. In addition, the use of CBPR as a method to explore community health needs, provides a valuable tool for communities to provide context-specific knowledge of their unmet health needs and identify existing community assets [43] from their experiences of living and working in the area. This could inform more effective and sustainable programmes tailored to the communities' needs to improve outcomes and decrease health disparities [44,45]. Further, with active and meaningful involvement of community members in research, there is increased awareness in the wider community about the health challenges that exist in the community, and increasing community capacity to co-create solutions, and decrease health disparities [44,45].

2.1 Aim of the study

The aim of this study was to identify community perspectives on health and wellbeing and community assets for health in four SHCP areas across Dublin, Finglas and Cabra, Ballymun, Cherry Orchard and Ballyfermot, and Darndale/Priorswood and Kilmore West.

2.2 Study objectives

Figure 2 The objectives of the study

We made adjustments to these objectives, particularly regarding the planned Photovoice activities, due to security concerns identified during initial fieldwork. Photovoice was replaced with Nominal Group Techniques (NGT) workshops, and the planned Photovoice exhibition was substituted with a stakeholder engagement workshop. A detailed explanation of these changes and rationale behind them is provided in section 4.1.

3 METHODOLOGY

3.1 Research Design

This study used a community-based participatory research and multi-method interpretive approach including participatory mapping and transect walks, adapted nominal group technique workshops, and focus group discussions to explore in-depth, the community perspectives on health and wellbeing needs and assets [46]. Each method built on data from the preceding one, providing a more comprehensive view of the communities' needs. While the Photovoice objective listed in Figure 2 above was altered, the rationale for this change is discussed in Section 4, as it also represents a methodological finding.

3.2 Ethical considerations

The study was approved by the Research Ethics Committee, Royal College of Surgeons in Ireland, University of Medicine and Health Sciences (202310017). A participant information leaflet was provided, study objectives discussed, and questions were addressed by the research team before signed informed consent was obtained from all participants. Copies of signed consent and participant information leaflets were provided to all participants. Refreshments and One-4-all vouchers were provided for all participants for their time and contributions.

3.3 Study areas

Four SHCP communities in Dublin were proposed in the study; Ballymun, Cherry Orchard and Ballyfermot, Darndale/Priorswood and Kilmore West, and Finglas and Cabra. A brief overview of the areas' demographic characteristics is presented in the figures below.

BALLYFERMOT/ CHERRY ORCHARD

Ballyfermot lies seven km west of Dublin city centre and south of Phoenix Park. The 2022 POBAL deprivation index classifies several parts of the area as 'very disadvantaged' and 'disadvantaged'. There is high prevalence of lone parent households, higher unemployment rates, low levels of educational attainment, and reduced access to opportunities.

Cherry Orchard (A, B, C, Drumfinn, Decies, Kylemore) is often described as a community within Ballyfermot. The deprivation index classifies the area as disadvantaged, placing it among the poorest 4% of the population. The area has a higher unemployment rate, nearly double the proportion of people with only primary education, and more than twice the average of lone-parent families, compared to national figures.

BALLYMUN

Ballymun (A, B, C, D) is an outer suburb about 6.5km of Dublin City Northside and about 7.3km south of Dublin Airport.

The 2022 Pobal deprivation index ranked the areas B, C, and D "disadvantaged to very disadvantaged" and area A as "marginally below average". The areas experience lower education attainment levels, higher unemployment rates, and twice the national average figures for lone parent households.

FINGLAS AND CABRA

Finglas (North A, B; South A, C & D) is about five km North of Dublin city centre, bordered by Cabra to the south, Glasnevin and Ballymun to the east, and M50 to the North. The deprivation index indicates several parts of the area are 'disadvantaged' or 'very disadvantaged'. Compared to national averages, the area typically reflects high levels of unemployment, lower educational attainment, and more than double the number of lone parent households.

Cabra (West A & B) is located southwest of the Royal Canal and northeast of the Phoenix Park and about 5.2 KM from Dublin city centre. Cabra demonstrates a mix of socio-economic conditions, with certain areas categorised as 'disadvantaged' according to the 2022 index. Indices of unemployment, low education attainment and lone parent families are considerable higher than the national averages.

PRIORSWOOD AND KILMORE WEST

Priorswood (B, C, D)/Kilmore West (A, B, C) is a cluster of several communities i.e., Darndale, Moatview, Belcamp, Priorswood, Bonnybrook and Kilmore West. Priorswood and Kilmore West are located Northeast of Dublin city.

Kilmore (A, B, C): According to the Pobal deprivation index 2022, the area is "disadvantaged" (A &B) while C is "marginally below average". These areas generally experience higher unemployment rates, higher rates of lone parent families, lower educational attainment levels and limited access to opportunities when compared to national levels.

Priorswood B, C, D: The deprivation index classifies the area as "very disadvantaged". The area has a higher unemployment rate, over twice the proportion of people with only primary education, and more than twice the average of lone-parent families, compared to national figures.

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3.4 Study governance

Prior to commencing active community engagement activities, a steering group (SG) consisting of community members and workers, LDOs, academic researchers, DCC staff, and the project research team was set up. A governance document was developed and implemented to guide the activities of the study. The group met quarterly; at the start of the project, to review and guide the process activities; after the first set of data collection to review the timeline and provide feedback on ongoing community activities and preliminary findings; and at the end, to review and guide the project dissemination activities. Despite setting up a community advisory group, attempt to hold meetings were not successful due to different time needs and other commitments of community members.

3.5 Sampling and recruitment

We used the entire community as the sampling frame for the study. The study was promoted through existing channels by the LDOs. In addition, we also met with community groups and attended community events such as the 'Cherry Blossom' launch in Cherry Orchard and the launch of the 'Traveller Way' to support the Ballyfermot 'Labre Park community women.

Purposive sampling was carried out with recruitment being led by the LDOs using their established relationships with community members and service providers in each of the study areas and guided by the research sampling protocol. The inclusion criteria are presented in Table 1 below.

Community mapping and transect walk.	**FGDs and NGT workshops.**
Participants must:	Participants must:
be over 18 years of age	be over 18 years of age
be a resident in the community for longer than one year or a health worker in the area	be a resident in the community for longer than one year
have a sufficient use of the English language to participate and engage in discussions	have sufficient use of the English language to be able to participate and engage in discussions.
Sufficient mobility to participate in the TWs.	

Table 1: Participant inclusion criteria by research activity.

3.6 Data collection

The data collection processes and the sequence of data collection are described below and in figure 4. Data collection processes took place between January and June 2024. Safe, central locations, well known to the participants, were secured by the LDO's in each area for all research activities.

3.6.1 Participatory mapping and transect walk

We carried out community mapping of needs and assets using transect walks (TWs) as a participatory tool [47]. This approach is best suited to identifying issues related to geographical locations, using community knowledge to mobilise and empower communities for action and social change [41,48]. The transect walks in each community area included community champions (well-known and respected community members and workers) with a wealth of knowledge of the community and were able to represent a wide range of community views [47]. Each area's TW started with a 30-minute pre-walk session to discuss the objectives, answer questions, obtain informed consent, and decide on the designated walk routes. The walks were led by at least two community members and/or workers and lasted about 1.5 to 3 hours. Various facets of the community were explored by observing, listening, questioning, and discussing the community's needs and assets around the observations. Areas of concern and assets were mapped to capture access and proximity of basic amenities, safety issues, and environmental issues, amongst others. The activities were audio-recorded, and photos were taken in areas where it was deemed safe to do so by the participants. A debriefing session was held with participants after the TWs to explore their views of the activity.

3.6.2 Adapted nominal group technique workshops

We adapted McMillan et al's. [49] NGT approach to fit the dynamics of our study community and to provide additional context to the data collected. This approach is widely used to elicit healthcare priorities for idea generation, problem-solving, and reaching consensus among groups[50]. Our approach included the following stages:

1. Silent generation: Participants were given 10 minutes to record a minimum of three responses silently and independently to the question, "What are the issues or needs in your community?"

2. Round Robin (adapted): Participants shared their responses with the group. These were captured on 'post-it-notes' and placed on a centralised board. The conventional approach calls for sharing the written idea with the group. However, we found this point of the data collection provided a useful opportunity for participants to discuss and debate the issues prior to ranking them in order of importance. This section of the workshop was therefore audio recorded

3. Clarification and consolidation (adapted): We summarised the consolidated ideas to the participants asking them to reflect on them and provide any additional information or needs not yet captured. Taking each consolidated concept, participants were asked to elaborate on (1) the impact of the issue on the community, (2) the extent, to which people are affected and the severity of the issue. This section of the workshop was also audio recorded

4. Ranking responses: Participants were asked to individually rank their top five priority ideas from the overall session, bearing in mind, the collective discussions throughout the workshops. These were collated after each workshop in an Excel ® for each areas and are reported in section 4.9.

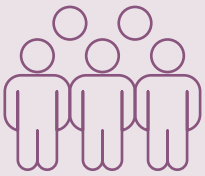
Our Approach	Review of Literature	Transect walks	Adapted nominal group technique workshops	Focus group discussions	Stakeholder engagement workshop
 **Objectives**	To review literature to inform methodology	To identify and explore issues and assets that are visible during a walk through the community	To explore the communities' views and rank health and wellbeing needs	To explore in depth, key and sensitive issues identified during the NGT workshop	To discuss the preliminary findings and finalise recommendations from the project with relevant stakeholders
 **Required actions**	Desk-based literature review	Structured observation-based walk through the community using maps **Duration:** 2-3 hours	Identified & discussed community health issues and ranked the top 5 needs **Duration:** 3 hours	Explored key issues identified in NGT to understand the depth and impact **Duration:** 1.5- 2 hours	Presentation and discussion of findings, and recommendations from the project **Duration:** 4.5
 **Participants**	Not applicable.	Six TWs, each with 4-8 community members, workers & the LDOs	Six NGTs each, with 8-19 community members One additional session held with 5 Traveller community members	Two FGDs each with 3-4 key community informants	A half day workshop with community members, health and Local Authority professionals, and policy makers from the four project sites

Figure 3 Data collection processes and list of engaged participants

3.6.3 Focus group discussions

Based on some preliminary findings and research team discussions with the LDOs, FGDs were carried out in Darndale/Priorswood and Finglas. We adapted Wang and Burris (1997) Photovoice methodology [10] by replacing the photography sessions with community generated insights from the TWs and the NGT workshops (see Section 4.1). A discussion guide was developed to reflect the insights from the TWs and NGT workshops which facilitated an in-depth exploration of the issues.

