Supplementar	у				
Table S1 Main fi	ndings of the included studies Intervention Population	Intervention	Description of Public Involvement in Intervention	Sample Size and Demographics	Main Findings
Educational Inter Abba et al., 2019	ventions Residents and health and social care staff of Cheshire, England.	Part of the Cheshire Living Well Dying Well (CLWDW) programme. 'Awareness-raising' presentations aimed to raise awareness of the benefits of planning for end of life and talking about plans and preferences. Events were 60-90 minutes long. 'How to' workshops aimed to increase participants' confidence and skills to facilitate conversations with loved	Community not involved with the development or delivery of intervention. It was intended that participants acted as a "seed, spreading ideas within the population" (p. 9).	Attendees (n=676); completed baseline questionnaires (n=498); completed post intervention questionnaires (n=478); and completed follow-up questionnaires (n=141). Responders were predominantly female (76%), aged 45-74 (66%), retired (47%), living with a partner or spouse (60%), and resided in the least deprived quintile in England (49%).	Both educational programmes were well received and rated as highly relevant to respondents. Of those who completed all three parts of the survey, 84% indicated their intention to 'take action' post-intervention, and 64% reported 'taking action' at the 3-month follow-up; the most frequently cited action was engaging in discussion with family and friends. The interventions had limited success in encouraging participants to make a will, with only 2 participants doing so at follow-up.
Aherne & Pereira, 2008	Healthcare professionals and community leaders across Canada.	ones about their end-of-life plans and preferences. Workshops were 150-180 minutes long. The Pallium Project used the 3Cs (coordination, collaboration, and communication) approach to support a rapid scaling-up of learning and development interventions.	"Strategically engaging local clinical and service opinion leaders as active collaborators and champions (i.e., co-owners) in goal-directed (i.e., access, quality and capacity) change intervention, using the aforementioned Action Learning and Collaborative Inquiry approaches" (p. 243).	72 learning and development sub-projects, including but not limited to: 40 weekend courses (n=957); 7 1-day continuing education workshops (n=310); 2 cohorts completed Clinical Pastoral Education programme (n=not stated); monthly continued professional development audioconference (3337 instructional contact hours confirmed during first year); and	Paper synthesises the findings, learning, and recommendations from the 72 sub-projects of the Pallium Project (Phase II).
Bollig, Kristensen & Wolff, 2021	General public.	Last Aid Course comprised of four modules: (1) dying as a normal part of life; (2) planning ahead; (3) relieving suffering; and (4) final goodbyes. Each module lasted 45 minutes; all modules were delivered in a classroom setting over the course of one day.	Community not involved with the development or delivery of intervention. Feedback used to refine course content. Intended that participation would "empower citizens to recognise the need for palliative care and to participate in its provision" (p. 140.	resource development. 408 courses (n=6014); respondents included in analysis (n=5469). Majority of participants were female (87.9%), with a non-medical profession (90.6%), with a median age of 56 years.	Respondents were positive about the course; 75.8% rated it as "very good", 99% would recommend it to others, and 84.4% reported they had learned new things. Qualitative analysis reported five topics (1) atmosphere and surroundings; (2) the instructors; (3) course content; (4) effects of the course on the participants' feelings of views; and (5) suggestions for improvement.
Bollig, Meyer, Knopf, Schmid & Bauer, 2021	General public.	Last Aid Course comprised of four modules: (1) dying as a normal part of life; (2) planning ahead; (3) relieving suffering; and (4) final goodbyes. Each module lasted 45 minutes; all modules were delivered online over the course of one day.	Community not involved with the development or delivery of intervention. Feedback used to refine course content. Intended that participants would be empowered to support dying people at home.	15 courses (n=174); respondents included in analysis (n=92). No demographic details provided.	Respondents were positive about the course; 80% rated it as "very good", 100% would recommend it to others, and 98% reported they felt more prepared to encounter death, dying, and grief. Qualitative analysis addressed the pros and cons of conducting the course online.
Bollig <i>et al.</i> , 2022 Hagström, 202	General public. 1 Families affected by parental suicide.	Last Aid Course comprised of four modules: (1) dying as a normal part of life; (2) planning ahead; (3) relieving suffering; and (4) final goodbyes. Each module lasted 45 minutes; all modules were delivered over the course of one day either online or in a classroom setting. Weekend camps for families bereaved by suicide using psychoeducational techniques. Parents and children separately explored nine themes: (1) information about suicide and suicide bereavement; (2)	Community not involved with the development or delivery of intervention. Feedback used to refine course content. Intended that attendance would "empower people to contribute to end-of-life care in the community" (p. 1). Community not involved with the development or delivery of intervention.	8 courses (n=79); respondents included in quantitative analysis (n=53). Majority of participants were female (90%), with non-medical profession (57%), and a mean age of 60 years. Attended focus group (n=49). 14 families attended the camp. Of these, 11 families agreed to be interviewed. Majority of parents were mothers (82%); children (6 girls and 5 boys) were aged between 6 and 13.	Quantitative findings indicated that the course was well received; 98% rated the course as "good" or "very good" and 96% would recommend the course to others. Qualitative findings identified four themes (1) general opinions and impressions; (2) effects of the course; (3) cultural and national differences; and (4) need for adaptation? Results are structured chronologically from narratives about life before to life after the support programme, with meanings and changes highlighted.
Hill et al., 2020	Couples living with dementia.	the family then and now: what happened; (3) what has changed; (4) grief responses and emotions; (5) my grief/others' grief; (6) remembering the deceased parent; (7) what helps and how do I take care of myself; (8) questions I wanted to ask but have not dared; and (9) what is my future. Programme consisted of six sessions: (1) introductions; (2) affirming our relationship; (3) strength, resilience, and	"The participants played a major role in developing this program beyond its original conception" (p. 3).	3 couples.	All participants felt they gained something from the programme. In particular, participants valued connecting with others and being
Matthiesen et al., 2014	Community inhabitants.	change; (4) nurturing ourselves and our relationship; (5) what have we learnt about navigating change; and (6) celebration. Sessions were conducted in person and lasted 2 ½ hours (including break). Employed a four-stage asset-based community (ABCD) development approach. Case study 1 (Cumbria Conversations for Life): aimed to improve awareness about, and increase, advance care	The authors drew upon participants' reinterpretation of one of the activities to demonstrate this. "The process of facilitated community development follows the following four steps: getting started, coming together, action planning and intervention" (p. 2).	No demographic details provided. Cumbria: Radio and regional newspapers estimated to have reached 200,000 people. The website received 3645 visitors.	Findings present (1) the nature of the assets available in communities, and (2) the common priority areas for action (information, outreach, education, leadership, and sustainability).
