PRIORITY POPULATIONS IN MENTAL HEALTH AND SUICIDE PREVENTION

Research Report

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Stretton Health Equity

Priority Populations in Mental Health and Suicide Prevention

A project supported by the National Mental Health Commission

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Research Report

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i. Introduction & overview

This report presents results and policy recommendations from a research project on **Priority Populations in Mental Health and Suicide Prevention**. The research was funded by the Australian **National Mental Health Commission**. The 12-month project was conducted during 2022-2023 by members of the **Stretton Health Equity** research unit, part of the Stretton Institute and School of Social Sciences at the University of Adelaide. Stretton Health Equity conducts research on social determinants of health, health equity, Indigenous health, primary health care and public policy, with a particular focus on Australia. The main aims of the research were to:

a) Conduct a critical assessment of how the concept of 'priority populations' is being understood and applied in current mental health and suicide prevention policy in Australia.
b) Develop recommendations for policy makers and other stakeholder organisation on identification of 'priority populations' as a means of improving mental health outcomes and reducing health inequities.
c) Develop a tool to support policy makers, service providers or community support organisations to analyse and identify priority populations in the communities/contexts in which they work.

The report presents our work on aims a) and b). The decision-making tool as per aim c) has been completed and will be made available for use by organisations aiming to identify priority populations. Any enquiries can be directed via email to the lead researcher, Dr Matt Fisher at matt.fisher@adelaide.edu.au.

ii. Summary of findings

The research analysed contemporary mental health and/or suicide prevention policy documents, conducted a review of literature and held interviews with 16 key stakeholders with expertise in mental health and/or suicide prevention policy and practice in Australia. We synthesised findings from these three elements of the research to develop the results and recommendations reported below.

Some key findings from the research are:

- Identification of Priority Populations (PPs) is common practice in contemporary mental health and suicide prevention policy in Australia with a wide range of defining criteria used to identify a very wide range of PPs. Policy foci on particular PPs varied somewhat between jurisdictions.
- In general, PPs were identified on the basis of either perceived higher risks of mental ill-health or suicidal distress compared to other populations, perceived barriers to affordable, available, appropriate, and culturally safe mental health care, or both.
- Concepts used to define PPs for the purposes of policy action remain at significant risk of constructing deficit-based views of those groups. Such constructions may represent members of that group as 'the problem' to be 'fixed' with interventions; diverting due attention on: a) social conditions or circumstances affecting health; and b) PP groups strengths which may serve as a basis for community-engaged mental health promotion strategies.
- Policies focused on suicide identified a number of PPs in common with broader mental health policies, but also recognised other populations affected by suicide specifically.

- PPs are sometimes identified in policy within no reference to evidence, often with reference to one or two statistics drawn from secondary sources, and occasionally with extensive review of evidence. Aside from information drawn from policy consultation processes, qualitative evidence was rarely used.
- The naming of PPs in policy is sometimes connected to clear proposals for action to address the needs of that group, but not always. PPs may be named in policies where relatively few or no policy actions are proposed to address the needs of that group.
- A biomedical, disease-focused view of mental 'health' predominates in current mental health and suicide prevention policy. This matters for PPs because it can create barriers to person-centred care, and limit policy attention and resources for mental health promotion, primary prevention, and action to address social determinants of mental health and suicidal distress.
- PP-related strategies and actions proposed in policy documents were primarily focused on access to, or quality of, remedial mental health care services, and primarily directed toward PPs defined in terms of existing or emerging mental illness, reflecting the underlying biomedical orientation.
- Interviewees were strongly supportive of both inclusive, person-centred mainstream services accessible to members of PP groups, *and* targeted services directed toward meeting the particular needs of specific PPs.
- Most policies acknowledged the impacts of social determinants of mental health and/or of suicidal distress but translation of this recognition into policy actions well-placed to improve population mental health outcomes, prevent suicide and reduce inequities was limited. Policy strategies tended to 'drift' (1) to biomedical or behavioural responses, and strategies that did address determinants tended to focus on people with more serious, chronic mental illness or other relatively small high-risk groups. While this is valuable and should continue, it is likely to have little effect on broader population health outcomes.
- Current policies continued previous practice (2) of recognising a need for whole-of-government action on mental health and suicide prevention. Such recognition is motivated in part by recognition of social determinants of mental health. A range of legislative or operational mechanisms are being tried to operationalise this commitment in practice. However, our research suggests that the question of what this commitment requires in practice to be effective remains unclear, and current intersectoral strategies (while having their merits) fall short of a genuinely systemic approach.

iii. Key points for policy makers and other stakeholders

Attention on PPs in mental health and suicide prevention policy is worthwhile and should continue. It is a relevant consideration, whether policy agencies and other organisations in the sector are focused on meeting needs across the population at large, or on a particular segment of that population. It provides for understanding of a diversity of mental health needs within the Australian population, which can inform universal or targeted, person-centre services, and inform nuanced understanding of the ways in which determinants can affect mental health and wellbeing across the life course. It can be a basis for effective participation of members of a PP in the planning, design and evaluation of services and preventive measures related to that group.

Members of PP groups and the population at large should have access to appropriate and culturally safe primary, secondary and tertiary mental health care services to meet their needs. Our research reinforces other recent, major reports (3-6) that members of PP groups and service users in general would prefer to be treated with compassion as a whole person, rather than as an instance of disease requiring administration of a pharmacological treatment. This is consistent with evidence showing that most patients would prefer psychological rather than pharmacological treatment wherever possible (7). Involvement of organisations with strong community ties, and of people with lived experience as peer workers, can improve access to services and mental health outcomes for PP groups.

Recognition of PPs in contemporary policy acknowledges and aims to redress inequities in mental health and suicide outcomes between population groups. However, while policy settings displayed in current policy documents may improve outcomes for specific PP groups, they are *unlikely* to significantly improve overall population mental health outcomes or significantly reduce health inequities. Effective action to achieve that wider goal – which is in the interests of all governments and other stakeholders – requires a combination of PP specific actions with effective policy actions to promote whole-of-population mental health and wellbeing, including through actions to address social determinants of mental health, tackle discrimination in multiple forms, and reduce socioeconomic inequalities. Such actions are likely to benefit many PP groups without necessarily targeting them directly.