3.6.4 Stakeholder engagement workshop

A workshop with the broader stakeholder group involved in the health and wellbeing of the four SHCP areas was held in October 2024. This workshop brought together community members, health and local authority professionals, and policymakers from Ballyfermot/Cherry Orchard, Ballymun, Darndale/Kilmore West, and Finglas/Cabra.

The aim of the workshop was to bring together stakeholders in the areas to (1) reflect on the draft project findings, (2) discuss next steps and draft recommendations on the way forward to address the identified health and wellbeing needs. The project overview and findings were presented, and participants were divided into diverse groups of at least eight people across nine tables to facilitate cross-area and cross-discipline discussions. Participants explored question such as how well the themes resonated with the issues and needs in their areas, resources available, priority actions, and one personal action they could do in their workplace or community. Each group chose a representative to present their feedback using flip charts and post-its. The stakeholder engagement process contributed to refining the study's recommendations

Non-identifiable data and collection instruments for this study can be made available upon request, pending approval from the research team. All participants received exit information, outlining next steps and potential future contact through the LDOs or research team.

3.7 Analysis

Thematic analysis using the Braun and Clarke approach [51] was employed in this study. Audio recordings were transcribed verbatim using MS TEAMS© auto transcription. All transcripts were reviewed and corrected as needed by the researcher and a sample double-checked by another person. Familiarisation was carried out with each dataset followed by coding. Themes were then generated, reviewed, and refined to ensure they represented the overarching patterns across the different data sources. This analysis approach helped support the synthesis of the community's views from the multiple data sources to provide a more cohesive and collective understanding of the health needs and assets in the communities.

4 RESULTS

Before presenting the results in this section, it is important to describe the modifications made to the study methodology from factors relating to different dynamics at play in real-life settings. These factors can be considered findings in themselves and will be relevant to community-based participatory research activities going forward.

4.1 Methodological modification and rationale

- Role of Local Development Officer (Objective 1): We were unable to carry out the work in Ballymun due to the absence of a LDO to facilitate access to the community. This highlights the crucial role that an LDO, as community enabler, who is familiar with and trusted by the different organisations and supports the research processes in the communities. Our partnership with the Ballyfermot/Cherry Orchard, Darndale/Priorswood and Kilmore West, and Finglas and Cabra LDOs was instrumental to achieving the research objectives. Their presence at the steering group and research team meetings provided community insight to research activities to enhance the communities' experience. In addition, their involvement provided the insider knowledge and engagement with various community organisations which supported diverse participant recruitment resulting in rich data collection.

- Data collection methods: The following adaptations were made during field activities to meet specific issues and community needs.

  1) Photovoice (objectives 3 and 4): During the transect walks, it became evident that the scale of the community drug issues posed a safety risk in asking community members to capture health issues through photographs. Considering this, and in collaboration with the LDOs, we opted for the adapted NGT workshops as a more secure data collection method.

  2) Focus group discussions: Through discussion with the LDOs, following the initial NGT workshops, we carried out FGDs with community stakeholders in two areas to explore in-depth issues around addiction and drugs not addressed in depth in the workshops. The FGDs used priority issues raised during the workshops, to guide and structure the discussions building on preliminary findings from the TWs and workshops. This provided participants, based on their experiences, an opportunity to offer further insights, discuss challenges, and propose possible recommendations.

  3) Additional Nominal Group Technique workshop: An additional NGT workshop was conducted with the Traveller community to ensure their needs were reflected in the area findings despite being a community within a community.

  4) Photovoice exhibition (Objective 6): No photographs were available for exhibition due to challenges in implementing the Photovoice method. Instead, we conducted a co-design workshop with multiple stakeholders from all four areas.

With all adjustments, we maintained the participatory element of data generation by ensuring the discussion topics reflected participant's perspectives of the community issues. The methods used allowed participants to generate in-depth reflection through group dialogue of the topic discussion while accounting for ethical considerations including participants' confidentiality and safety.

The remainder of this chapter presents aggregated findings in relation to health and wellbeing needs across the three communities, followed by a summary of assets identified in each area and the ranking of the most pressing issues from a community perspective.

4.2 Environment and health

The relationship between environment and health is known to be deeply interconnected. This section presents a community account of how various environmental conditions such as air pollution, poor road conditions, and exposure to hazardous chemicals impact on the health experience of local people.

4.2.1 Environment and inclusivity

Participants discussed the need to ensure that green spaces were accessible to all members of the community. Specifically, the zigzag entrance gates to community parks are not passable for people in wheelchairs. The design, aimed at keeping scrambler bikes out, was described by a wheelchair user as "automatically keeping those in wheelchairs out." Where there are alternative entrances, these often include other hazards such as steep inclines, or they open on to oncoming traffic, offering potential hazards to other park users. One participant described the impact this has on wheelchair users, specifically around their involvement with children's activities in the parks.

> *"Over their [park], there are 11 gates. There's not one you can get in. They are all kissing gates… can you imagine, being in a wheelchair… it is impossible… If you have children, you can't go in with them if there is a football match…. Also, they [authorities] need to put up a barrier because if you go up the ramp into the park, it is a steep ramp down, especially if you are in a manual wheelchair. You can't stop the wheelchair coming down like that." (NGT workshop participant)*

4.2.2 Environment and safety

In addition to access limitations in local parks, safety concerns were also raised.

Lack of safety features in parks

Inadequate lighting contributes to making the park feel unsafe at night and even in low light during the winter months. In addition, the absence of bio-hazard boxes for drug users to use for needle disposal, increases the risk of accidental needle stick injury and encourages the potential re-use of discarded needles in the parks. Participants expressed that this constant exposure to drug paraphernalia not only jeopardises physical safety but also contributes to a 'normalisation' of drug use, which influence the attitudes and behaviours of children to drugs in the community.

> *"Just for the issue around the school, like if you walk kids to schools on a Monday morning early before the Local Authorities get up, get in to clean up… it's the bottles and the cans and the needles and the wrappers, and all that the paraphernalia from the night before can be seen everywhere. They're [children] exposed to that on the way to school…. So, you are talking about a 10-year-old being exposed to that daily." (FGD participant)*

Other issues in relation to the parks include flooding resulting from the malfunctioning of an installed drainage pump, rendering the park and football pitch unusable for significant periods of time.

Unsafe pathways and footpaths

Significant safety concerns were also raised concerning broken and uneven footpaths, as well as illegal car parking on the walkways, especially around the train stations forcing school children, wheelchair users, those with prams, and the elderly onto busy roads to avoid obstacles. The illegal parking on walkways in areas around train stations was linked to lack of proper planning for park-and-ride facilities for commuters. Additionally, the location of roundabouts around busy areas such as schools, coupled with speeding of cars, were implicated in road traffic accidents involving school children. And in some areas, participants reported no allocation of school traffic wardens to support safe crossing of the roads, further jeopardising the safety of young pedestrians.

> *"We have had deadly accidents here involving school children. It is really a bad spot for a roundabout and high speeding with a school, and a health centre here. And the cars just come flying, you see even for us now crossing the road, it's not safe." (Transect walk participant)*

Unsafe living environment

The overall condition of residential areas was described as intolerable, unsafe, and detrimental to health and well-being. Community members expressed concerns about the "worsening" of environmental and safety conditions of their homes and surrounding areas. While these issues were particularly highlighted in the Traveller communities, people living in sub-standard and unsafe houses was also an issue in the wider community.

The Traveller communities highlighted the dysfunctional state of government-provided accommodations, some with no proper lighting and heating. Most importantly, sub-standard electrical fixtures were reported to pose significant fire hazards, making these accommodations unsafe especially during the winter months.

> *"Sometimes, when you put the heating on in the wintertime, all the electricity is out. It gets tripped off. You see, the power is not well connected in the caravans, and everything goes off. So that means you're left without heating, and you have to stick it with the whole family, especially in the wintertime …Literally, everything we're talking about, everyday life is affected… Really guys, it is very, very rough…It's extremely hard." (NGT workshop participant)*

With the basic necessities of life including cooking, washing, use of a fridge, and heating being impacted, community members see the very poor quality of their living conditions as directly impacting their health and wellbeing. Overall health, including mental health was perceived as poor. Reports of dampness and mould on walls and ceilings were common and seen as contributing to widespread allergies, particularly among children, who are regularly on antibiotics and allergy medications.

> *"In fact, it [poor living conditions] caused an awful lot of sickness in our children and their mental health being covered in this. They just say to go to chemists and doctors rather than doing anything." (NGT workshop participant)*

In addition, participants linked frequent illness in the community to high flooding when it rains. The flood, described as a result of inadequate drainage, is reportedly accompanied by rat infestation.

4.2.3 Environment and pollution

The community expressed significant concerns regarding several environmental pollution issues that they see as directly affecting their health and quality of life.

Illegal Dumping, Open Burning and Unsanitary Living Conditions

One of the most frequently reported concerns involves illegal dumping and open burning in residential areas. This practice, combined with rat infestation, persistent exposure to dampness and mildew, and excessive flooding due to poor drainage systems, were described by the communities as unsanitary and hazardous to their health. According to the communities, this leaves them in a cycle of poor living conditions, ill health and constant use of antibiotics, which contributes to the high levels of deteriorating health and lower life expectancy. At the household levels, littering and illegal dumping of household waste was reported to be a consequence of lack of support for low-income families, some of whom cannot afford the waste disposal charges, forcing people to dump or burn their household waste on the streets (Figure 4). The household waste dumping is further aggravated by dog and horse faeces on the street and parks with the community suggesting the need for more litter bins.