Martins Pereira et al., 2018	religious activities of the parish,	their understanding of palliative care and pose questions; (2) education-intervention phase informed by phase one;	As part of Action Research cycle education-intervention responded to educational needs of community identified through preparatory phase.	11 workshops (n=93), majority female (79%). Merseyside and Cheshire: the activity undertaken across the region led to the participation of 143 organisations. Attended educational session (n=69); completed evaluation (n=67). 69% were teenagers, 12% parents, 16% catechists, and 3% community members.	The session was rated as "very good" by 71% of respondents, and 65% rated the education phase as "very good". Field notes indicated teenagers were open and had a positive attitude towards discussion with high levels of engagement.
Mueller <i>et al.</i> , 2021	the catechists and community members Non-medical hospital staff (although open to all hospital staff)	and (3) evaluation phase. Delivered over 3 hours in classroom setting. Last Aid Course comprised of four modules: (1) dying as a normal part of life; (2) planning ahead; (3) relieving suffering; and (4) final goodbyes. Each module lasted 45 minutes; all modules were delivered over the course of one day in a classroom setting.	Community not involved with the development or delivery of intervention. Feedback used to refine course content.	Course attendees (n=56); survey respondents (n=55). Majority of participants were female (90.9%), non-medical staff (67.3%). The sample was heterogenous with regard to age, profession, and patient contact.	Respondents were motivated to participate in the course to prepare for the emotional and medical aspects in care for the dying, and to gain knowledge in supportive services and facilities. Overall, respondents rated the course highly; 76.4% rated it as "good" or "very good", 99.1% would recommend it to others, and 87.3%
Patterson <i>et al.</i> 2022	, General public.	End of Life Aid Skills for Everyone (EASE) course consisted of four modules (1) an introduction to death in Scotland (2) serious illness and frailty; (3) realities of caring and dying; and (4) caring for the carer. Each module lasted 2 hours; course delivered flexibly (e.g., 2 hours per week for 4 weeks, or 2 modules over a morning/afternoon). In response to Covid-19 pandemic, EASE ONLINE introduced. Course delivered 3 hours per week for 4 weeks.	bereavement support, general practice, and palliative care nursing" (p. 2) which informed course development. Course content was refined following survey with general public and pilot study.	Survey responses (n=208); majority (80%) were from people who had supported someone informally at the end of life. Number of focus group participants not stated. No demographic details provided.	reported they had learned something. Findings from survey informed course content. The EASE course was piloted in two locations. Experiential evaluation found the course was well received. The course was revised in response to feedback to improve the course. Paper indicates that the EASE ONLINE course was well received but does not report the findings from the pre- and post-course questionnaires.
Paul <i>et al.</i> , 2019 Pereira <i>et al.</i> ,		Employed an Action Research methodology to develop a five-phase educational intervention: (1) preparation and	Used an Action Research methodology which "is a developmental process in which participants resolve the issues in question" (p. 3) in order to develop knowledge and practice. "Pallium positions itself as a Knowledge-to-Action broker () [that] brings together palliative care subject matter	Hospice (n=22); School 1: staff (n=7), children (n=21), parents (n=4); School 2: staff (n=6), children (n=12). No demographic details provided. From 2015-2019, 1603 courses were delivered.	Three action areas were identified, (1) raising awareness of hospice care and end-of-life care issues more broadly; (2) education and training; and (3) providing leadership in death education and bereavement. Phases 4 (pilot) and 5 (evaluation) were ongoing at the time of publication. Paper summarises (1) main findings from programme evaluation and impact research (2) success factors and spread accelerators; and
2021	was only available to community- based primary care professionals. Since 2014, versions for different settings, services, and specific disease groups have been made available	care competencies. Course (classroom) consisted of the following modules: (1) self-awareness; (2) taking ownership; (3) decision-making; (4) advance care planning and goals of care; (5) essential conversations; (6) pain; (7) dyspnea; (8) nausea and GI symptoms; (9) psychosocial and spiritual needs; (10) delirium; (11) last days and hour; (12) palliative sedation; and (13) quality improvement. Originally delivered as a 2-day workshop.	experts from across the country to identify best practices and evidence and synthesise and spread them to health professionals" (p. 2).	A total of 28,123 learners have participated in LEAP courses from 2014-2019. Nurses make up the largest proportion of learners (55.3%), followed by physicians (14.3%), and paramedics (12.9%). In response to Covid-19 pandemic 103 online courses were delivered to 1979 learners. Additionally, 25 webinars (average 288 registrants) which addressed emergent pandemic-related topics were delivered.	(3) challenges and barriers.
Plunger <i>et al.</i> , 2015	People living with dementia who access participating community pharmacies.	Three workshops were conducted with key stakeholders to review their needs. In phase two, pharmacies will carry out small-scale projects to increase the wellbeing of people living with dementia	Based on Participatory Health Research approach, "the core elements of the approach are participation, action and reflection" (p. 140. Phase two (in progress) involved implementing small-scale "community outreach" projects.	40 staff (almost exclusively women) in 18 pharmacies actively participate in the project. Focus groups with caregivers of people with dementia (n=9); interviews with caregivers of people with dementia (n=not stated). No demographic details provided.	Pharmacists reflected upon the unique affordances and challenges supporting people living with dementia in the semi-public environment as well as identifying areas of professional development. People living with dementia identified different obstacles to care based on whether they lived in an urban or rural location.