Some PPs already recognised in national policy such as children and young people, and people subject to socioeconomic disadvantage (and others) represent large population segments where major improvements in mental health outcomes are possible over time, with effective, preventive action focused on reducing exposure to risk factors and increasing access to protective factors for psychological wellbeing (8).

Our research suggests that strategies to assess mental health needs and PPs at a local or regional scale and to tailor service and health promotion strategies accordingly has significant potential to match policy to needs more effectively. This approach should also include actions to engage with community actors locally to understand their needs and issues, and actions to support community-led promotion and prevention strategies.

Key recommendations

***Recommendation 1:* The naming of PPs in mental health and suicide prevention policy should be linked from the outset with assessment and planning for 'best fit' strategies most likely improve health outcomes for each named group and reduce inequities between each group and the broader Australian population. Policy planning should be based on co-design with PP group members/representative organisations, and consider access to mental health care services, primary, secondary, and tertiary prevention, mental health promotion and action on social determinants.**

***Recommendation 2:* In order to improve mental health, prevent suicide, and reduce health inequities, PP specific policies should be combined with whole-of-population strategies to promote mental health, including through actions to address social determinants of mental health and/or suicide and reduce socioeconomic inequalities.**

***Recommendation 3:* Organisations aiming to identify PPs for the purposes of policy and/or service delivery should take a planned decision-making approach relevant to the whole population that they work with, have responsibility for, or are able to influence.**

Other recommendations

Conceptual and ethical issues:

***Recommendation 4:* All stakeholders in mental health and suicide prevention, including researchers, should adopt and promote causal models recognising both internal and social-environmental causes of mental health and illness.**

***Recommendation 5:* Governments and sector stakeholders should aim to advance health equity in mental health and suicide outcomes in Australia, in ways that include but are not limited to equity of access to health care services.**

Recommendation 6: Sector stakeholders should recognise a broad view of human rights related to mental health, suicide prevention and health equity, encompassing specific rights related to users of clinical mental health services.

Recommendation 7: Sector stakeholders should support Aboriginal and Torres Strait Islander peoples' calls for recognition of First Nation Peoples' rights.

Terminology used to describe PPs:

Recommendation 8: Stakeholders should consider use of 'priority populations' as standard terminology, while also recognising the difference between risk groups and equity groups.

Recommendation 9: While evidence-based recognition of inequalities in health outcomes or risk is necessary to identify PPs, stakeholders should be educated about and avoid deficit-focused representations.

Definition of Priority Populations:

Recommendation 10: Definition/description of PPs in policy should aim to represent social determinants or service access as the problem (rather than 'deficient' group members) and acknowledge group strengths and capabilities.

Recommendation 11: Stakeholders in mental health and suicide policy should recognise the potential for proliferation of named PPs and discuss consequences for effective policy.

Recommendation 12: Stakeholders in mental health and suicide policy should recognise a difference between risk groups and equity groups and consider implications for effective action to improve mental health outcomes and reduce health inequities.

Information or evidence used to identify PPs:

Recommendation 13: Stakeholder organisations identifying PPs should look for quantitative evidence on prevalence, incidence, and burden of disease compared to other groups. Other evidence relevant to PP group identification may include evidence on: exposure to risk factors; health or social service usage rates; barriers to health service use; or efficacy of services, programs or strategies to meet specific PP group needs

Recommendation 14: Stakeholders should recognise the value of qualitative data for identifying PPs, understanding service access issues, and gaining insights into lived experience and determinants of mental health or suicidal distress.

Recommendation 15: Evidence on PPs used in mental health or suicide prevention policy making should be able to be parsed to identify PP needs at a regional scale in order to inform tailored strategies at that scale.

PPs named in current policy & literature:

Recommendation 16: Identification of PPs should be cognisant of the difference between equity groups and other risk groups, and the potential for differences between PPs relevant to mental health policy objectives, and PPs relevant to suicide prevention.

Actions proposed and the groups they are directed toward:

Recommendation 17: Stakeholders in the mental health and suicide prevention sector should examine ways to reassess policy and practice, to include but extend beyond biomedical conceptions and practices.

Recommendation 18: **Policy makers should recognise populations affected by climate change/extreme weather events as a PP group and plan 'best fit' strategies to meet their needs.**

Responses to Aboriginal and Torres Strait Islander social and emotional wellbeing:

Recommendation 19: **All stakeholders should continue to support and fund Aboriginal and Torres Strait Islander leadership in policy development and delivery for Aboriginal and Torres Strait Islander social and emotional wellbeing.**

Intersectionality:

Recommendation 20: **Stakeholders in the sector should understand intersectionality and seek to address it in their responses to priority populations.**

Mental health promotion, illness prevention and suicide prevention:

Recommendation 21: **Sector stakeholders should support calls for development of a mental health promotion system in Australia, informed by the Ottawa Charter for Health Promotion.**

Recommendation 22: **Mental health promotion, illness prevention and suicide prevention strategies should encompass: a) both whole-of-population and targeted PP strategies; b) actions on health promoting environments and reducing risk factors, as well as on skills and behaviours; c) actions at all three levels of prevention.**

Recommendation 23: **Localised, community-driven strategies such as SA's suicide prevention networks warrant consideration for additional policy support, funding, and expansion.**

Role of health services:

Recommendation 24: **Support PHNs and other localised methods of mental health service planning and delivery to enable services to be tailored to PP needs within regional locales.**

Recommendation 25: **Support innovative service models to improve access to care, including nonhospital-based emergency mental health care with pathways for referral as needed.**

Recommendation 26: **Where targeted services are desired by named PP groups, they should be funded and seen as an opportunity for peer support, promotion and prevention, group empowerment and action on determinants such as social support.**

Recommendation 27: **Sector stakeholders should debate the potential value of a CPHC model for integrated primary care and mental health care, informed by lessons from the Aboriginal Community-Controlled Health Organisation (ACCHO) and Victorian community health sectors.**

Social determinants of mental health and health equity:

Recommendation 28: **All stakeholders in mental health and suicide prevention policy – including PP groups – have common, urgent interests in effective, preventative policy action on social, economic, cultural, and environmental determinants of mental health and should work toward a united approach to advocacy on this issue.**

Recommendation 29: **Planning for policy action should aim to recognise and address specific social determinants of mental health and/or suicidal distress affecting different PP groups.**

Whole-of-government and/or inter-sectoral policy action:

Recommendation 30: **Stakeholder in the sector should seek to hold governments to account, to operationalise principles of whole-of-government or intersectoral approaches in ways that address social determinants of mental health and suicidal distress.**

Recommendation 31: **Policy actors should give consideration to holistic mental health promotion frameworks following the principles of the Ottawa Charter for Health Promotion, Health in All Policies, and Healthy Cities as tools for conceptualising inter-sectoral approaches.**

Introduction

1.1 About the research

The aims of the research were to:

1. Critically assess the nature and variability of concepts, processes, and evidence used in the mental health and suicide prevention sectors in Australia to identify priority populations and monitor intervention outcomes.
2. Make recommendations to policy makers regarding the identification of priority population groups as a means of improving mental health outcomes and reducing inequities in such outcomes in Australia.
3. Develop and promulgate a tool to support policy makers, service providers or community support organisations to analyse and identify priority populations in the communities/contexts in which they work.