Figure 4. Household litter and dumps in the community. Findings from transect walk

Additionally, serious environmental pollution concerns were raised from illegal dumping and landfill. These include constant burning of waste at illegal dump sites "with thick black smoke," and specifically in the Traveller community, the presence of a waste warehouse and a large number of factories (e.g., cars and wood mills) in close proximity to homes. The constant emissions of pollution from these sources were also seen as contributing to the high rates of respiratory illness and cancer in the communities.

> *"Yeah. Well, I mean, what we have now about the air we're breathing in; watching our children breathe in for more than 20 years, the filth, the dump…." (NGT workshop participant)*

What is more, communities reported living in and waking up daily to the sight of the dump and black smoke as detrimental to their mental and physical health, being forced to keep their windows closed all the time to keep the pollution out. In the Traveller community, the exposure was described as being made worse by businesses spraying fragrances to mask the putrid decomposing waste smell when complaints were made.

The long-standing nature of these issues are seen as arising from a lack of effective governance with lack of enforcement of environmental regulations in addressing issues of importance to them, as well as lack of belief that anything will ever change.

"…They're allowed to continue, to continue, and it is affecting families in the area. On the site where we are, there are two to three mobiles [homes] that are like boxes at the back of people's yards. They keep promising…. only mould on the wall. It's very stressful. It is mental health. And as that girl said over there, if you have the courage to go and look for help, you are treated like 'crap' straight away…. It's the lack of meeting with people. Even this [research], hopefully something comes out of it, but it is going on a long time. Something needs to be done. I think when you are disadvantaged, you're definitely getting the skunk from the council. You are definitely not getting luck, loads of promises, that's all…." (NGT workshop participant)

Also, participants are of the view that the site (Belcamp/Moatview) on which the illegal dumping takes place, could be used to address other community identified needs, such as housing and lack of green space.

The environmental hazards of derelict buildings

A significant number of boarded up houses and buildings were observed during the transect walks. These were viewed by community members as posing significant challenges to health, as they have become places for illegal dumping of waste which attract rats and further promote the spread of disease. Likewise, these spaces are used as sites for drug-related activities and anti-social behaviour which impacts on sense of security in the community. Community members suggest that buildings could be used to address housing shortages and/ or provide recreational spaces for youth and community activities.

"This issue has been all over TikTok and social media... Yeah, it's a bit frustrating as well. The longer they leave it derelict, people are leaving their rubbish and dumping illegally which leads to the infestation of rats which is another health issue in the community. They [Dublin City Council] should be making use of those buildings because everything is tied to our health." (NGT workshop participant)

4.3 Addiction and mental health

This theme captures the views and the interrelatedness of illicit drugs and alcohol misuse, addiction, and mental health problems that impact the communities.

Community members see these issues as closely related and have expressed the view that they need to be addressed in tandem with each other. The following four key summaries highlight the communities' viewpoints on addiction and mental health impact.

Historical neglect: Community members believe that there has been long-standing neglect of the areas by state agencies and poor response to the drugs problem. They view state agency responses as inconsistent, irregular, and often targeting those who are buying drugs rather than the dealers and suggest a loss of control by state agencies, leading to inter-generational trauma through the years.

Normalisation of illicit drugs, and alcohol: Alcohol, drug dealing, and drug use is viewed as a way of life and can be seen everywhere in the communities. Participants describe it as so normalised, that it leaves young people extremely vulnerable, to being groomed into the drug trade as a way of life or as a means to an end. Alcohol misuse is described as 'huge' and 'accepted' with people 'turning a blind eye.' A similar view is expressed with regards to unrestricted access to nitrous oxide gas for children and young people, despite the rise in use and concerns about addiction and health impact.

Widened inequalities: Due to the normalisation of these problems, engaging with drugs is seen as a normal progression from childhood into adulthood, a situation that is seen to differ from young people growing up in more affluent areas, who are not exposed daily to drug use.

Mental health: Communities view the high incidence of mental health problems to be strongly associated with drug-related activities, including the grooming of children at an early age, dealing, excessive use, intimidation, sexual exploitation, and threat-to-life. Constant exposure to these factors is seen as linked to an increase in stress, self-harm, and suicide in those affected, especially in children and young people.

4.3.1 Key drivers of youth involvement in illicit drug activities

"It is not fair. The society is failing those kids"

The following factors reflect participants' views on what influences young people's decision to engage in illicit drug activities.

The role of the education system

Secondary education is viewed as not working in tandem with the challenges that exist in a child's life, such as threat to life, poverty, bullying and intimidation which significantly affect wellbeing and school attendance. In addition, children not being managed through TUSLA, or other social services were reported to get missed in receiving the extra support needed. Concerns were also raised about the secondary school system's harsh punishment of children who might be dealing with home and life challenges, often labelling them as disruptive or non-compliant with school rules, such as dress code violations. The reported punishments include reduced school hours or, in some cases, dismissal from school, which were viewed as increasing the risk of these children being drawn into drug use and other anti-social behaviours.

"And sometimes I think the school are very rigid with the uniform policy. Like families don't have necessarily the means to get the jumpers. They [school] don't need to. The fact that they [school children] are showing up in school, it shouldn't matter what they are wearing… And sometimes the school system, just because of their [student] behaviour (because of their case at home), the school system is working towards keeping them out, in terms of like reduced timetables." (FGD participant)

Further, limited school spaces were reported by the community, citing children who have been transferred to secondary schools in a more affluent area experiencing bullying, resulting in an increased risk of school dropout. The merging of students from diverse socio-economic backgrounds was also perceived as 'making it difficult' for teachers to recognise the varied needs of students from disadvantaged households. In an appeal to the Department of Education to enhance teachers' awareness of this issue, one participant elaborated on the real challenges faced by children from very disadvantaged backgrounds.

"Some teachers don't realise that there are kids coming from areas like this. And they need to understand these kids… That they're actually sleeping in the crack house all night. That they are in house where there is mama and dada addicted to drugs and there is prostitution going on all night that they haven't slept. There are five kids in one room with no bed cover, no sheets, no duvets, no food in the fridge, you know. And if they get into school, that is half of the battle, coming in, because the school is a better option than sitting at home, that is neglected and dirty and there is rat and mice, and drug paraphernalia and people coming and going all day, every day." (FGD participant)

Poverty, safety, and glamour

With some households reported as 'having nothing in the fridge' and parent/s living with addiction, domestic violence and sex for drugs, the affected children are reported as "easy targets" for grooming. The hero worshipping, perceived sense of power and the glamourised lifestyle of people involved in drug-related activities are viewed as appealing to some children, as a way out of a perpetual life of poverty and feeling unsafe.

> *"…because if you're a young person, [and] you look at somebody who has money, who is not looking over their shoulder every minute… [who says] you can trust me. I will have your back if you get any [trouble], I will look after you. They are most vulnerable young people, so they believe that, because that is what they need." (FGD participant)*

4.3.2 Drugs and mental health awareness in children

> *"It is not too early."*

According to participants, education about the dangers of drugs is not introduced into schools until children reach transition year. This education comes after the stage at which children are most vulnerable to being groomed into drug use and drug dealing, as well as being exposed to bullying. The community report that by the time the school introduces drug awareness during the transition year programme, many young people have already experimented with drugs or are in active use and already have mental health issues, including increased risk of attempting suicide, especially among girls. The communities see the opportunity to prevent drug use and addiction, as key in promoting good mental health and wellbeing in children and suggest this could be supported by introducing a mental health awareness campaign and mindfulness classes earlier in schools. Several participants shared their views on when it might appropriate, most indicating that children see it every day anyway and are exposed further to sex, drugs, and violent content through social media, creating a real need for an earlier preventative approach to these issues. One parent suggested that earlier introduction of mental health awareness and drug education in schools, would be much more appropriate, as young people are now exposed much earlier to mental health risks through social media use.

> *"Well, they offer sex education… when they are in fifth class in primary schools… So, why not introduce the whole aspects right to them. About the drugs, why not about the mental health then? Every teenager is advanced now…The social media is a very bad influence… So why not introduce that subject on their mental health at a young age if we are introducing sex education? Why not introduce it from third class?" (NGT workshop participant)*

4.3.3 Addiction recovery and mental health services

"It is hard when you are trying to stay off, to stay clean"

Community members report several gaps in services available to support people who are in recovery. Community members with lived experience of addiction, described the challenges of recovery at an individual level. The limited availability of effective and supportive addiction recovery programmes and services is seen as facilitating a backslide into drug and/or alcohol abuse, creating an ongoing cycle of mental health issues, addiction and poverty. One community member described their need to be supported with services to assist their daily struggle on their way to recovery.

"We need a place where we just go in, have a shower after sleeping rough, and have a warm meal. Maybe have someone assist with job screening. A drug free place, a day group, you know, it is hard to wake up and have nothing to do. I need the day programme and I'm not the only one. We have the AA meetings, but that's in the night-time and they're only for an hour. We need a group that goes on a few hours. We need a programme to tackle poverty and housing, to tackle this addiction." (NGT workshop participant)

One community member living with addiction described the importance of having somewhere to go, where they are supported and understood on their recovery journey.

"A place where someone welcomes me, listens to me, to understand me, counsel me and support my addiction journey as well." (NGT workshop participant)

Other issues raised in relation to addiction and recovery services, focused on existing effective services in the communities such as ADVANCE, FAST, and The DALES centres. However, consensus across the communities was that there were simply not enough of these types of services. In addition, while the services are described as excellent, some are very small, making them inadequate to meet the needs of the number of people that need them. In addition to limited addiction services, the community reported long waiting lists for counsellors for mental health issues and proposed that these two services ought to be joined up, to save time and facilitate a more effective recovery journey.