Prince <i>et al.</i> , 2019 Tieman <i>et al.</i> ,	Community inhabitants. General public.	Paper focuses on community educational strategies of the End-of-Life Care in First Nations Communities (EOLFN) Project. Initiatives unfolded in three phases: (1) assess educational needs in each community; (2) develop recommendations based on the findings; and (3) develop and implement educational resources in response to identified needs. Course consisted of four modules: (1) how we engage with death and dying; (2) representations of death; (3) if	"Consistent with the PAR [Participatory Action Research] approach, all aspects of the research and palliative care program development were controlled by community members" (p. 4). S Community not involved with the development or delivery of intervention.	Surveys (n=94), respondents were aged between 30 and 60, the majority were female (94%). 62 focus groups and interviews (n=185) with community members, Elders/Knowledge Carriers, and external health care providers. Enrolled in the Dying2Learn MOOC (n=1156), completed some content or activity (n=895),	Findings are organised using the following headers, (1) educational needs of clients and families; (2) educational needs of First Nations community; and (3) education needs of Canada's health care system. Paper also summarises community-led initiatives developed to address the educational needs identified in the community assessments. Findings indicated the course was well received; 96.5% reported the course was enjoyable, 94.5% would recommend to others, and
2018 Zuniga-	Bereaved inhabitants of city.	death is the problemis medicine the answer; and (4) digital dying. Content was delivered online over six weeks (four modules plus introduction and reflection sessions). Session was divided between (1) psychoeducation covering topics related to loss, grief, and bereavement; and (2)	It was intended participation would "build community engagement with death and dying" (p. 2). "The grief and bereavement support program emerged from within the community; recently, a local palliative care	completed the MOOC evaluation at both time points (n=208). The majority of those enrolled were female (92.1%); aged 40 and over (78.2%); self-identified as a health professional (68%); resided in Australia (94%). New attendees registered (n=827).	91.2% agreed the course gave them a deeper understanding of death. There was a statistically significant increase in agreement with the statements "death is a normal part of life"; "I am comfortable talking about death/dying"; and "social media provides different perspectives to mainstream media on death/dying" following participation in the Dying2Learn MOOC. Most common reasons for attending the programme were personal experience of loss (69.5%) and wanting to learn about grief (23%).
Villanueva et al. 2021 Cultural Interven Marsh et al.,		discussion of personal loss. Delivered as weekly 2-hour sessions. Adopted a Participatory Action Research framework which consisted of: (1) information evening; (2) four "weaving convergations" sessions facilitated by an artist based on the themes of death and new life; and (3) a one-day		Information session (n=23); weaving conversations (n=19); one-day workshop (n=36); interview	Most frequent type of losses were the death of a partner (30.1%), death of a parent (14.3%), and death of a child (8.4%). There was no statistically significant difference between the types of losses among men and women. Themes identified (1) "Conversations" - the need to talk about death and dying; (2) "Informal caring" - the need to be with others in the time of death and grief to give and receive support; and (3) "Community gardening" - needing toil tea, and tranquillity.
2017 McLoughlin et al., 2016	Community inhabitants.	conversations" sessions facilitated by an artist based on the themes of death and new life; and (3) a one-day workshop to develop the garden. Sessions were held over the course of three months. The World Café approach was used to organise themed discussions about the importance and challenges thinking and talking about death, dying, loss and care. Discussions were supplemented with presentations and short films. Events were delivered in person and lasted 2 ½ hours.		(n=5); focus group (n=9). No demographic details provided. Attended information session (n=74); completed evaluation (n=51). Respondents were predominantly female (84%) with a mean age of 55.6 years.	time of death and grief to give and receive support; and (3) "Community gardening" - needing toil, tea, and tranquillity. All respondents would recommend Café Conversations to a friend. Statistically significant post-Café improvements were observed in all key domains, with the exception of participant's' self-rating of difficulty discussing death, dving, and bereavement.
Richards et al.,	O General public. General public.	issues pertaining to palliative care. Death Café – 'pop up' events where people meet informally to discuss aspects of death and dying.	Intended that intervention would "support both professional and community capacity for end-of-life care" (p. 252). Death Cafés are framed as opportunities to "engage in death talk" (p. 32) but "should not be used as a method of	Death café organisers (n=49).	difficulty discussing death, dying, and bereavement. The #PallANZ hashtag enabled interaction between 25 participants, who posted 230 tweets generating close to 750,000 impressions, followed by 55 participants sharing 107 tweets resulting in a further 210,000 impressions over the next 24 hours. A second chat involved 32 participants posting 256 tweets, followed by 67 participants sharing 120 tweets in the subsequent 24 hours. Findings organised into the following sections, (1) how international is the Death Café movement? (2) who are the organisers and who are
2020 Service Intervent		Official guidelines stipulate that Death Cafés operate (1) on a not-for-profit basis; (2) with no intention of leading participants to any conclusions, product or course of action; (3) as an open, respectful, and confidential space; and (4) that food and refreshments are served. The Health Connections Mendip employed the following process: (1) patient identification; (2) goal setting and care	community consultation or engagement" (p. 5).		the attendees? (3) international variation in the Death Café form; (4) why organisers think Death Cafés are needed; and (5) the perceived effects, beyond the event itself. There was a progressive reduction by 7.9 cases per quarter in unplanned hospital admissions across Frome: a decrease of 14%.
Abel <i>et al.</i> , 201 Abel & Townsend, 201	criteria, including anyone giving "cause for concern". Carers of hospice patient.	The Health Connections Mendip employed the following process: (1) patient identification; (2) goal setting and care planning; (3) enhancement of naturally occurring supportive networks; and (4) linkage to community resource. Delivered from April 2013 to December 2017. Volunteer Community Champion (VCC) were recruited from Hospice pool of volunteers (i.e., carers group, bereavement support group, befrienders) and received training that included but was not limited to communication bereavement, end of life, boundary setting.	without always involving health and social care services" (p. e808). Community Development was used to "start to develop naturally occurring supportive networks" (p. 17).	Somerset and 9885 in Frome. No demographic details provided.	There was a progressive reduction by 7.9 cases per quarter in unplanned hospital admissions across Frome: a decrease of 14%. In comparison, there was a 28.5% increase in admissions per quarter within Somerset. Cost of unplanned admissions in Frome reduced by 20.8% between 2013/14 and 2016/17. Paper provides descriptive summary of key outcomes and reflects upon the lessons learned implementing the programme.