The research was conducted by **Dr Matt Fisher (lead), Dr Toby Freeman, Dr Miriam van den Berg**, and **Prof Fran Baum**, working within the Stretton Health Equity research unit, part of the Stretton Institute and the School of Social Sciences at the University of Adelaide. Stretton Health Equity focuses on public health research to investigate public policies and their impacts on social determinants of health and health inequities. The team combined experience in research in areas such as Australian health policy, primary health care, Indigenous health, digital health services, social and commercial determinants of health and mental health, telecommunications policy, urban planning policy, and informal employment.

The research project reported here adopted a public health view of Australian health policies addressing mental health and suicide prevention, taking account of the relationships between public policy and access to mental health care services to meet needs, opportunities for mental health promotion and illness prevention, social determinants of mental health, and inequities in mental health. The research did not address any clinical aspects of mental health care services in relation to PPs.

The research and the issues addressed occur against a background of high and in some cases worsening mental health and suicide outcomes in Australia (9). As in other countries, mental ill-health and suicidal distress are not equally distributed in Australian society. Inequalities in mental health occur on a gradient across all quintiles of socioeconomic status (10) and disproportionately affect a number of population groups defined according to socioeconomic status, gender, Indigeneity, ethnicity, sexual orientation, age, location, occupation or other criteria. These and other population groups may also face inequities in affordable access to health care services to meet their needs. These inequities are reflected in recognition of Priority Populations (PPs) in Australian mental health and suicide prevention policies. Increased spending on mental health care services has not resulted in improvements in population mental health (11).

1.3 Terminology in this report

In this report we use terms of ‘Aboriginal and Torres Strait Islander’ or ‘Indigenous’ to refer to First Nations Peoples of Australia. Hereafter, for the sake of brevity, we sometimes refer to health policy agencies and other stakeholder organisations involved in mental health and suicide prevention policy as ‘the mental health and suicide prevention sector’ or simply ‘the sector’.

2. Research methods

2.1 Policy document analysis

We searched federal, state and local government, non-government organisation (NGO) and Primary Health Network (PHN) websites directly and used Google to identify relevant policy documents using the following search terms: 'priority population/group', 'mental health' and 'suicide', along with the name of jurisdictions (e.g., South Australia, Australia). We also added search terms for specific priority populations (e.g., women, men, LGBTIQ+ and so forth) based initially on the 15 PPs named in the *National Mental Health and Suicide Prevention Agreement 2022*. We then worked to identify other PPs named in policies, include those 'emerging' as relatively new groups of interest. The search strategy was piloted for two states and refined.

Policies with a strategic focus on mental health and/or suicide prevention and published on or after 2017 were included, while subsidiary or operational policy documents were excluded. As we chose to focus only on current government, NGO, and PHN policies, strategies or position statements, we did not include in the analysis several recent, major publications on Australian mental health and suicide prevention policy such as the Productivity Commission Mental Health Inquiry Report (5), the Royal Commission into the Victorian mental health system (6), the National Suicide Prevention Adviser Final Advice (3) and the National Mental Health Commission *Vision 2030* (4). However, these documents have informed our contextual understanding of mental health and suicide prevention policy and systems as these relate to PPs and are cited in this report.

In total, 127 policies were identified during the initial search in August/September 2022. We selected 62 of these policies with regard for the following criteria:

- Geographical representation: we selected policies to cover all Australian states and territories, as well as Australia as a whole. We also included policies relevant to urban, rural, regional, and remote jurisdictions. We limited inclusion of policies to eight per jurisdiction.
- A mix of government and non-government policies: we selected a representative sample of policies from federal, state and local government, as well as smaller, selected samples of policies from key NGOs working in mental health and/or suicide prevention, PHN mental health plans, and local government public health plans.
- A mix of mental health, suicide prevention and other public health policies: we looked at policy titles to include a range of mental health, suicide prevention, a combination of mental health/suicide prevention, priority population health, and other public health policies. When considering the inclusion of broader public health policies, we first scanned the policies for substantial content on mental health and/or suicide prevention.
- Use of the term Priority Populations or specific reference to the mental health and/or impact of suicide on specific groups: we scanned policies for the use of PP terms and reference to specific priority groups in the context of mental health and/or suicide.
- Priority population policies: we selected some government policies that were specifically focused on a single population group. In some cases, the policies were specific to mental health or suicide prevention, and in other cases they were focused on health and wellbeing more broadly but included a priority focus on mental health or suicide prevention.

Application of inclusion and exclusion criteria resulted a final list of 62 policy documents being analysed using Nvivo software. A full list of included policies is provided in **Appendix 1.**