Furthermore, participants suggested a need to enhance the quality of some counselling services with some describing their 45 minutes session cut to 5 minutes on occasion due to the high demand for the counsellor's time. Also, the quality of treatment received by people in recovery was of concern to the communities with participants describing the services as being non- holistic and of individuals "being seen only through the addiction" without consideration of other factors such as stress, or mental health that might be going on with the individual.

"OK, I just see a lack of joined thinking in where there is an addiction. It is not seen as a mental health…It's not seen as a mental health issue and so both are treated separately. And where I think if there was like those dual joint services, done, where there was a centre where you could go in, you know, [that] people could go in and go; one space for mental health and just walk into the same building for the addiction issues. So that's where they'll go to." (NGT workshop participant)

ADVANCE: is a free confidential drop-in centre that provides low threshold one to one or group basis supports for people living with drug and alcohol use and their families in Dublin 10 using the person-centred approach. https://ballyfermotadvance.ie/

FAST: The Finglas Addiction Support Team provides inclusive access to high quality care to every person experiencing problematic drug and alcohol use and to families impacted by problematic drug and alcohol use. https://fastltd.ie/

The DALES: The centre provides 'open door' policy support to people and families through each stage of addiction in Dublin 17. The centre works with a harm reduction philosophy in addressing problems or issues that people are experiencing as a result of drug or alcohol use. https://dnetaskforce.ie/project-dales-centre/

Similarly, participants during one transect walk described the Darndale methadone clinic as "cold, tucked away, barricaded, and lacking a human touch." In one of the workshops, the community expanded on the impact of the lack of a holistic approach to overall health, describing services as unpleasant to use, unplanned, and unsupportive of patients' re-integration into the community.

> *"The building is very hidden. It is in an orange box down in a back road. They are treating people like aliens. The state of that place. How do we make them have some faith? That they are a part of something, that they are a part of the community.... How do we show that there is a way out? Because there's nothing in the area that shows them that they don't have to do this, and they don't think there is anything else. Even in the clinic, they don't give them much support. They just hand them down a couple of methadone. Yeah! No one is sharing with them any plan, telling them that you can deal with that, whether it's true mental health and addiction, or the dual diagnosis, or the hormones" (NGT workshop participant)*

Other community views on addiction treatment emphasise the compounding impact of the lack of accommodation after completing recovery programmes, as some people would have given up their accommodation to join these programmes. In cases where accommodation is provided, participants report that some individuals in the same accommodation are still actively using substances, making it harder to commit to recovery and negatively impacting on mental health.

Additionally, the pervasive fear of being misunderstood and the stigma surrounding addiction were highlighted as barriers to accessing support services, especially for people from the minority groups.

> *"And the thing about the services is that we have been told for years and years… to try harder… [But it] is very different, and there is huge stigma, telling people about your problems with alcohol, drugs. But they [people living with addiction] are really struggling for support… you might have one or two coming down, and they would get asked 'what you are going down there for? They only want to let everybody else know that the Travellers are this and that'...' They are a minority group, but there is a lot of fear in that area." (FGD participant)*

The difficulty in accessing support is seen as a problem across all the communities. One participant, sharing his experience with alcohol addiction, highlighted how social isolation and depression perpetuate the cycle of alcohol misuse. He also suggested the need for platforms where people could freely talk and share.

> *"I'm with 'friends for football off alcoholism."... We have been off alcohol now a year next month. We still hang around with them people. They [people living with alcoholism] have no one to check up on them, they have no family, but they are wonderful. I've been through all that …when I lost all my family, I used to be drunk all the time, and I want to talk, to cry about my agony. … now we have to learn to help these people. I talk to them on Facebook and say talk to me…." (NGT workshop participant)*

Given the multiple factors linking mental health and addiction, such as poverty, stigma and trauma, community members stressed the importance of training healthcare providers in trauma-informed care and addressing unconscious bias to help prevent excluding individuals who need services but are hesitant to seek them due to fear of being stigmatised.

> *"And I know that we've done a lot on trauma and in this area of different groups…. And I apologise for what I am going to say... but I think that a lot of people need to get educated on trauma response and how to deal with people when they're going for their initial treatments. So, they're not turning people away from the services that are there." (NGT workshop participant)*

Finally, community members expressed the great need for more services for younger people coming into addiction and more advertisements in schools and where young people gather, to let them know what help is there and where they could go to access those services. The community suggests that such information sharing should be done "in every situation, not just drug addiction, but everything."

4.4 Access to healthcare services

This section outlines how participants see barriers such as geographic location, socioeconomic status and inadequate healthcare infrastructure lead to delayed treatment and worsening health outcomes in these communities. The findings also emphasise the disparities in health service availability and the impact of these gaps on overall health and well-being.

4.4.1 Limited access and availability of healthcare services

Healthcare access is viewed as limited across the communities and across different age groups and needs. While there are community health centres in Kilmore West, Finglas and Cabra, communities reported a lack of drop-in services such as Urgent Care Centres where, for example, children need access to minor injury care, but only have the option of attending accident and emergency departments at a considerable distance away. Alternatives are often private medical centres that require payment.

> *"They're sitting in A&E [Accident and Emergency], and the child might only be needing a paper stitch or a plaster. So, if there was something in between, they'd probably won't go and take up the space for a child that's critically sick. We need something for minor injuries and reduce the visits to the A&E." (NGT workshop participant)*

Likewise, access to services was reported as limited for the elderly and those living with disability. In one example given, people living with visual impairment or mobility issues in Ballyfermot, must travel to Finglas to access the health services for people with disability issues; a situation described as not ideal, especially with limited access to reliable transportation. Additionally, a participant described her lived experience with the lack of carer support for people under 65, living at home with chronic disease and how it limits good health outcomes and daily living activities.

> *"Well, I suffer with chronic disease of the bone, so they break down without notice and it means bed rest not getting up on your legs. And for anybody to come in to do anything like even to make your lunch, or whatever, No, you are not entitled to it unless you are over 65." (NGT workshop participant)*

Other essential healthcare services such as occupational therapy are viewed as non-existent for children with autism, leaving parents without support outside of the school system's play therapist services, which also has a waiting list.

4.4.2 Health assessment and access to services

> *"But there's no help for our children"*

All communities viewed health assessment for children as lacking. Participants mentioned the long waiting list on CAMHS (Child and Mental Health Services), even after the school had made recommendations for the children to be assessed. The long waiting list for diagnosis for children with special needs and other health issues is known to further exacerbate other health conditions and impact academic performance. One mother of a teenager described her agony of watching her daughter depressed and self-harming for 3 ½ years while waiting for assessment. The profound impact of long waiting lists for families without the ability to afford private insurance, exposes the inequity resulting from poverty and lack of access to affordable healthcare.

> *"If I hadn't gone private, my child would have been dead." (NGT workshop participant)*

CAMHS: Child and Adolescent Mental Health Services provides assessment and treatment for young people (up to 18 years) and their families who are experiencing mental health difficulties. Access to the service is by referral by the General Practitioner.

https://www.hse.ie/eng/services/list/4/mental-health-services/camhs/

Furthermore, several participants mentioned gaps in services when children eventually get into the health system. This includes services being disrupted "just when the kids are getting used to it," related to lack of resources. The current state of mental health services for children in the community was described as 'rationed', "where one child is taken off, so that another child can get in."

For children, the long waiting times are further compounded by inadequate numbers of healthcare professionals and problems with the referral system which increases the burden of care on the carers.

> *"… You can't even get to the doctors… Your head could be falling off and you can't get through to them. Never mind an appointment.… [yet] you need to get a doctor's letter, get letters from the school, get letters from SNAs, [Special Needs Assistants] before you even [get] to the waiting list on CAMH's…." (NGT workshop participant)*

Similarly, in the adult population, long waiting lists to access mental health services were viewed as detrimental to overall health and family stability. One participant shared the impact on her new family while dealing with post-partum depression.

> *"The problem is also the backlog. Because, for example, me having depression after having my child; and we have to be referred from my GP, and it took ages and ages. It was 12 weeks by the time I got to be seen, by the time I got invited down to the COPE foundation in the city centre. Dealing with a new-born with depression really took a toll." (NGT workshop participant)*

Additionally, where referrals are made, participants gave examples of referrals to hospitals situated a significant distance away leading to a high cost of travel if public transport was not available. This was especially reported to impact the elderly who might not have social support.

> *"Yeah, they have another practice in Donnycarney which is far from here. If you don't have transport and even for an elderly person... they might have to take a bus down. When they get to the point of getting there, there is quite a lot of stairs. And they are not able and not fully mobile, they don't go upstairs. You know it is not fair on them. They are not able." (NGT workshop participant)*

Likewise, navigating the healthcare system was viewed as stressful. The communities reported services as 'fragmented,' not consolidated, disjointed, and often judgemental.

> *"I had a lot of stuff going on and I felt extremely uncomfortable, vulnerable waiting to pee in a cup. I had postpartum depression and not on drugs. So even when they have these services in place, the treatment and tarring everybody with the same brush. I didn't get seen to because I felt so embarrassed and had to walk out of there... And that's across a lot of services and organisations." (NGT workshop participant)*

Lack of health literacy was further viewed as compounding the complexity of the issues, especially among the elderly population. Health-related information is seen as often too complex to facilitate understanding of health issues, which contributes to stress and a limited understanding especially among young parents, the elderly and women dealing with menopause.

4.5 Safety and distrust of authorities

4.5.1 Sense of security- mistrust relationship with law enforcement

Difficult relationships with local Gardaí were reported in all communities but the issue seemed to be felt more keenly in some areas more than others. Lack of trust between Gardaí and the communities was viewed as long standing, compounded by the generations passing down their experiences and lack of belief in the capacity of Gardaí to address the issues faced. Also, indiscriminate and disproportionate arrest of young people was reported to heighten the problematic relationship between the Gardaí and the community.