Aoun <i>et al.</i> , 202	O Adult patients with advanced illness(es)/ palliative care needs.	VCCs were matched with carer of hospice patient with the aim to provide emotional support, network development and bereavement support. Volunteer Compassionate Communities Connectors (VCCC) will attend a 2-day training programme delivered by content experts. VCCs will be matched with vulnerable older adults with the aim of mobilising their network of Caring Helpers	Intervention framed as a "community-led" (p. 1) "partnership between the community and the palliative care service" (p. 8). Intervention relied on community volunteers, but community members were not involved with intervention design.	No demographic details provided. Proposed sample size of 10 VCCCs and 30 patients/families.	Not yet available.
Bruce <i>et al.</i> , 2021	Community dwelling older adults with advanced chronic illness.	(friends, family, and neighbours willing and able to provide instrumental support). VCCCs will visit/telephone the client a minimum of six times over the course of three months. Part of the Nav-CARE (Navigation – Connecting, Accessing, Resourcing, Engaging) programme (see Pesut et al., 2017, 2020). Volunteers are trained and matched to client(s) with the aim to connect them with persons, resources, and services	Level of public involvement unclear. But frames programme as "working in collaboration with patients, families and communities" (p. 572).	Clients (n=23), majority female (73.9%) living at home (60.9%) with mean age 72.06 years. Volunteers (n=33), majority female (84.4%), with mean age 64.81 years.	Paper reports three themes (1) pandemic emotions; (2) negotiating social interactions; and (3) growing through the Covid-19 pandemic.
Cronin, 2015	Practice population of Stretton Medical Practice identified to be in greatest need.	in the community to improve their quality of life. Volunteers visit client(s) every two weeks for 1-2 hours. Compassionate Communities (Co-Co) in Shropshire matched Community Volunteers with older person identified as being at risk of loneliness and/or social isolation. The type of support and frequency of contact is agreed between volunteer and client and is regularly reviewed.	Described as a "locally derived model developed in response to feedback from frail and vulnerable people" (p. 31). "It is not a service provided by an organisation but rather a community development supported by Severn	Compassionate Community Developments (n=14); Community Volunteers (n=80); clients (n=38). No demographic details provided.	A year after commencement of the programme an audit of outcomes was undertaken. Total visits to practice, total phone calls to family doctor, total A&E admissions, total hospital admission, total calls to/visits by out-of-hours services decreased over the 6-month period following deployment of volunteers.
Howard <i>et al.</i> , 2018	Adults living with disabilities in the catchment area(s).	A community facilitator will coach individuals to identify needs and priorities, and link with resources.	Hospice working in partnership with local medical practices" (p. 33-4, emphasis in original). Level of community involvement unclear. States "intervention aimed at reducing social isolation by mobilizing individuals to act on their health and social needs individually, and in collaboration with fellow members of their community".	Proposed sample size of 1000 participants.	Total planned hospital admissions increased. Not yet available.
Librada Flores et al., 2018	Residents of Saville with an advanced or terminal illness,	Prisoners are trained, after which they are gradually introduced to join teams in caring for patients in the hospice wards. Volunteers work up to 8 hours a day for no payment. From 2003-2008 project limited to one hospice in Gdansk but has since expanded to other hospices in Poland. REDCUIDA (part of the All With You programme) intervention will match a Community Promoter with person living with advanced illness and/or their families to identify unmet needs and mobilise support network(s). The intervention will be delivered in person over seven weeks.	Programme stemmed from community observation. Authors state, "we are exploring further the foundation of our practice experience with community development, policy reform and social and political change" (p. S112). Intervention relied on community volunteers, but community members were not involved with intervention design. Seeks to address unmet patient needs "through mobilisation of the community" (p. 2).		93% of survey respondents agreed that prisoners should have opportunities to work in places like hospices. The qualitative research identified differences in how prisoner-volunteers relate to the world, to others, and to themselves compared to prisoners who had not volunteered. Not yet available.
McLoughlin et al., 2015	are receiving palliative care supervision, and identified as having unmet needs. Community dwelling adults with advanced life-limiting illness in Limerick.	In accordance with MRC Framework for the Evaluation of Complex Interventions the INSPIRE study (part of the Good Neighbour Partnership) will be completed in three phases: (Phase 0) explore relevant theory and evidence to inform intervention development; (Phase 1) identify components of intervention and the underlying mechanisms;	Described as a "volunteer-led model of social and practical care/support for community dwelling adults living with advanced life-limiting illness" (p. 3). Intervention relied on community volunteers, but community members were not involved with intervention design.	Proposed sample of 10 CVVs and 80 community dwelling adults living with life-limiting illness.	Not yet available.
Pesut <i>et al</i> ., 2017	Clients had to be over 55 years of age and have one or more	needs and mobilise community-based resources and supportive networks.	Study followed a "community-based research approach" that included advisory committee (representation from hospice societies and allied professionals) to guide project.	Volunteers (n=7); all female, mean age of 60 years. Clients (n=18); majority female (n=10), mean age of 70 years.	Volunteers dedicated 378.4 direct contact hours visiting clients engaged in multiple activities with clients. Including but not limited to, facilitating greater connection with others, signposting to services and resources, and engaging strategies to assist clients to engage
Pesut et al.,	advanced chronic illnesses that could reasonably lead to death within the next year. People living with advanced	Volunteers visited client according to client preference (typically every 2-3 weeks) over 12 months. Expansion of Nav-CARE programme to eight community-based hospice societies.	Intervention relied on community volunteers whose feedback has been used to refine programme training materials. Described as a "volunteer-led navigation intervention" (p. 3).	Clients (n=49); family (n=38); volunteers (n=38); stakeholders from healthcare and hospice settings	more fully in life. Overall, there was high degree of satisfaction particularly in supporting clients over the long term. Clients reported volunteer navigators had transformed their illness experience. Both clients and volunteers expressed some uncertainty over the meaning of 'navigation activities'. Key contextual factors that determined the ease with which Nav-CARE was implemented included (1) the individual skills and
2020 Pfaff <i>et al</i> ., 202	illnesses who accessed the participating hospice societies. 1 People with chronic disease, people living in social isolation,	Volunteers are recruited, trained, and matched with clients to identify unmet care needs, mobilise community-based resources and supportive networks, and support client with desired activities. Volunteers visit clients in person every 2-3 weeks. The planned action cycle was 12 or 18 months, depending on site. Vulnerable Persons Project (part of Windsor-Essex Compassion Care Community) oversaw staff and volunteers assist clients to identify their own personal needs, goals, and preferred intervention.	Intervention relied on community volunteers, but community members were not involved with intervention design. Study builds upon findings from pilot studies. WECCC "is a collective of volunteers and 65 health/social care organisations that partner in identifying and reducing the unmet needs of persons living with complex health and social issues" (p. 2).	No demographic details provided. Focus group with clients (n=5); interview with clients (n=3); stakeholders (n=16). No demographic details provided.	characteristics of the volunteer coordinator champion; (2) organisational capacity and connection; (3) the successful recruitment of older persons; (4) the adequacy of volunteer preparation and mentorship. The findings are presented in the following sections: (1) participant characteristics; (2) intervention characteristics; (3) programme processes - taking time, advocacy, and empowerment; and (4) impacts and opportunities for improvement.