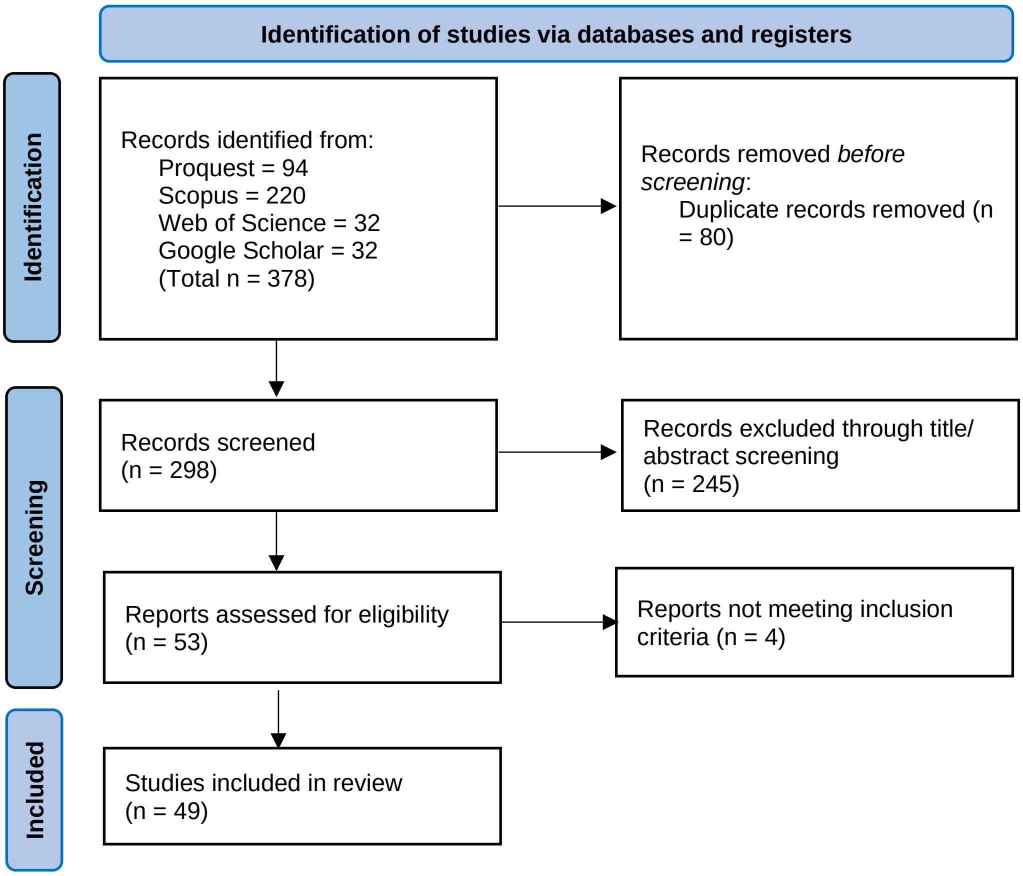
Documents were analysed thematically using QSR NVivo software to identify: health topic (mental health and/or suicide prevention, other), terminology used to describe PPs, recognition of social determinants of mental health/suicide, priority or target group definitions, groups named, evidence used, proposed actions and which groups actions were directed towards. Coders recorded reflections for each policy document and met regularly to discuss views. Microsoft excel was used to compare and contrast quantitative data related to the use of terminology, recognition of SDH, the prevalence of PPs named, and proportions of actions directed at each of the PPs. Policy quotes were extracted to illustrate these findings in further detail.

2.2 Literature review

We sought to review contemporary Australian literature on priority populations in the mental health and/or suicide prevention field to understand how the term is being applied, to what population groups, and what issues and considerations have been identified in the literature.

We searched the databases Web of Science, Scopus, Proquest, and Google Scholar in October 2022 for Australian articles on mental health and/or suicide (including alcohol and other drugs literature) using the term “priority populations” or “priority group”. The search was limited to 2014 onwards (to capture literature published subsequent to the comprehensive 2015 Public Health Ontario report on priority populations (12). A total of 298 unique references were identified from these searches. A total of 53 references were shortlisted based on screening titles and abstracts. Four further references were removed after reading the full text (2 because they were not from Australia, 1 was not relevant to mental health or suicide prevention, and 1 did not contain any references to priority populations or similar), leaving a final result of 49 included references (see PRISMA diagram in Figure 1): 44 peer reviewed journal articles, 3 academic reports, and 2 preprints.

Figure 1. PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) diagram of identification of studies to include in the literature review.



The 49 references were imported into QSR NVivo for analysis. Each reference was coded against a framework developed by the research team, capturing characteristics of the priority population(s) identified, what evidence and arguments were used to justify the population group(s), what terminology was used, and what solutions were proposed. Memos were used to capture key quotes and coder reflections, and highlight questions raised and implications of each article. All references were coded by one researcher team member (TF), with preliminary findings regularly discussed and debated at team meetings.

2.4 Interviews

We conducted 16 semi-structured interviews with key informants employed in senior roles within a government health agency or non-government organisation working within the mental health and suicide prevention sector, or in a relevant research role with a recognised Australian university. Interviewees were identified through the literature review and professional networks, and snowball sampling. Interviewees were selected to include participants from both service provider organisations and representative/advocacy organisations in the sector, and participants with expert knowledge of Aboriginal and Torres Strait Islander health, CALD health, and LGBTIQ+ health, as these relate to mental health and suicide prevention policy and services. Ethics approval was gained from the University of Adelaide Human Research Ethics Committee.

Audio recordings of interviews were transcribed into text and imported into NVivo for analysis. We conducted a thematic analysis to identify participant views on themes such as: organisations' conceptualisation of, and approach to PPs; broad orientations to PPs in current policy; issues affecting access of PPs to mental health care services; intersectionality; current policy approaches to illness prevention and mental health promotion; current approaches to social determinants of mental health and/or suicidal distress; and current approaches to whole-of-government policy.

2.5 Reference group

The project was supported by a reference group comprised of representatives of key stakeholder organisations in the mental health and suicide prevention field. A list of invitees was drafted by the researcher team with input from the National Mental Health Commission and invitations emailed to contacts at each organisation. After the first reference group meeting, one further organisation was suggested and invited to join the reference group, which was accepted. A total of five organisations plus the National Mental Health Coalition were represented on the final reference group, covering service delivery, Aboriginal and Torres Strait Islander mental health and suicide prevention, and government policy makers. The reference group met three times over the course of the 12-month project, providing input into the project plan, emerging findings, and draft tool. We would like to acknowledge the valuable and knowledgeable time and support provided by these organisations during the project.

2.6 Development of decision-making tool

The development of the tool for organisation decision making about PPs was informed by all of the methods above. Interviewees were asked about the value of such a tool and what issues it should address. Reference group meetings included discussion to inform development of the tool. In the latter stages of the project an online workshop including Reference group members and other invited sector experts reviewed a final draft of the tool. We also consulted with an Aboriginal and Torres Strait Islander health research team to gain feedback on a final draft.

3. Results and recommendations

3.1 Conceptual and ethical issues

Findings of the research raise several conceptual and ethical issues which affect the broad orientations of mental health and suicide prevention policy and practice toward priority populations (PPs) and warrant serious consideration in the sector.