> *"The frustrating issue with the Gardaí [and] young people is that they [young people] say 'they're targeting us', but they're not going after the others. They'll say, I'm just hanging out with my friends, chilling, me smoking a bit weed. I've got nothing on me, and literally down there, there's the real guys." (FGD participant)*

The arrests, especially in relation to issues with drugs, were viewed as 'unfair' to kids who as the 'runners' were often coerced into the drug trade and to some users who might be struggling with addiction, while dealers and sellers often appeared to be left alone and evade arrests. This dynamic was reported to deepen feelings of insecurity, primarily in reference to drug-related activities and intimidation, leaving communities unsure of who to call or turn to when they need protection.

The feelings of lack of safety arising from the complex relations with Gardaí , was highlighted as a major issue that needs to be resolved to enhance community wellbeing.

> *"So, it's that complex mindset that has to change within the individuals within the community, and the Gardaí . But that has to come from bottom up and top down and that's where you were right about the partnerships." (NGT workshop participant)*

4.5.2 Feelings of neglect and not being heard

> *"…We also matter. It's like we are the forgotten about."*

Distrust of authority was presented as a recurring viewpoint, accompanied by feelings of a lack of acknowledgement of the community viewpoint and situation, perceived as limiting opportunities for good health and wellbeing.

Several participants highlighted concerns about pollution, safety and access to healthcare and social infrastructures. These issues were reported as often ignored by local government, who are viewed as prioritising other areas over their concerns. This contributes to the widespread belief that the authorities are indifferent to the communities' voices, resulting in loss of trust in the issues ever being resolved.

Examples cited by the communities' included issues related to drug and gun violence, illegal dumping on council land in Moatview, a waterlogged park in Darndale, and unsafe living conditions in Labre Park. Several participants recalled 'discussions and promises' over the years with nothing done to address the issues raised, despite the community perceived impact on their health and wellbeing.

> *"And to fast forward on things that have been brought up in this room, first of all, about the dump there…Everything that's being said by people [are] not being listened to and they go off and they want to build walls... But that is [a] typical thing in the DCC. They haven't had any community voice whatsoever…." (NGT workshop participant)*

The lack of attention to communities' requesting support regarding illicit drug activities is described it as 'turning an eye away' despite the wide impact on the community's wellbeing and how the outside world views and relates to them.

> *"If you were to say, drugs around the area, the corporation knows straight away the guys that are doing it, those that are involved. How cruel is it that they do nothing when they know there's something going wrong? But when there is something nice, they come out here." (NGT workshop participant)*

Participants acknowledged the existence of issues such as antisocial behaviour, drug use, and intimidation within the community, but emphasized that these problems are caused by a small minority. And while this is viewed by people outside the community as widespread and representative of the entire community, using it as a reason for discrimination and removal of services, these issues also affect other people who live within the community. They described harassment, extreme noise and loud music at night disrupting sleep, the indiscriminate parking of cars often blocking house entrances which increases risk during emergencies. Community members expressing the feeling that they are "afraid to talk about the issues" due to fear of retaliation from the few individuals engaging in antisocial activities is compounded by a lack of support from authorities when help is needed leaving them with a deep sense of "disregard."

> *"It is like living constantly in it, with people with power outside punishing us and taking away the little we can get…There's no winning in the situation… when the authorities will not even take your call talk, even less, back you up…" (NGT workshop participant)*

In addition, community members suggested that on the rare occasions where promises were kept, they are often not sustained.

> *"You see like multiple times in the past where people have been promised, the experience is that nothing comes of it, sometimes it was promised, and it did come. But then, after maybe two years, three years later, it was gone. And like everybody said, it is a goner." (FGD participant)*

The participants raised concerns about the impact of the lack of engagement and action of Local Authority with community youth and viewed it as having a ripple effect on how children and young people relate to and engage with authorities.

> *"Yes. young kids are not being listened to at all. They have things to say. They are watching to see if things would really work, And the people and the corporation, they just listen, and just walk off. Like someone just said, it is a vicious cycle. I am here 43 years, and it is the same issues." (NGT workshop participant)*

Participants also expressed views about lack of community and children's voices in some programmes such as the 'hot meal initiative' in primary schools. Participants mentioned that some children living in extreme poverty, in solidarity with their family who are not in school, often refuse the food provided because they are not allowed to take their leftovers home.

"The Hot School Meals operates in schools and aims to provide regular, nutritious food to children to support them in taking full advantage of the education provided to them"

https://www.oireachtas.ie/en/debates/question/2024-02-20/58/

This was mentioned to not be an issue when children were able to take their left-over sandwiches home to share with their families. Participants suggested that incorporating children's views into decision making in schools would help to tailor local practices in this regard.

> *"It ought to be meeting at the level of the need, rather than a prescribed solution at a national level." (FGD participant)*

According to the communities, their feelings of 'not being listened to or heard" and years of unkept promises have deepened distrust in government and authorities, with any interest in the community viewed as when authorities are "gathering good deeds" and "just ticking a box."

4.6 Amenities and social networks

Participants view limited social amenities and support as a concern for their overall health and well-being. These views were expressed across all age groups, particularly in relation to social isolation among the older population, which is seen to have increased since the pandemic. The situation was associated with several other factors seen as having a profound impact on the physical, mental and emotional wellbeing of the elderly. These factors include:

4.6.1 Environmental factors

Uneven and broken pathways, speeding cars, and the long distance to available amenities, was reported to contribute to the older adult's isolation. With associated physical health decline for some, fear of falling or being knocked down by speeding cars or scooters is a contributory factor to decisions to remain indoors. In addition, indiscriminate dumping of rubbish on the streets and pavements poses a safety hazard to the elderly. The impact on daily activities of the elderly is captured below and highlights the lack of action to address the issue.

> *"And like that, the elderly won't go out, to walk to the shops, not even to church. Because as we were saying, if they are not getting knocked over by a scrambler, or a horse, [then] it is manoeuvring around the rubbish, the broken bottles through the footpaths. All the way up, they have bins burned on them. It is a trip hazard all the way up to the local park." (NGT workshop participant)*

In addition, navigating through the gang and drug dealing activities and related intimidation and harassment while accessing services, is also seen as contributing to elderly isolation. The the elderly population are reported to often be targets of gang intimidation and extortion of their social welfare funds which not only adds to the decision not to leave home, but also contributes to economic hardship.

> *"They mostly don't go out now. The gangs are waiting for them at the post office, collecting their social welfare from them as they are coming out of the post office. You can imagine, the impact, they can't buy food or get the things that they need then." (Transect walk participant)*

4.6.2 Transportation and proximity to amenities

A long distance to amenities and limited public transport further exacerbates the isolation and overall wellbeing of the older people.

> *"There is no transport. When they were first built back in 1970, the apartments for the old folks down there. Then there was the 78 bus, then it was taken away and there was no transport put on around that area. Even if it was like a little minibus to take them [older people] around." (NGT workshop participant)*

Where services are available such as the 'Active Edge' in Cherry Orchard, they are reported to be limited due to funding.

"… They do bingo. They do line dancing. They do quizzes, but like, a lot of them [older persons] say it's not enough for once a week, you know. And for the cherry orchard, it will stop for April and that is due to the DCC. They [older persons] want a structured thing." (NGT workshop participant)

Active Edge: A weekly community programme with various activities to foster active engagement in the older population in Cherry Orchard.

The issue of proximity of amenities is also of concern to the general community with no supermarkets available nearby in some areas. While there are bus services, they do not service all the routes required. In Darndale for example, access to the closest supermarket, is about a 15-minute walk away, a big issue for people without cars after food shopping, forcing them to rely on a local shop with a limited and expensive selection of healthy foods.

4.6.3 Limited affordable social activities and spaces

The limited provision of structured activities for the elderly was further highlighted during the transect walks, sparking a debate about the role played by privately run betting shops. While betting shops provide structure and a purpose to get out of the house, some viewed them as a high risk of loss of income for the elderly.

"Yes, there is a lot of them, and it is worrying. But it provides a getaway for many people. The old people that don't have anywhere or anything to do in the community. But then you wonder, the addiction and loss of money and if they are having enough to live on." (TW participant)

In addition, overly strict health and safety requirements were viewed as contributing to limited social interaction opportunities especially among the elderly who live in communal arrangements. In cited examples, communal activities such as cooking together was stopped because of health and safety regulations, without appropriate alternatives being offered. While the elderly are able to cook in their own accommodation, the social aspect of cooking and eating together has been lost, contributing to social isolation.

Social isolation is not limited to elderly people. Some participants, particularly in Cabra, also report lack of physical spaces to meet socially, including cafes and report the need to go out of the community to access such facilities. Existing social groups such as The Men's Shed were highlighted as not funded by state agencies and in some areas, there are ongoing issues about spaces provided being unsuitable for the group activities.

In relation to children and young people, there are also limited opportunities to access recreational facilities. Lack of available facilities such as stables for horses, and the high cost of recreational facilities such as swimming, horse riding and football has become a barrier. In addition, the added cost of equipment and clothing such as uniforms, football boots etc. often prevent participation in these recreational activities. Suggestions were made by the community for government funded activities to support children's engagement in recreational activities.

"So, I was saying about… once a month or something that your child can go swimming… If it's linked with DCC that they might be able to do once a month. That you just have a sign up and that you get sent a voucher that has to be used within that month, for that child and they can just have one swim and one thing that they just get to go to…." (NGT workshop participant)

Lack of funding to keep the services provided by these projects open and functioning, and available to young people was also described as a major concern as they are typically only funded in the short term. Community members suggested that the closure of some programmes due to financial issues such as needing funds for a caretaker's salary, or to maintain existing staff, further validates their feelings of being neglected in relation to issues they deem important to prevent and manage anti-social behaviour among children and young people.