Riley <i>et al.</i> , 201	older people. 8 Bereaved people who had accessed Weston HospiceCare.	Intervention varies from in person consultations with fully integrated health and social care supports, to scheduled calls to assess client goal setting and quality of life. Clients are never discharged. Peer-led bereavement support for carers of palliative care patient. Meetings happen monthly for two hours; it has no structured therapy sessions.	Intervention relied on community volunteers, but community members were not involved with intervention design. Aligned with "participatory development" where "the hospice had a role in facilitating this process rather than leading it" (p. 69).	150 bereaved people have attended Buddy Groups. No demographic details provided.	Buddy Groups have been self-sustaining with bereaved participants taking on facilitation and organisation roles. In addition to monthly meetings, the group also go on social outings (e.g., cinema, day trips, coffee mornings).
Ummel <i>et al.</i> , 2021	People bereaved by Covid-19 complications or during the Covid-19 pandemic.	Online support group for bereaved people based around: (1) education and training; (2) hospices and nursing homes; (3) media and social media; (4) commemoration; (5) celebrations; (6) artistic practices and storytelling; (7) marginalised populations; and (8) review and evaluate.	Group developed in response to community needs and delivered by Hospice. Facilitation has since been assumed by former carers. "The overall research design was informed by participatory research approach, which emphasises research as a collaborative, practical, emancipatory, critical, and reflective social process between the researchers and participants" (p. 3). Activities were co-constructed with community members.	Community participants (n=35). Majority of participants were married (57,1%), Canadian (86%) women (88.6%) bereaved by parental death (71%). Majority of deaths occurred in hospital (65.7%) caused by Covid-19 (71.4%).	Participants valued having people outside of their family to talk to and to empathise with their experiences. Paper reflects upon the eight areas of activities co-constructed within the intervention (see 'Intervention').
Walshe <i>et al.</i> , 2016	Adult patients identified to be in the last year of life and their self-identified informal carer.	End-of-Life Social Action Study (ELSA) protocol. Volunteers will be trained and provide support (befriending, signposting, practical assistance) to people identified to be in their last year of life. Support will be provided 1-3 times per week in person or by telephone. The trial will last 8 or 12 weeks, but support	Intervention framed as a "social action volunteer befriending service" (p. 3) for adults in the last year of life. Intervention relied on community volunteers, but community members were not involved with intervention design.	Only 17.1% had been able to hold in-person commemorations. Proposed sample size 350 participants per arm.	Not yet available – see Walshe et al (2016) below.
Walshe <i>et al.</i> , 2016	Adult patients identified to be in the last year of life and their self-identified informal carer.	may continue beyond this. ELSA Study: volunteers trained and provided support (befriending, signposting, practical assistance) to people identified to be in their last year of life. Support was in response to client needs but was typically once a week for 1-3 hours. Intervention duration was eight weeks, although support could continue beyond this.	"The content (coping strategies to maintain wellbeing) and chosen delivery mechanism (via trained peer mentors) are derived from our previous qualitative study" (p. 2). Intervention relied on community volunteers, but community members were not involved with intervention design.	Participants were recruited from all 11 sites (range 3-40 participants per site). Participants mean age	No statistically significant difference in effectiveness between volunteer provided support and 'treatment as usual' (control). There was however a pattern of deteriorating levels of quality of life in the control group, a decrease not observed in the intervention group, and which tended to disappear when all received the intervention.
Walshe <i>et al.</i> , 2020	Adults living with advanced cancer and their family/informal carer.	r Peer mentors attended 2-day training and were matched with patient participants. Support was delivered either in person or by telephone in response to need. Typically volunteers met with clients 1-2 times per week (capped at 2 hours) for up to 12 weeks.	Intervention framed as a "social action volunteer befriending service" (p. 2) for people in the last year of life. Intervention relied on community volunteers, but community members were not involved with intervention design.	Intervention (n=8); control (n=10); peer mentor (n=12). Interviews conducted with clients (n=4); carers (n=2); mentors (n=7). Majority of patients in control (67%) and 50% of patients in intervention group were male, with mean age of 69.6 and 64.8 years respectively. All participants were British and most (75%) were married and living with together with no children.	Peer mentor recruitment and training met feasibility targets. Patient participants were not recruited to feasibility targets. Outcome data must be treated with extreme caution due to small numbers but indicate the intervention may have a positive effect on quality of life.
Wang <i>et al.</i> , 2020	Adults aged 18 years and above willing to complete training and provide 6 months' care in specific communities for end-of-life patients and their families.	The following phases were followed (1) recruitment and motivational screening; (2) training; and (3) evaluation of training effects in building volunteers' confidence providing end-of-life care (EoLC).	"The transformative sustainability-learning framework was adapted to guide the development of the four-step capacity building program" (p. 410) for volunteers in EoLC.	Majority of peer mentors were female (67%), British (91.7%) with an average age of 60.8 years. Recruitment enrolment (n=171); eligible participants after motivational screening (n=92); participants who join the training and complete pre-test (n=88); participants who complete training and post-test (n=81); participants who complete 6-month follow-up test (n=56). Majority of course attendees were female (74.7%), nearly 60% were aged 50-69 years, and more than half were retired or unemployed.	Competence in EoLC, awareness of self-care, and death work competence all significantly improved after training and remained intact at 6-month follow-up.