3.1.1 Problem definition and causation

A key finding of our research is that a biomedical and clinical view of mental health and illness dominates current mental health policy and practice in Australia – as will be discussed further below. This matters for PPs because a strongly clinical approach can create barriers to acceptable care for members of those groups, and because the way a 'problem' is defined for the purposes of public policy can delimit policy actors' conceptions of the 'right' solution; marginalising other perspectives and strategies (13, 14). A biomedical view of mental health and illness defines mental ill-health and its causes in terms of endogenous biological vulnerabilities leading to symptomatically defined mental disease within the individual brain/mind (15). This view underpins the dominance of clinical strategies by defining appropriate 'solutions' to mental ill-health in terms of individualised medical or psychotherapeutic treatments, operationalised in prescribed drug treatments or cognitive-behavioural interventions (15, 16). A biomedical view restricts the concept of disease prevention in mental health to early access to clinical care. A biomedical view of mental health and illness may not only be held by individuals but also be embedded in institutional structures and norms.

> *"I think there is a fundamental tension between the perspectives on what the origins of these human experiences are. So, my experience in the health, especially the psychiatric, sector, is there is a strong belief in a biological vulnerability. Now, whether this is genetic and inherited or related to hormones […or] to serotonin uptake, there is a very, very strong belief, and that underpins a lot of research, that if somehow this biological key can be found, pills can be prescribed, then there will be improvement, and my strong belief is that that's not the right way to think about these things. […] I've had huge clinical experience. […] Much more what I see is people are describing forms of social adversity […] experiences of loss, humiliation, maltreatment, […] feeling socially marginalised […It is] that constellation of factors that is much more strongly associated with being distressed rather than not distressed, and these are not things fixable with a pill."* Researcher
>
> *"And yet when the evidence comes in, the burden of disease continues to show that mental ill health holds one of the highest burdens of disease, but we haven't shifted that dial in mental health. We haven't changed the narrative. Because we're still relying upon things called doctors and nurses and psychiatrists and psychologists. And we've got to move away from those models. We've got to keep them, but we've got to move away from the models as being the answers."* PHN representative

While clinical treatments will continue to play an important role in a system of mental health and suicide prevention policy and practice, the dominance of a biomedical view and clinical strategies limits policy attention and resources for other perspectives and strategies with much untapped potential to improve system performance and health outcomes for PPs (14). These are strategies which address social and environmental determinants of mental health and suicide and seek to promote mental wellbeing and prevent ill-health in individuals and populations.

3.1.2 Equity

The recognition of PPs in health policy implies that persistent inequalities between population groups in mental health or suicide outcomes, or in access to relevant health care services and supports, ought to be addressed as a matter of priority, because such inequalities are ethically inappropriate or unfair. Here we adopt Braveman and Gruskin's definition of *health equity* as "the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy" (17).

Concomitantly, health *inequities* are the presence of such systematic disparities. We define *equity of access* as a situation where people are able easily to use health care services appropriate to their needs, regardless of their private ability to pay (18). It follows from these definitions that goals of health equity and of equity of access, while related, are not the same. It also follows that not all groups that might be identified as a PP will necessarily constitute an instance of health inequity. For example, while rates of suicide among some groups of health professionals are higher than the population average in Australia (19), these inequalities are not seen to arise from systematic social, economic or cultural inequalities.

Current headline policies in the mental health and suicide prevention sectors commit to a principle of equity of access (2, 20) but not to equity in outcomes. In our policy analysis, the concept of equity was most commonly used to mean equity of access, but was deployed in a variety of ways, including in references to health equity, gender equity, human rights or prioritisation of resources based on need or risk. For example:

> *"The populations of men that experience a relatively high burden of adverse health outcomes are listed in Table 1 [inc. males in rural and remote areas, Aboriginal and Torres Strait Islander males, males from socioeconomically disadvantaged backgrounds]. To improve health equity, targeted interventions are needed to address the complex, multi-dimensional needs of these priority population groups."* National Men's Health Strategy

> *"The City strives towards an equitable approach to health and wellbeing, which means greater attention is given to those at the greatest risk of poorer health outcomes."* Geelong Community Plan 2021-2025

3.1.3 Human Rights

Human rights recognise the intrinsic value of every person, "regardless of background, where we live, what we look like, what we think or what we believe" (21). Australia is a party to eight international human rights treaties including the *International Covenant on Economic Social and Cultural Rights*, which recognises that "every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity" (22), and the *United Nations Declaration on the Rights of Indigenous Peoples* (23). These commitments are recognised in *The Fifth National Mental Health and Suicide Prevention Plan* (2).

The right to health includes mental health and is directly related to PPs, demanding that "health policies and activities prioritise the needs of those furthest behind first towards greater equity" and that health should be enjoyed equally without discrimination on the grounds of race, age, ethnicity, gender or any other factor (24). Among the policies reviewed, about one-third either generally or specifically recognised human rights as a core underpinning principle, including policies focused only on mental health or suicide prevention, policies encompassing both, and other public health policies. Human rights were broadly represented within mental health/suicide prevention policies in two ways:

Recognition of human rights as a fundamental cornerstone of inclusive, equitable and socially just communities:

> *"In Victoria we are proud to have a strong commitment to upholding the human rights and dignity of all people. Over the past decade, policy and human rights developments, both at the state and national levels, have created a strong impetus for positive and lasting change in the way governments, services and communities conceptualise and approach mental health, mental illness and wellbeing."* Vic Ten-Year Mental Health Plan

> *"Addressing the ongoing impacts of colonisation including trauma, grief, loss, discrimination, societal racism and the violation of the human rights of Aboriginal people are also critical elements influencing factors on the SEWB (social and emotional wellbeing) of Aboriginal people."* WA Suicide Prevention Framework 2021-2025

> *"Human rights and social models of disability should be applied to intersex people. It is the way that intersex people are treated and marginalised in society because of their characteristics that creates barriers to their full participation in society."* WA LGBTI Health Strategy 2019-2024

Rights of people living with mental illness, within the mental health care system:

While people living with more severe or chronic forms of mental illness are subject to the broader rights considerations above, they are also seen to be subject to specific rights considerations related to their experiences in the mental health care service system:

> *"People with a lived experience are more likely than other Queenslanders to have their human rights violated through the use of seclusion and restraint, indefinite detention, and the loss of personal and parental rights"* Shifting Minds: Qld Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023

An interview participant also discussed recognition of human rights in mental health and suicide prevention as an imperative to expand policy responses beyond disease-focused medical treatment to address social determinants of health:

> *"I've really been advocating around the human rights principles because I think that works for everybody. […] generally, it's a fundamental flaw in mental health services to see it as a medical condition and to see services […] narrowly focused on that. […] And that's where the UN approach is saying, 'That's not good enough. You need to have linkages to housing, education, health, employment. And if you don't have […] a pathway for that, that's really strong, then you're not doing the right thing.'"* State/Territory NGO

Despite recognition of the *UN Declaration on the Rights of Indigenous Peoples* in headline policy and legitimate claims of Aboriginal and Torres Strait Islander peoples to those rights for reasons of health and wellbeing (25), we found very little recognition of Indigenous people's rights in the polices analysed.