According to participants, limited availability of services and amenities is threatened further by ongoing construction of a housing complex in Darndale, and plans to convert a green space in Finglas to housing units without consideration of the limited resources already available to the community.

> *"They are building that huge housing complex over there. The community is already struggling with very little resources, I mean, schools for children, health centres would be impacted." (TW participants)*

SPHERE 17 Regional Youth Service provides a support project for young people age 10-24 years. The programme provides a range of services including recreational, educational, health, personal, and social development.

https://www.sphere17.ie/

Finglas Youth Resource Centre: A community space with the mission of meeting the needs of young people by providing a variety of response-based supports, fun activities, and enabling opportunities to learn, grow, and be safe in their own community.

https://fyrc.ie/

Kilmore West Youth Project: A community-based youth and family service providing a range of supports and services to meet the needs of young people and families in the Coolock area.

https://www.kwyp.ie/

Cabra for Youth Project: A community-based independent youth service working directly with young people aged 10-24 years living in the greater Cabra area.

https://cabraforyouth.ie/

4.7 The cycle of poverty and family structure

4.7.1 The invisible burden of caring

The high unemployment rate and lack of economic opportunities is seen as a major barrier to health and wellbeing. Some relate this to low educational attainment and unwillingness of employers to give them a chance based on their address. This keeps people in the intergenerational cycle of poverty, stress, and poor mental health. In addition, many parents who wish to return to work or pursue further education, face significant barriers due to insufficient support from current welfare services. This lack of assistance includes inadequate access to affordable childcare, limited financial aid for educational pursuits, and a lack of job training or placement programmes tailored to parents re-entering the workforce.

> *"It's huge [burden for carers]!... Some [parents] want to get back into education and work, and the childcare is not there for it. It's either so expensive or just not available. There is a community crèche… but once your child starts school, they are no longer admitted into a full-time crèche place. So…if you go to work 9- 5, and they [CHILD] go to school from 9 until half one, then they've nowhere to go, half one until six. So, you'll either have to leave your job, reduce your hours… or take out sports for your children…." (NGT workshop participant)*

Without these essential supports, parents struggle to break out of poverty, as they are unable to secure the necessary education or employment opportunities that would allow them to improve their economic situation.

This in turn perpetuates a cycle of poverty and is viewed as making it difficult for families to achieve financial independence and stability, impacting on all areas of health. For example, the effect of poverty on nutritional choice was described by one participant as difficult for a parent.

> *"You know, so that's the way, and a very big impact on health and wellbeing. So, you're giving to your family junk [because] you can't afford to get the good stuff. So, you're opting to fill them up with the cheap stuff just to keep them full, to feed them. So that's reality in this day and age, which is very sad." (NGT workshop participant)*

4.7.2 Lack of adequate financial support for dual-parent households

The current welfare system tends to provide more financial assistance to single-parent households than to dual-parent households. While this support is crucial for single parents, the disparity can unintentionally discourage family unity when two parent families face similar financial hardships. This imbalance can lead to the fracturing of family support structures, as some couples may feel pressured to separate to qualify for the financial aid needed to provide for their children. Consequently, the system may inadvertently promote the dissolution of families, undermining the stability and well-being of children who benefit from a cohesive family unit.

4.8 Discrimination due to disability and Eircode

The suggestion of 'discrimination by Eircode' was reported in Darndale and Ballyfermot (Labre Park), and in Cabra. Taxis and food delivery services were reported to refuse to pick up or drop off in the community due to stigma and the "bad name" that is associated with the community. The community perceive this as isolating, limiting their social interaction with people outside the community and impacting their sense of safety.

> *"Now if I am coming in a taxi, I will not say I am from Darndale because the taxi will drive me up the road and drop me in Belcamp. He will not drop me in Darndale, won't even drive me here. You know that is our reality." (NGT workshop participant)*

In a similar way, community members with disabilities such as wheelchair users, reported discrimination when trying to access taxi services. While some saw it as due to a limited supply of vehicles with disability access, one participant who is a wheelchair user, perceived this lack of availability, as services being "selective" which contributed to her social isolation and reduced her access to essential services.

Further, community members reported the impact of cessation of postal services to a section of the community since January 2024. According to participants, the cessation of postal services coincided with an incident of a dog attack on a postal worker. Attempts to recover post from the post office and/or arrange for drop off at an arranged point, were reported as not having been successful. This has resulted in community members "missing long-awaited medical appointment" notifications.

> *"Why should this happen? And for what? We don't understand, one misappropriation and we can all get the punishment? But most of this was a postman who was [affected] by a dog or something. I have waited years for that appointment, and they [postal service] told me they sent it back." (NGT workshop participant)*

4.8.1 Loss of identity

> *"We have to get this discrimination stamped out"*

There were several instances of a lack of sense of community including isolation, living with drugs, and widespread stigma and discrimination. The feeling of loss of self and identity can be heightened among the Traveller community, with one member who suggested you must be a 'certain type of Traveller' to be seen and listened to, and to fit in.

> *"… and then you have an awful lot of Travellers trying to hide the fact that they're they are Travellers because they're getting treated differently…, which they shouldn't be. They are saying this new thing— oh I am actually a settled Traveller— which is a joke. Even if you haven't travelled in 20 years, you are a Traveller. They think if they say that, people will say you're grand. You're different. You're settled. It is like we are back 20 years ago, when we are told to keep our voice down so we can get a seat in a restaurant." (NGT workshop participant)*

4.9 Community ranking of factors affecting health

The tables below give a snapshot of participants' ranking of their community's needs for each area during the NGT workshops. The scores represent the number of times participants assigned a rank to an issue, with 5 being the highest level of need. Each issue was ranked on a scale of 1 to 5, based on its perceived importance or urgency by the participants.

Table 2 Ranked health and social needs: Ballyfermot and Cherry Orchard

Highest ranked needs (themes)	Target areas	Score
Environmental health action Better protection and safety	• Provide rubbish bins in the parks and community. • Provide safety needle bins in the parks. • Improve and refurbish the parks to support activities. • Improve roads and pavement conditions for wheelchair users and create speed ramps in estates to reduce car speeding.	9
Addiction services and support- Drug and antisocial behaviour prevention	• More aftercare addiction, aftercare services including a place to have showers and warm meals. • Address homelessness. • Drop-in support centre for addiction. • Education awareness and motivational talks in schools to prevent young children getting into drugs and crime. • More speakers from people with lived experience and less statistics • Support groups/ mentors for those in active recovery.	8
Mental health support	• Services to address and support mental health issues in young people. • Safe places for people struggling with their sexual orientation to talk with others with similar experiences. • Outdoor talks / casual talks around mental health for everyone, especially for men, who may find it hard to reach out for help.	8
Community identity	• More opportunities to raise awareness of community matters. • More advertising of events and activities in the community. • Forum to bring the community together, such as WhatsApp, Facebook, and radio for those not online. • Community activities such as fishing etc.	8
Support for parents	• Funding for children's activities such as free or subsidised swimming classes to offset the cost to parents. • Age-appropriate and adequate after-school programmes to allow parents to work. • Psychological and social support for young parents, including young fathers to address the impact of inter-generational trauma.	7
Support for elderly	• Social places for meeting and taking part in activities. • Transport to get to the shops and to access services. • Support to deal with isolation. • Need for digital literacy. • Increase awareness of emergency contacts in the area and the local first aid service. • Services to advise on the complex process of older people giving up their homes to take up assisted living.	7

Table 3 Ranked health and social needs: Priorswood

Highest ranked needs (themes)	Target areas	Score
Mental Health support	• Provide adequate support for isolation due to illness or immobility in the elderly population. • Provide adequate mental health outreach and support, including intergenerational trauma support. • Need for community support centres and • peer support groups. • Support and training to address high levels of stigma and discrimination. • Provide dual diagnosis (mental health and addiction) and address service splits.	12
Environmental health actions	• Address the presence of illegal landfill dumping and high pollution from burning rubbish and general litter in the community, including in the green spaces. • Reduce pollution from cars and fire.s • Repair footpaths that are not passable for wheelchair users. • Resolve the flooding in the park which can make it unsafe to use during winter months.	12
Drug and addiction	• Provide a real and sustainable solution to drug use in the area • Offer more recovery-focused events. • Provide support for dealing with health-related outcomes of substance misuse. • Address the issue of grooming of children into gang/drug activities. • Provide drugs education, especially in schools. • Increase the presence of Gardaí in the community. • Need for better location of isolated methadone services. • Need for combined mental health support with methadone service (dual diagnosis). • Support and services to improve sense of safety.	11
Recreational facilities and support for children and young people	• Provide recreational facilities for children and young people: e.g., horse stables, youth projects, playgrounds and social meeting spaces. • Address the lack of trust in authorities. • Ensure school spaces for young children and invest in their overall welfare.	9
Access to GPs and health services	• Prioritise the high waiting list for children with special needs and other health issues. • Prioritise the high waiting list for health services and GP care for the older population. • Provide health information in simple language to support people's understanding of their health issues. • Provide services such as dental, occupational and public health services in the community.	8

Table 4 Health and social needs: Kilmore West

As indicated in previous sections, attempts to engage community in NGT were not successful. The health challenges observed and identified during the TW is presented in table below without ranking.

Highest ranked needs (themes)	Target areas
Environmental health	• Address uncontrolled car speeding. • Resolve haphazard pavement parking in school areas which increasing risk of car accidents. Community reported most of the parking is due to people using Beaumont Hospital. • Listen to community and stop the proposed housing construction at the intersection of major roads- high risk of road accident .
Drugs and addiction	• Hidden drug dealing: Affects people living in social housing so the issues are not addressed because it is not seen. • Increased use of helium gas canisters around the community and in derelict buildings.
Poverty	• Address the increase poverty in older adults and working families with some having to choose between filling the electricity metre and other basic amenities.