Warner <i>et al.</i> , 2021	People living with advanced illness.	Nav-CARE study delivered in eight sites across three Canadian provinces. Volunteers attended a 2-day training course and then matched with older person to provide support and help them navigate community services. The precise frequency and timing of visits was negotiated with the client.		Participants (n=16) included, hospice staff, volunteers, advisory committee members, and community stakeholders. No demographic details are provided.	Five themes are reported, (1) intraorganizational perceptions of Nav-CARE; (2) public and healthcare professionals' perceptions of palliative care; (3) interorganisational partnerships and relationships; (4) community and national-level factors that should have facilitated Nav-CARE implementation; and (5) suggested changes to Nav-CARE.
Clinical Intervent	2 Parents of children receiving	Drew upon two established bereavement support programmes as they responded to the Covid-19 pandemic: (1) the Bereavement Supporter Project which provided peer support for bereaved people living within ExtraCare Charitable trust, and (2) Cruse Bereavement Care's national support service. The Carer Support Needs Assessment Tool was adapted for use with parent caregivers.	Bereavement Supporter Project sought "to develop the capacities of communities to support friends, neighbours, and family members through "normal" processes of grief" (p. 4). Goal of study was to "obtain feedback [from parents] regarding their experience using the CSNAT (Paediatric)" (p.	43 diary entries were submitted. No demographic details provided. 28 parents completed the intervention, all of whom were interviewed.	Themes identified (1) when only physical presence will do; (2) talking and remembering on hold; (3) absence of forward momentum; (4) virtual spaces of bereavement support; (5) re-collectivising bereavement; and (6) welcome respite from "mandatory happiness". Five themes were identified (1) caregiving challenges, perceived gaps, and feelings of isolation; (2) practicality and usefulness of the
Daddow & Stanley, 2021	palliative care Patients accessing palliative care.	Parents used the tool either independently or in discussion with health professionals to identify their unmet needs and develop an action plan. The tool was completed a second time 2-8 weeks later. 'Heidi's Have a Go' programme supported patients to pursue unique experiences and 'have a go' at something they have longed to do.	321). "It is a uniquely patient-led program in a regional locale, providing non-clinical, informal environments with no prescribed schedule nor outcome, positioned within an integrated model of palliative care" (p. 533).	The majority were female (93%), were married/de facto married (82%), and aged between 27 and 55 years old. Survey (n=10) and interviews (n=4) with staff/volunteers who had participated in the programme. No demographic details provided.	systematic assessment; (3) emotional responses to self-reflection; (4) validation and empowerment; and (5) receiving support responsive to their needs. Staff reported that the programme had helped them understand patient priorities (90%) and needs (70%); 60% noticed changes to patients' physical wellbeing and 70% noticed changes to patients' emotional wellbeing.
Stanley, 2021 Stanley & Daddow, 2022	Patients accessing palliative care.	There is no predetermined schedule of activities but instead responds to patient requests.	Intervention "features no pre-determined programme activities and responds to individual and family requests as they emerge from conversations with clinical, allied staff and volunteers" (p. 4).		Three themes are reported (1) privileging the whole person; (2) strengthening networks of care; and (3) shifting the balance of power in care relationships. Three themes are reported (1) providing respite from a medicalised focus; (2) nurturing emotional processing and legacy; and (3) altering perceptions of palliative care.
Multi-dimensiona Gómez-Batiste et al., 2018		There is no predetermined schedule of activities but instead responds to patient requests. The full extent of intended and/or completed activities is unclear. Paper focuses on cultural and educational activities.	"A group of eight organisations composed the "core nucleus" of the project, helped in the design of activities, and met regularly to follow up" (p. S34). The "core nucleus" then partnered with community organisations who committed (to various degrees) to "establish	Organisations registered (n=48); attended training course, workshop, or activities (n=1470). No demographic details provided.	The training was well received by the 51 attendees who completed the survey. SWOT analyses informed programme changes for the 2nd year.
2021 Grindrod &	OSPN coordinating committee. Community inhabitants.	Study is part of the Healthy End of Life Project (HELP) Ottawa, a community-based participatory action research project to build the community capacities needed to form, maintain, and sustain Compassionate Communities. This paper focuses on community consultation with LGBTQ2S+ people as part of phase one of the project. Study is part of HELP which seeks to build the community capacities needed to form, maintain, and sustain	policies and protocols to promote positive attitudes and volunteer proposals in their organisations" (p. S35). HELP is a "community-based participatory action research project" (p. 2). Study was part of an "initial community consultation" that sought to "centre the voices of LGBTQ2S+ people from the outset of this larger project" (p. 3). The Ottawa Charter for health promotion, "a public health standard for shaping and creating health through	Focus group (n=9).	Themes identified (1) many of us are survivors of trauma; (2) 'where can I go that is safe'? Creating our own safety; (3) 'connection is very important': disrupting ageism and stigma; and (4) asking for - and receiving - help. Themes identified (1) social norms can be unhelpful; (2) social interactions can undermine community capacity; (3) vulnerability can be
Rumbold, 2018	, , , , , , , , , , , , , , , , , , ,	Compassionate Communities. The enquiry was carried out in three phases: (1) investigated individual and community experiences of providing end of life care; (2) literature review to establish an evidence-based framework for HELP; (3) project implementation and evaluation. At the time of publication phase three was ongoing; paper focuses on phase one.	participatory action" (p. S75) was used as the organising framework for HELP.	attending community meetings (n=16). No demographic details provided.	engaged constructively; and (4) community culture needs to be collaborative.
Hasson <i>et al.</i> , 2022	Inhabitants of city.	The Getxo Zurekin initiative consisted of four iterative, non-linear phases, based on the social innovation spiral concept: (1) listening; (2) co-creation; (3) modelling; and (4) constant evaluation. Paper focuses on phase one.	Project applies "community action model" where co-creation and development of actions rely on the close involvement and constant participation of community members" (p. 8).	16-90 years. Phase Two (co-creation) has led to talks/workshops (n=1442); Death Cafés (n=387); training courses (n=497); conferences (n=5020); telephone support (n=18 families). Phase Three (modelling): the identification of new ideas that would meet community needs were followed by collaborative development.	Main ideas identified from interview data included: (1) services cannot reach and attend to the needs of everyone in end-of-life situations; (2) healthcare and educational professionals lack specific training to care and support people at the end of life; (3) stigma around help seeking; and (4) social care structures do not take advantage of people in the community.