3.1.3 Recommendations

Recommendation 4: **All stakeholders in mental health and suicide prevention, including researchers, should adopt and promote causal models recognising both internal and social-environmental causes of mental health and illness.**

Recommendation 5: **Governments and sector stakeholders should aim to advance health equity in mental health and suicide outcomes in Australia, in ways that include but are not limited to equity of access to health care services.**

Recommendation 6: **Sector stakeholders should recognise a broad view of human rights related to mental health, suicide prevention and health equity, encompassing specific rights related to users of clinical mental health services.**

Recommendation 7: **Sector stakeholders should support Aboriginal and Torres Strait Islander peoples' calls for recognition of First Nation Peoples' rights.**

3.2 Terminology used to describe priority populations.

1.2.1 Findings

Policy analysis: We coded terms used to describe PPs and conducted quantitative analysis to assess extent of usage. The term 'priority population/group' (PP) was used in 35 of the 62 policies reviewed (56%). The terms 'vulnerable' and 'at risk' were more commonly used than PP, in 47 (76%) and 45 policies (73%) respectively. Overall, policies were more likely to use the terms 'at risk' (421 citations) and 'vulnerable' (290 citations) than PP (188 citations). Other commonly used terms included 'disadvantaged' (27 policies), 'marginalised' (18 policies) and 'target group' (17 policies). Terms were sometimes used interchangeably or in combination. Analysis is shown in Fig. 2 below. Here are examples, with key terms highlighted:

> *"Improved mental health for **vulnerable** South Australians and communities with unique geographic, cultural, social, physical or developmental needs."* SA Mental Health Strategic Plan 2017-2022

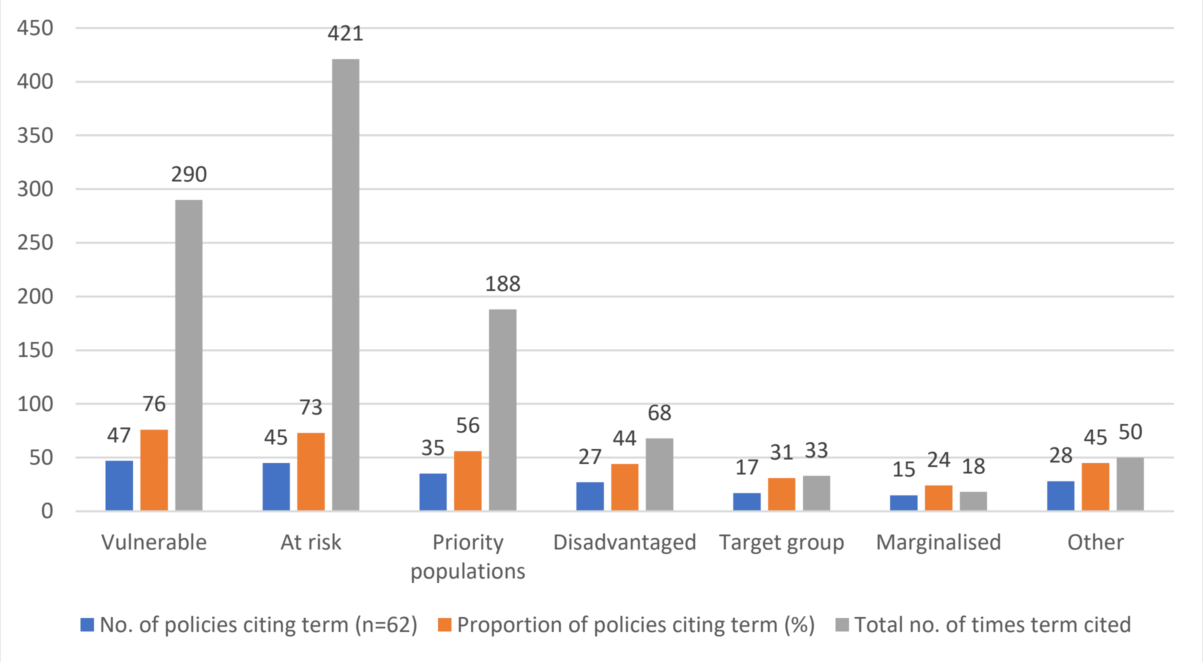
> *"Defence recognises that ADF members who do not deploy are equally **at risk** of developing mental disorders as those who deploy."* Defence Mental Health & Wellbeing Strategy 2018-2023

> *"**Priority populations** may include, but are not limited to, young people, Aboriginal communities, emergency services, LGBTI communities and key industries affected by suicide such as construction and mining."* Strategic Framework for Suicide Prevention in NSW 2018-2023

> *"**Marginalised** and **disadvantaged** population groups of women are identified to be at greater risk of experiencing mental health related issues."* WA Women's Health and Wellbeing Policy

> *“Families and carers of people with mental health issues are also identified as a **target group** due to the valuable role they play in people’s lives.”* ACT MH and SP Plan 2019-2024

Figure 2. Use of PP and related terms across policies



A wide range of terms with similar meaning were also used, describing a group or groups of specific interest within the document concerned with concepts such as: unmet / different / complex needs; hard to reach; struggling; diverse; minority; enduring disadvantage; life stage or life transition points; inequities in health/wellbeing outcomes; disproportionately impacted; the missing middle[1]; experiencing suicidal thoughts; and (groups linked to) priority actions.

While policies focused only on mental health and those focused only on suicide prevention did name somewhat different PPs (see Section 3.5), and this is an important consideration, we did not identify any significant differences in the terminology used.