Table 5 Ranked health and social needs: Cabra

Highest ranked needs (themes)	Target areas	Score
Access to doctors and health services	• Reduce waiting times for hospital appointments and long waiting list to see GP. • Better access to appointments and preferably nearer to home. Referrals are too far away. • Address disjointed services.	7
Transportation	• Improve access to transportation for vulnerable people • Provide taxis for people in wheelchairs to get to health appointments. • Better transport to remove barriers due to mobility issues, and to reduce the high cost of taxis due to lack of public transport.	4
Safety	• Address speeding and pavement parking so that wheelchairs and pushchairs are not forced into the road. • Resolve the problem of cycling and e-scooters on the footpath to enhance safety. • Provide lighting in parks and on roads.	4
Environmental health action	• Better cleaning services to address the littering on the footpaths. • Bins for dog faeces and law enforcement to address dog and horse faeces on the street.	4
Drugs and antisocial behaviour	• Address anti-social behaviour. • Keep open drug dealing out of the area.	4

Table 6 Ranked health and social needs: Finglas

Highest ranked needs (themes)	Target areas	Score
Mental health (services)	• Need for mental health hubs. • Need for trauma informed approaches in HSE/community services. • Need for an integrated approach to Intergenerational trauma. • School refusal leading to anxiety. • More information on trauma and fatigue.	13
Children and Youth	• Address the lack of early intervention in children. • More community spaces. • Investment in youth services .	8
Drugs and alcohol and antisocial behaviour	• Priority of drug use, violence and related homelessness. • Addressing of anti-social behaviour.	5
Access to services	• Need for improved access to existing services. • Need to invest in primary care placed disability services (OT/Physio etc). • Healthcare worker additional training and support. • Bring disjointed services together/ improve awareness between professionals. • More funding for services. • Services for adults with ASD / ADHD.	
Exercise / diet / education	• Need for education on food and healthy living. • Improved education.	5
Housing	• Need for affordable housing to address homelessness.	

4.10 Existing community assets

Despite the challenges and needs identified as negatively affecting health and wellbeing, several assets were observed during the transect walks, while others were highlighted at other points of the study by participants. Although some of these assets have limitations, such as limited access and safety concerns, there was a general consensus that the services support the communities' health and wellbeing. The following list is not exhaustive but captures a wide range of services available in the areas. In addition to the services, there are committed and motivated community members actively volunteering in several capacities in the community and dedicated community workers across several services and programmes. Most outstanding is the communities' resilience and vision for change despite the challenges they faced.

Ballyfermot/Cherry Orchard- Assets

- Some primary schools in the area support child mental health through play therapy and timely reporting of observed learning disabilities or mental health issues
- The running club in Cherry Orchard provides physical health opportunities and social support for children 6-16 years old. [Free for 6-12 years]
- Swimming Club: Provides swimming training for children under 18 years. [Fee paying. This limits accessibility for those children who cannot afford it]
- The ADVANCE centre in Ballyfermot provides a drop-in centre for addiction services including support, talking, and counselling
- The Blue Door provides mental health support services
- Communal effort to decrease anti-social behaviour in the high-risk areas, such as putting up Christmas lights around high-risk areas to "change the outlook."
- The Liffey Partnership host and support a range of programmes dedicated to employment, education, employment, and education to address unemployment and poverty
- Ballyfermot Adult Learning Centre caters for older people's care
- Familibase Ballyfermot- a 'one stop shop' integrated service catering for complex and/or multiple needs including school/training, weekly home visiting, street-work, and individual key-working to facilitate positive outcomes for children, young people and families
- Cherry Orchard Equine centre and support for young people and families in the area such as horse riding, and career classes amongst other benefits
- Cherry Orchard Development Group access community service providers and initiatives to identify and determine how best to enhance existing community interventions
- Cherry Orchard Community Centre provides a community and social enterprise hub for a wide range of services including childcare, a foodbank, wellbeing activities, women's health, hairdressers etc.

Priorswood-Assets

- There are several parks in the community including Darndale park and Belcamp park
- Darndale Park offers soccer pitches including Darndale FC which is located at the back and a small lake which provides freshwater habitats. The park is used at weekends for community activities, including activities organised by the runners' club such as 'The Park Run.' A 'Plant a-Tree' initiative is going on in the park and a new playground has been completed. Access to the park is marred by significant anti-social behaviour and drug activities in the area. Also, by regular flooding of the football pitch from a faulty water pump
- Presence of green space (grassland) in and around most of the housing blocks. However, most of the spaces are used for bonfires and fly tipping
- Sphere 17 youth programme provides holistic support for children and youth, including counselling and a safe space to play and/or do homework
- Other community assets include The New Life Centre, Darndale Belcamp Village Centre, Preparing for life, Jigsaw early years and Darndale primary care, all based in Darndale Square although this can also be marred by anti-social behaviour
- Priorswood Parish Centre provides age-friendly group meetings.

Kilmore West- Assets

- Strong sense of community
- Close proximity to large shopping areas
- Availability of HSE health centre
- Community-led garden
- Kilmore West recreation centre provides a safe space for the local community to meet and interact. It provides space for local children to engage in sports, after school programmes, and a youth group programme for age 12-24 years
- Not seen as a generally unsafe area: areas tend to be well lit and the community feel safe.

Cabra- Assets

- The Sancta Maria Day Centre provides a social outlet for older community members including in-house meals, social activities, transport pick up from their home to the centre, and meals on wheels
- Kickboxing club for children and young adults in the sport facilities- this was being faced with closure due to legal issues relating to the rental agreement at the time of the study
- An active Men's Shed group
- Cabra for Youth' provides services for children aged 10 to 18 and offers diverse projects. This is a referral system mostly from Gardaí or schools for young people at risk of criminality or involved in criminality. Various social activities, including kayaking, painting and other activities are offered depending on the need, age, and interest
- Several green spaces such as Ventry Park are available. There are some issues with destruction of planted trees. Some parks also have outdoor gym equipment
- Cabra Parkside Community Sports Centre, referred to locally as the "The Bogies," offers an indoor, multi-functional facility serving the social and recreational life of communities within the Cabra area
- Cabra Health Centre- an HSE health centre within walking distance from Cabra West provides health services to the community
- The Local Drug Task Force play a key role in the community from an educational perspective in schools, at policy level, finding local initiatives that address issues of drugs etc.

Finglas- Assets

- A diverse range of local shops, all conveniently located within a mini-shopping complex in the community. These include a Centra, a pharmacy, a butcher, a pub, a beauty salon, a Euro shop, and a fast food (fish and chips) outlet
- Well-serviced by buses within and outside the community perimetres. This includes travel to the three large supermarkets (Tesco, Aldi and Lidl) that sit outside the community boundaries. The buses are regular, but not available 24 hours
- Several green spaces, including four fields and three large parks with amenities such as football fields and a clubhouse, children's playgrounds, and range of exercise equipment
- A 500m^2 community teen space funded by DCC, complete with granite benches and table tennis. Efforts are underway to establish internet hotspots in this area to provide a safe and comfortable space for young people to meet.
- Finglas Resource Centre, which offers a range of services, including support for suicidal behaviour, and a non-paying crèche for some (means tested)
- Well laid out community primary schools marked with pencil bollards, brightly coloured fences, and pavement activities such as hop-scotch to promote road safety and discourage drug activity
- Finglas Sports and Fitness Centre which offers a full range of services that cater to the fitness and sporting needs of the community including a six-lane pool, a basketball and tennis court, aerobic classes, and swimming lessons
- Participants however mentioned the excessive cost to utilise these services
- Wellmount Health Centre- HSE located in the middle of the SHCP area.

5 DISCUSSION

INTRODUCTION

This study has explored community perspectives on health among people living in the Dublin Sláintecare Healthy Community Programme areas of Ballyfermot/Cherry Orchard, Cabra/ Finglas, and Priorswood/ Kilmore West, taking an interpretive approach to understanding their health and wellbeing experience. To our knowledge, this is the first community assessment in Ireland that has used in depth qualitative methods to assess health need.

The communities' lived experience highlights the complex interaction between social determinants of health and health experience and brings into focus, a significant amount of unmet health needs that existing services do not fully address.

Six main categories of health and social needs were identified in the study, each with mental health as a significant component: amenities and social networks, sense of safety, family structure, environmental issues, illicit drug use and access to health care. Underpinning these categories, are three consistent themes running throughout; community disempowerment and lack of involvement in decision making; mistrust and lack of confidence in authority; and interventions offered which do not correspond with the health needs identified by the communities. Health experience is seen as being a product of deprivation, with communities feeling trapped in a cycle of poverty that they cannot break. Thus, actions are needed to address the cycle of poverty as well as to address the serious health challenges the communities face.

In terms of priority areas, mental health is an issue which cuts across all themes and all areas and should be considered as a priority area within the SHCP. It is particularly closely tied in with addiction. In addition, the health of young children is highlighted as a priority area. The importance of investing in young children is also underlined in the literature as key in improving long term health for young children growing up in disadvantage, but also from an economic perspective, as it can prevent significant expenditure on poor health in adulthood [52]. Ireland does have a National Policy Framework for children and young people (2023 – 2028) [53] which could feed into a systematic approach to national action on inequality going forward.

In addition, the communities identified a number of key community assets including services offered for youth empowerment, Garda projects with young people, and green spaces for example, as well as dedicated community workers and talented artists and creatives. They demonstrated great resilience and vision to see change happen and provided many examples of committed community members working hard to make a real difference on the ground. Members suggested innovative ways of building on existing assets, illustrating that they are well positioned to develop solutions that are appropriate and easily translatable in community settings.