Hazelwood & Patterson, 2018	General public.	Good Life, Good Death, Good Grief (GLGDGG) is an alliance that seeks to engage, support, and enhance the assets of communities, organisations, and individuals who have the potential to improve the experience of death, dying, and bereavement in Scotland. GLGDGG has built a portfolio of community-driven initiatives in addition to providing infrastructure, developing	"GLGDGG is non-prescriptive in its approach, aiming rather to provide a sounding board to build capacity and inclination of individuals and organisations to undertake the change they think needs to happen in their local area" (p. S101).	Phase Four: mechanisms in place to continuously monitor activities. As of November 2017, GLGDGG has over 1100 members – 800 individuals and 300 organisations.	Paper explores the key challenges and successes to implementation.
Horsfall <i>et al.</i> , 2020	General public.	resources, and coordinating promotions and events. The GroundSwell Project launched two Compassionate Communities projects (The National Compassionate Communities Forum and the Nepean Blue Mountains Primary Health Network) that have been combined here. The projects employed multiple intervention strategies including current needs assessment, educational workshops and seminars, discussion and support groups, organisational partnerships, cultural events, and volunteers to signost local end-of-life services.	"Both projects were underpinned by a strong ethos of community development work where building capacity of people to work together and take collective action to address their common needs and interests is central (p. 11, emphasis in original).		Paper organised into two themes, (1) resistance and struggle; (2) what does it take to do this work? Each theme consists of multiple subthemes.
Horton <i>et al.</i> , 2015	Inhabitants of city.	signpost local end-of-life services. The Cheshire Living Well Dying Well (CLWDW) programme employed multiple intervention strategies including public health partnerships; resource development; public education; care mobilisation through informal help or formalised volunteering; and workplace initiatives.	"The vision of the programme is driven by an underpinning belief that palliative care services have a role to play in the empowerment of people and that a community development approach releases assets 'into' and 'out' of communities. A drive for knowledge transfer on many levels is key" (p. 66).	CLWDW Champions (n=176); events (n=64); attendees (n=676). No demographic details provided.	Range of bespoke courses and resources have been developed. Community sessions have changed perceptions about death and dying and encouraged 60% of attendees to have conversations about their end of life wishes or made some other change post-session. Challenges identified: (1) organisational change within the NHS (National Health Service) and local governments; (2) leaders feeling overwhelmed; and (3) healthcare professionals struggled with concept of public health end of life and so were resistant to the
Kelley <i>et al.</i> , 2018	Community inhabitants.	The Improving End-of-Life Care in First Nations Communities (EOLFN) Project was a six-year participatory action research project which employed a four-phase community development model: (1) having necessary antecedent community conditions; (2) experiencing a catalyst for change; (3) creating a palliative care (PC) team; and (4) growing the PC program.	Using PAR, "each community developed their own PC [palliative care] program into existing health services. Each community created an Advisory Committee that ensured development was consistent with their visions, community capacity and context" (p. 13).	Surveys (n=94); interviews/focus groups with community members (n=82), elders/knowledge carriers (n=68), and external health care providers (n=35). No demographic details provided.	programme. Findings presented in three sections, (1) summarises community needs assessment; (2) outcomes to guide development of PC programs in First Nations communities; and (3) outcomes to guide policy and planning.
Librada Flores et al., 2018	Inhabitants of city.	"All With You" programme was developed in accordance with the Compassionate Communities Charter to meet the needs of people living with advanced illness or are at the end of life. The process was designed in four phases (1) systematic review of literature and methodology; (2) creation of centra office and observatory; (3) creation of a living lab and demonstration project to test and check the methodology; and (4) replication within other organisations and cities.	All With You method was "co-developed by members of the team including representatives from the leading community partners and the NHF [New Health Foundation] team" (p. 5). Team identifies community partners to commit to implementing a "compassionate-driven initiative" (p. 5) within their community and support the design, implementation, and evaluation processes.	City Hall, along with 42 organisations representing the corporate, public, and non-profit sectors, have committed to the movement. Awareness programmes have reached 16,077 members of the public; 4040 children; 270 university students; 1420 caregivers; and 95 trained health professionals.	Paper summarises (1) the development of the eight-phase "All With You" Method; (2) preliminary findings and learning from the pilot study in Saville; and (3) the current progress of 9 Compassionate Communities initiatives following "All With You" protocol.
Lindqvist & Tishelman, 201 Liu <i>et al.</i> , 2022	Variety of publics. 6 Community inhabitants.	The Döbra programme seeks to diminish avoidable suffering related to dying, death, and bereavement. The aims are aligned with four facets of the Ottawa Charter: (1) to strengthen community action and develop personal skills; (2) to create supportive environments; (3) to build public policies to support health; and (4) to reorientate health services. The Compassionate Communities in Taipei project is informed by the Compassionate Communities Charter.	Döbra combines Action Research, experience-based co-design, and knowledge exchange which "all aim to bring together a variety of stakeholders to exchange ideas and expertise, and co-create experience-based evidence through knowledge generation, dissemination, and sharing" (p. 21). The project "constructed a public-private framework by connecting government agencies, communities, social	Not stated. 'Life Issue Café' events held in 2018 (n=4), attended by older people (n=27) and students (n=60).	Paper identified some of the Döbra Projects, which includes but is not limited to: the development of the first Advanced Care Planning programme in Sweden; community awareness and competency-building; the Room for Death project; and using photographs and interview quotes to compile 'trigger films' that will be used in workshops to elicit discussion among patients, caregivers, and staff. Questionnaires from 'Life Issue Café' events found respondents believed it was important to talk about death matters (84.2%/90.9%) but
McLoughlin, 2013	Inhabitants of cities.	Four implementation strategies were employed: (1) humanistic care; (2) social network; (3) holistic care; and (4) the wisdom of life and death. Milford Care Centre's Compassionate Communities Project employed a three-strand framework aligned to the Ottawa Charter: (1) whole population approach through the distribution of information and resources,		No demographic details provided. There are now 20 Compassionate Communities across the 12 districts of Taipei city. See key findings.	that it was difficult to do so (78.9%/90.9%). Paper identifies the following to be important for developing Compassionate Communities: (1) glocalisation; (2) collaboration, partnership, and integration; (3) communication and public education; and (4) local culture and religion. This is a comprehensive interim evaluation report, findings are organised into the following sections: (1) social media, printed media, posters, radio, tv; (2) leaflets, website; (3) programme events; (4) training programmes; (5) grant scheme; and (6) community mentor
Patel, 2015	Community inhabitants.	and development of marketing/PR strategy; (2) engaging and supporting communities through educational programmes, seed grants, public events; and (3) Good Neighbour Scheme. Compassionate Communities in Sandwell employed multiple implementation strategies including education and raising awareness; community and organisational engagement; supporting individuals and carers to utilise support from their networks; and training Compassionate Communities Champions.	"Murray Hall's community development approach is to encourage and foster solutions to inequalities found in the		programme. Study describes overview of activities, learning, and challenges.