Literature review: We selected documents on the basis of using the terms ‘priority population’ or ‘priority group’. However, other terms similar to those above were applied in the 49 articles reviewed, including: at risk (8 articles); target group (5 articles); vulnerable (5 articles); marginalised (3 articles); disadvantaged (3 articles); and underserved (2 articles). One strong theme in the literature was the potential for language to perpetuate a “deficit discourse” blaming members of priority populations for their increased risk, or viewing the population only through the lens of this risk. This was noted for multiple priority populations. For example, for older people:

> *“The dominant discourse through which the ‘problem’ of older people and mental health is represented is one of ‘being at-risk’. Although older people and mental health are rarely mentioned in Commonwealth policy, where they are mentioned, the policies identify groups of individuals deemed to be at increased risk of mental health problems and, therefore, requiring targeted risk management… This representation is underpinned by a discourse of ageing as decline and dependence.”* (26)

In an analysis of policy documents, Gentile and colleagues noted:

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[1] The ‘missing middle’ refers to a group whose mental health needs are more significant than can be met by a primary care service, but not so severe as to qualify for access to a clinical mental health service.

> *"The idea of Aboriginal people being lesser than Gubba [non-Indigenous] people was also consistently reinforced in all documents via various graphs and figures of targets and outcomes. This provided an unbalanced discourse with sparse reference to Aboriginal success*" (27, p. 5)

The authors concluded that:

> "*The discourse analysis identified that the documents often wrote about Aboriginal peoples rather than writing documents with or by Aboriginal peoples. This typically: absented complexities of consultation occurring within a complex power imbalanced cultural interface; did not support an Aboriginal paradigm; centred Gubba people in power and; promoted a paternalistic view of 'helping' Aboriginal people.*" (27, p. 6)

Such controlling language was particularly observed in the tobacco literature, with authors using language such as *"groups where levels of smoking appear intransigent"* (28, p. 546), or prevalence remaining *"stubbornly high"* (29, p. 1), suggesting that targeted groups are deviant hold outs, or recalcitrant.

Relatedly, language also has the potential to "other" a priority population, highlighting how they are different to a dominant majority. For example:

> *"A striking feature of all the policy documents analysed is the differentiation of LGBTIQ consumers from the hetero- and/or gender normative majority. Here LGBTIQ people are categorised as a relatively unified group whose patterns of substance use can be distinguished from the "population at large"... [this] powerfully legitimizes law and the state as appropriate protectors against injury and casts injured individuals as needing such protection by such protectors"* (30, pp. 191-2)

This is particularly relevant since homosexuality and gender diversity have only been declassified as mental health disorders in recent history.

Lastly, some articles reflected on the challenges of the term 'Cultural and Linguistic Diversity', noting it brings attention to the needs of multicultural populations, but lacks a concrete definition, and is often operationalised according to what data is available, such as language spoken at home, or county of birth, leading to a wide variety of working definitions (31). Rahim argued that:

> *"Australian history can be characterised by mainstream Anglo population's domination over groups perceived as 'others' ... These ethno-cultural 'others' refer to ethnic or cultural groups perceived as different from mainstream Anglo-Celtic Australians. One of the more recent manifestations of this desire to describe the 'other' is through using the concept of Culturally and Linguistically Diverse (CALD) populations. CALD is a concept unique to Australia"* (32, p. 3)

While there is not a preferred term in use, it is important to note the shortcomings of the current approach. If priority populations are identified in order to pursue better health equity for such groups, it is imperative that the language in which the identification is framed does not add to the stigma, discrimination, and problematisation of such groups.

Interviews: Interviewees offered a range of thought on use of terminology in the sector reflecting on the significance, utility, and potential downsides of terminology used to identify PPs or equivalent, for example:

> *"You have to be aware that there are inequalities and unless you [...do so] you're not going to rebalance the social gradient. You have to accept that some people have additional, special, extra needs, and that's got to have a label or terminology for that, but the least discriminatory and the most strengths-based label or terminology is ideal. [...] 'Priority population' feels a bit better to me than 'at risk' or 'vulnerable'. 'Vulnerable' sounds like that's it, you've got nothing going for you. Whereas 'priority' just means you're prioritising."*
> National NGO

"I find this nomenclature difficult. I don't think people are equally vulnerable. You know, people who have had the good fortune to grow up with the opposite of what we talked about before [socioeconomic disadvantage] and especially who have some degree of socioeconomic advantage are not equally vulnerable." Researcher

"Sometimes people use the term disadvantaged or marginalised communities, and we prefer to use the term priority because it's more of a strengths-based approach." National NGO

"I think some CALD communities, while we might talk about them as disadvantaged, it could be a term that would bring a lot of shame. All those terms, being a priority population can be seen as something that can bring shame in or, 'I don't belong to that priority population'. It depends if there's a negative connotation with it but certainly 'disadvantaged' has a negative connotation with it […] in some communities, they might not identify with being 'disadvantaged'." State/Territory Health department

"I did find the term that [name] was using and that was 'populations disproportionately impacted by suicide' and I think that that's a great term that can be used in multiple settings because at the end of the day, the reality is […] everyone is affected by those things. As somebody who isn't identified as a priority population can think 'well I'm not going to get anything from this then because I'm not one of them.'" National NGO

3.2.2 Discussion

Several key points emerge from our research about use of terminology in the metal health and suicide prevention policy sector.

a) Terminology used to identify PPs is varied and inconsistent among government policy actors, and across the sector.

b) Identifying PPs does require evidence-based recognition of inequalities in health outcomes or risk/protective factors between population groups, and terminology for this purpose is required. Risk is a standard concept applied in epidemiological research, but it is essential to see risk in a social context.

c) However, consistent, unqualified representation of groups as 'disadvantaged', 'vulnerable', 'marginalised' or like terms can contribute to negative, deficit-based perceptions of those groups; in the public at large, among policy makers or within health services (33) (see also 3.3.2). Deficit-based representations can be avoided by: not using terms such as 'disadvantage' as an adjective to describe a group, use of non-pejorative terminology, reframing of the problem to focus on determinants rather than group identity, and recognition of group strengths (27).

d) 'Priority Population' is a more neutral term, avoiding potential pejorative connotations. However, use of neutral terms without qualifying information may mask differences between risk groups and equity groups (see section 3.3 for discussion of this difference).

e) In a service delivery context, identification of an individual with only one priority group may fail to take account of intersectionality (see Section 3.7) and prompt simplistic assumptions about the person's circumstances, risks or needs.