Engaging and including the community voice in health and wellbeing research and initiatives is not without its challenges. Long term material deprivation, intergenerational cycles of poverty and historical feelings of being silenced, have played a significant role in shaping the views of the communities in this study. Additionally, we recognise that health literacy issues can impact on participation, as some community members may not know how to express their individual needs and seek support to maintain their health and wellbeing. Nevertheless, overcoming these challenges has provided rich and invaluable insights into community priorities. The findings challenge the assumption that using survey data or consulting with the community, constitutes meaningful participation in health needs assessment, and they support the argument for more in-depth qualitative approaches to assessing health need going forward.

POSITIONING THE FINDINGS WITHIN A PLACE-BASED APPROACH

Engaging directly with the community has uncovered key issues that impact on health experience on a day-to-day basis. The health needs identified are complex and inter-related, and cannot be resolved by short term behavioural interventions alone, but rather, need to be addressed through a holistic multi-sectoral approach [11,12]. The individual factors can be seen as part of a bigger picture of socio-economic inequality which spans health and wellbeing, economic opportunities, housing, education, environmental disadvantage, social networks and access to healthcare.

In principle, a place-based approach (PBA) to promoting health is well placed to offer a multi-sectoral approach to addressing the key issues identified, since it seeks to promote community empowerment, it underlines the importance of building trust, and it enables communities to participate actively in identifying health need [13,14]. Issues of disempowerment and mistrust, are currently barriers to the effective use of a PBA and addressing these issues, will be an important first step in ensuring that the SHCP areas can be used effectively going forward. One of the ways this could be addressed, would be for each SHCP area to produce an engagement plan, outlining exactly how communities will be engaged in decision making going forward. The plan should build on existing community assets, and the SHCP should ensure structures are in place to enable meaningful collaboration between the community and relevant stakeholders, to respond to community identified need and to support local capacity building. Involvement of the community in local decision making and addressing some of the more easily tackled issues identified in the short term would be a useful first step forward and contribute to trust building between the community and stakeholders in this respect. The development of a multi –agency plan that also addresses the trust relationship with Gardaí , using a co-design approach would further aid in improving relationships and foster a sense of trust between the communities and the local Gardaí . This is key as communities need to experience a sense of basic safety before they will feel empowered enough to contribute actively to improving their health.

Currently the SHCP offers the same suite of interventions across all SHCP areas and to date these have been developed without consultation with the communities concerned and are largely behavioural focused. Whilst behavioural interventions can be useful in improving health, they are not able to address the more complex embedded issues faced by these communities. Future SHCP interventions would benefit from a formal health needs assessment process that enables communities to contribute meaningfully to decision making regarding interventions required at a local level to ensure they meet community need.

A further consideration is that SHCP (and place-based approaches in general) tend to assume community, as a homogenous unit. In Ireland, the SHCP communities have been co-opted into a geographical community, based on areas of high deprivation but the individuals in these areas have not necessarily seen themselves as communities previously. Lack of a recognised shared identity or sense of belonging can influence how communities advocate for their needs and give their voice to issues that matter to them. This is evident in the Cabra and Finglas SHCP where Cabra has a significantly older population with quite different needs and assets, compared to Finglas, and in Priorswood and Kilmore West, two distinct communities, with Priorswood being much more disadvantaged compared to Kilmore West. There is a need to consider whether the areas identified, most appropriately lend themselves to becoming recognised communities and / or whether actions are needed to create community identity across the identified areas. With the latter, this may be most effectively achieved by treating the SHCP areas as having distinct communities within their boundaries, as opposed to attempting to create community identity across areas that have very different demographic characteristics.

In addition, there are communities within communities, and there can be a stark contrast in

the health needs across different groups within these geographical-defined communities. For example, the Traveller Community in these areas, have quite distinct needs and perspectives compared to other groups. However, this is not necessarily recognised in relation to the uniform health interventions that are being rolled out across the communities to all members in the same format. Going forward, each SHCP area should clearly identify the specific needs of different groups, and ensure interventions are available to meet the differing health needs identified.

To support all of this work, there needs to be a clear long-term commitment to funding. Keane et al. and O'Dwyer et al. suggest a medium to long-term funding commitment, is vital to the effective implementation and success of PBAs [13,54]. Whilst there is, indeed, ring fenced funding for the SHCP programme, to date this has been short term and in addition, other place-based services provided by DCC, such as youth services, also experience uncertainty year-on-year regarding whether or not funding will be secured for the following year. This results in unstable short-term employment for highly skilled community workers, difficulty in retaining good staff, it hinders project activities and puts key community support programmes at risk of failure. A medium to long term funding commitment would enable longer term planning for change, enable skilled staff retention, and provide a suitable framework for addressing many of the more embedded community issues such as addiction and drug use.

Similarly, PBAs cannot be measured meaningfully with short term key performance indicators. Thus, a longer-term Department of Health financial commitment to ensure there is time to build partnerships and trust with community members and enhance long-term sustainability of the project should be considered. This a crucial factor in its potential long-term success alongside identifying progress and outcome indicators that reflect improvements in social determinants of health as well as health outcomes.

METHODOLOGICAL CONSIDERATIONS

With community-based research, recognising the needs of different communities and being flexible with regards to methodological approach is key, and stands in contrast to top-down approaches, where particular information requirements dictate specific approaches. During the course of this study, we adapted some of the methodological approaches used as the study progressed so as to meet community need.

A decision was made to remove Photovoice as a method following the transect walks, for safety reasons. Due to the high incidence of crime and antisocial behaviour witnessed, including open drug dealing, taking photographs could have presented a personal risk to community members.

We found that it was crucial to identify groups within a community that may not typically engage, and to be flexible in accommodating their specific needs. Tailoring focus groups to explore issues related to drugs and addiction, the older population, and the needs of Travellers helped ensured that the health and social perspectives of diverse groups were adequately represented.

Finally, the participatory transect walks proved highly effective for both community members and workers in reflecting on and articulating the impact of their physical environment on health and wellbeing, as well as appreciating the existing assets in the community, and we would recommend these as an ideal starting point for any community-focused work.

Gathering community perspectives and being flexible to the community dynamics can however be resource intensive. While the data collection methods used in this study are straightforward, they do require time, resource and qualitative research skills, to harness meaningful engagement with the community, as well as significant time for analysing and

writing up research findings. In terms of building such an approach into day-to-day community work, it would be necessary to consider resource implications and examine whether a simpler methodology could be used that is less time and resource intensive. Such an approach could include providing training to community workers to reduce the need for external expertise to be brought in. In tandem with this, the value of a Local Development Officer or equivalent role, as a 'community enabler' is critical in gaining access to community members and community organisations. Their established rapport with the communities provides a critical link and without this, researchers would need significant time to identify community groups and build up trust, before being able to start fieldwork.

IMPLICATIONS FOR NATIONAL POLICY

We have emphasised the importance of the community voice in articulating health needs and addressing inequalities. It is important however to acknowledge, that the international evidence clearly underlines that while community voices bring tangible value to addressing health inequalities at a local level, many of the changes needed, require policy change at a national level. Marmot outlines how poor health outcomes among disadvantaged populations, both within and between communities are largely driven by the unequal distribution of power, income, and services which shape how people access healthcare and education, work environments, living conditions, and opportunities for leisure. He asserts that such disparities are the result of flawed social policies, unfair economic systems, and poor governance [16], and he is not alone in this. The need for policy change at a national level to tackle inequalities effectively, is well accepted among international experts in the field [17-19].

Given the strength of the international evidence, we therefore advocate for a co-ordinated approach to addressing inequalities nationally through a National Inequalities Strategy that addresses inequalities across multiple sectors. Indeed, there is a financial incentive to doing so. The Marmot review of health inequalities in the UK emphasises the economic benefit of reducing health inequalities on a national scale, through improving overall health outcomes, increasing tax revenue and reducing treatment costs [18]. The strategy would support local efforts undertaken as part of the SHCP to improve health and wellbeing, as well as providing a framework for the HSE, the LA and community organisations to work together locally, regionally and nationally to address SDOH, enabling a synergy of top-down and bottom-up approaches.

FUTURE RESEARCH

In light of the findings from this study, further research is needed to explore the value of the community voice and the impact of place-based approaches on improving health. Such studies could include, identifying how community perspectives can be incorporated into health needs assessment at scale nationally; undertaking a longitudinal (cohort) study to measure the impact of PBAs on health experience and outcome; identifying suitable SDOH measures that can be used to measure PBA impact; developing frameworks for measuring level and outcomes of community participation in local decision making; and exploration of the economic benefits of reducing health inequalities through PBAs. In addition, a process evaluation of the current SHCP, would provide useful insights into how it can most successfully be developed and rolled out in future years.

Finally, this study has not attempted to identify the most effective interventions for the different issues outlined. Indeed, for each issue, there is scope for further research to assess which interventions might be most appropriate in terms of Reach, Effectiveness, Availability, Implementation and Maintenance or Sustainability (The REAIM approach) [20,21]. Additional research would need to be carried out to identify which interventions may be most suited to these communities and within the context of a place-based approach.

6 CONCLUSION

Community engagement is an important component in assessing health need to enable a better understanding of community lived experience of their needs and priorities in order to improve population health [55]. Indeed, community empowerment cannot be achieved by 'telling' and 'doing for' the community. Rather, it is an outcome of active engagement with communities and is something particularly valued by the communities in question. Meaningful community engagement in health needs assessment, involves co-creating knowledge and solutions to the health issues, such that initiatives reflect the needs deemed as a priority by them as well as by health professionals. Currently there is no formal mechanism for engagement with communities as part of SHCP. Strengthening the role of the community voice in shaping how health and wellbeing needs are addressed and building on local assets to build local capacity is key to addressing health inequalities in these disadvantaged areas. However, local actions alone, are not sufficient to address inequalities. Meaningful policy change is needed at a national level and requires a focused, all-of-government commitment.

Reducing inequalities nationally is not just a matter of health and social justice, but will benefit the economy by enabling a fairer distribution of health and opportunities, so that every child and adult in Ireland has the opportunity to reach their full potential.

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