et al., 2021	Community inhabitants. 8 Those with advanced cancer,	Madrid Charter aims to promote the development of Hospice and Palliative Care volunteering, promote research and best practice, and to develop policy, training, funding, and research. Paper assesses the awareness, reach, and use of the Charter to evaluate its perceived usefulness. Employed three key practices (1) community members are the locus of care-giving, decision making, and fund-	"Charter aims are to promote the development of HPC [Hospice and Palliative Care] volunteering for the benefit of patients, families and the wider hospice palliative care community" (p. 2). Project described as a "community-based palliative care intervention" which "emphasised the bottom-up role of		The majority (64%) had heard of the Charter, 44% had signed it, but had not used it (70%). Qualitative analysis identified that participants saw the potential in the Charter as an advocacy tool and to make global connections. But many reported it lacked practical utility. Paper focuses on three 'moments' that influenced the translation of community-based palliative care practices to Nadia: (1) the
Vijay et al., 201 Wegleitner & Schuchter, 201	chronic renal conditions, and the chronically bed-ridden. Inhabitants of region.	raising; (2) palliative care is conceptualised as 'total care' and includes medical, social, and financial support, rehabilitation and bereavement services for patients and families; and (3) integration of community organisations into public health. Caring Community in Living and Dying (Landeck) project aimed to encourage citizen-orientated approaches in elderly and end of life care in German-speaking countries.	communities in improving their health status and reaching a state of physical, mental and social wellbeing" (p. 3). Followed "community-based participatory research process" where "research is understood as a collaborative process that engages researchers and community members in knowledge generation, capacity building and	No demographic details provided. Focus groups with family carers (n=11); hospice volunteers (n=6); coordinators of self-help groups (n=3); home care team (n=4; all women).	translator's enactment of symbolic power; (2) translating member relations; and (3) translating social participation. Findings focus on lessons learned (1) the caring community is already there: making it visible and learning from it; (2) caring communities as a collective learning process; (3) making citizen wisdom and knowledge available for the community; (4) reflecting and processing the
Wealeitner of a	., Inhabitants of region.		action for social change to improve community well-being as well as to reduce health disparities" (p. 3). Project "began as a research and development concern" within a university context and "follows community-	Focus group with GPs (n=4; 3 male); interview with undertaker (female), and pastor (male). International expert workshop (n=40). Not stated.	question of a good life until the end; (5) dealing with care (in)justice; and (6) maintaining the "critical" potential of caring communities. Themes identified (1) 'Collapse of the world': disturbance of everyday life at every level (practical, social, self-identity and social role),
2015 Wegleitner et a	., Inhabitants of region.	care cultures and traditions in end-of-life care; (2) strengthening local networks and self-help resources; and (3) supporting implementation and sustainability of initiatives and measures for caring networks in living and dying. Caring Community in Living and Dying (Landeck) project.	based participatory research and a community development approach" (p. 110). Described as "large-scale community-based participatory research" that "aimed to strengthen networks and	Focus groups with family carers at different stages of their caring process (n=11; all women);	caring experienced as a crisis that requires a fundamental reorientation in life; (2) 'narrowness of caring': burden that requires relief; and (3) 'guilt': particularly difficult issue for family caregivers. Paper also reflects on lessons learned and hopes for the future. Important 'ingredients' of a compassion community also identified. Analysis identified 'ingredients' of a 'supportive care web', (1) contributing specific competencies; (2) sharing wisdom of life; (3) keeping
2018		This article focuses on phase 1 (of 3) which aimed to better understand local care cultures and traditions in end-of-life care.		hospice volunteers (n=6; all women); coordinators of self-help groups (n=3; all women); community general practitioner (n=4; one woman); ambulatory nursing care team (n=4; all women). Interviews with a local undertaker and a local Catholic priest.	an eye on each other; (4) sensitively gaining access to house and soul; (5) vicariously organising care; (6) moderating care arrangements; and (7) enabling freedom from care.

Table S2 Taxonomy of Interventions at the end-of-life [reproduced from Clark et al. (9)]

Focus	Definition			
Policy	Decisions taken or rules adopted by governing authorities to deliver, facilitate, monitor, or regulate end-of-life issues			
Advocacy	Expressions or actions on end-of-life issues that aim to influence decisions on the institutional elite and/or promote the interests of specific populations, groups, or individuals in particular contexts			
Educational	Development of knowledge, skills, good judgment, and character required for the delivery of appropriate end-of-life care			
Ethico-legal	Frameworks included within laws, guidelines or ethical codes that relate to issues at the end of life and which permit, facilitate, or require specific courses of action			
Service	Medical, nursing, and other services for the prevention, alleviation, and/or reduction of suffering at the end of life through inpatient, outpatient, home care, or other forms of services			
Clinical	Medical, nursing, allied health, and psycho-social procedures at the individual level to relieve symptoms and sufferings associated with advanced illnesses and when death is imminent			
Research	Systematic enquiry on end-of-life issues for the purposes of establishing new knowledge and understanding by description, prediction, improvement and/or explanation			
Cultural	Initiatives taken to influence patterns of shared knowledge and symbolic meanings in particular communities, through which people perceive, interpret, express, and respond to end-of-life issues			
Intangible	Actions to promote the recognition and significance of aspects of human existence that have intrinsic value at the end of life			
Self-determined	Actions, decisions, or choices made by individuals to engage in or refrain from something that has implications for them at the end of their life or the life of another			
Multi-dimensional	Not included in original taxonomy. These were multi-faceted, multi-phased, multi-agency initiatives that embraced a multi-dimensional approach by incorporating three or more intervention categories from Clarke et al.'s taxonomy			