3.2.3 Recommendations

Recommendation 8: **Stakeholders should consider use of 'priority populations' as standard terminology, while also recognising the difference between risk groups and equity groups.**

Recommendation 9: **While evidence-based recognition of inequalities in health outcomes or risk is necessary to identify PPs, stakeholders should be educated about and avoid deficit-focused representations.**

3.3 Definition of Priority Populations

3.3.1 Findings

Based on our research, we define a **priority population** or **priority group** in mental health/suicide prevention policy as a group of people defined according to a shared characteristic (e.g., socioeconomic status, gender, Indigeneity, ethnicity, sexual orientation, age, location, occupation) who:

a) Experience higher risks of mental ill-health, suicide or suicidal distress compared to others, because of the conditions in which they live and work, because of social inequities and discrimination, and/or because of poor access to mental health care services or supports.
b) Are identified by an organisation working in mental health and/or suicide prevention as a specific focus of their policy and/or practice.

Our research indicates that *definition* of a PP for the purposes of policy requires terms to define a group as such coupled with terms to define need or risk within that group. Our analysis of policy documents and academic literature reveals a broad range of possible ways in which PPs may be defined. The main terms available and in use to define groups, and terms to define risk or need are shown in Table 1 below. A potential for wide-ranging and diverse of PP definitions arises in part because one of more of the terms in column 1 can be used to define a group and may be combined with one or more of the terms in column 2. Notwithstanding this potential diversity, definitions of PP groups identified in our analysis can be usefully summarised in four categories which we describe as 'illness groups', 'service user groups', 'risk groups' and 'equity groups'.

Illness groups: PPs are defined primarily in terms of existing or emerging mental ill-health.

> *"South Australians who experience particular kinds of mental illness may also require targeted and ongoing support – these include but are not limited to people with severe and complex mental illness, borderline personality disorder, eating disorders, and people experiencing co-existing mental illnesses, substance use disorders, or other co-morbidities."* SA Mental Health Strategic Plan 2017-2022

Service user groups: PPs are defined primarily in terms of existing users (or 'consumers') of mental health care services:

> *"The term, 'transition' is used to describe the process of planning, preparing and moving from a paediatric health care service to an adult health care service. There is increasing evidence that over this period young people are particularly at risk of suboptimal medical follow up, reduced treatment adherence, [and] increased service costs resulting in poorer health outcomes."* WA Youth Health Policy 2018-2023

Risk groups: PPs are defined according to demographic criteria associated with increased risk of mental ill-health or suicidal distress, where known risk factors associated with the population ***do not include*** exposure to structural or systemic socioeconomic or cultural disadvantages. Examples would include older people, youth, men, children, construction workers, or health professionals. (Of course, sub-parts of these groups may be subject to such disadvantages, e.g., unemployed men.)

> *"Not all people who attempt or die by suicide have lived experience of mental health issues. Many factors influence a person to attempt to take their life. These factors may relate to the individual or be social, contextual, or situational in nature, and people can experience more than one risk factor at any one time."* NSW Strategic Framework for Suicide Prevention 2018-2023

Table 1: Terms used to define PPs

Definition of groups	Definition of risk/need
Mental health status, e.g.: – Current or previous mental illness – Emerging mental illness – Complex mental health needs – Current or previous suicidal thoughts or behaviours **Health/social service use, e.g.:** – Mental health service consumers – Children in out-of-home care **Demographic criteria, e.g.:** – Age group – Location – Sex – Sexual orientation – Socioeconomic status – Indigeneity – Ethnicity – Occupation/former occupation – Housing status – Family/partner relation status (parents, families, children, partners, carers of a person with a mental illness) – Contact with justice system – Life transition point	**Higher prevalence/incidence/burden of mental ill-health or suicidal distress compared to other groups.** **Higher relative risk of mental health-related morbidity or premature mortality, or of suicidal distress, due to:** ***a) Life demands associated with disability*** ***b) Chronic physical illness, or mental-physical health comorbidities*** ***c) Inadequate quality of, or access to, healthcare services, e.g.:*** – Availability, affordability, acceptability – Cultural safety – Person-centredness – Service coordination ***d) Poor health behaviours or health literacy, e.g.:*** – Smoking; high drug or alcohol use – Lack of self-care or help seeking ***e) Exposure to adverse social-environmental conditions (determinants) or events, e.g.:*** – Economic deprivation/insecurity – Unemployment or poor working conditions – Racism or discrimination – Childhood abuse or neglect – Family violence – Social isolation – Housing insecurity or homelessness – Extreme weather events – Suicide of a relative or friend ***f) Lack of access to protective/promotive conditions, e.g.:*** – Secure employment with good working conditions – Social support – Secure housing – Safe living environment

Equity groups: PPs are defined according to demographic criteria associated with increased risk of mental ill-health or suicidal distress, where known risk factors associated with the population ***include*** exposure to structural or systemic socioeconomic or cultural disadvantages. Examples would include people subject to low socioeconomic status (socioeconomic inequality), women (sex discrimination, gendered violence), Aboriginal and Torres Strait Islander Australians (colonisation, racism, incarceration, etc.), LGBTIQ+ people (discrimination based on sexual orientation or gender identity) or people who are unemployed (discrimination, socioeconomic inequality).

> *"We must recognise the rich and resilient culture, grounded in strong connection to community, family and*

> *Country, that continues to sustain and strengthen Aboriginal and Torres Strait Islander peoples and communities. We must also recognise the significant disparities and challenges experienced by Aboriginal and Torres Strait Islander peoples."* Qld Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023

Regarding 'illness groups', one interviewee offered a rationale for recognising groups as PPs based on existing mental health conditions:

> *"Can I just explain a bit further, the eating disorder being a priority area […] I think the go-to general definition […] is just people experiencing or a population experiencing poorer outcomes. But there's also an opportunity or at times a definition used that is about people who are requiring or a population that is requiring mental health and alcohol and other drugs support who then require customised support tailored to their unique presentations or circumstances. So, I think that's where we at times see conditions becoming a priority."* PHN representative

3.3.2 Discussion

Three important issues arise for policy makers and stakeholders in relation to *how* PPs are defined for the purpose of mental health and suicide prevention policy.

a) Defining a PP solely according to a demographic criterion associated with elevated risk of mental ill-health or suicidal distress, and using terms such as 'at risk', 'disadvantaged' and so on, while it may be consistent with evidence, may also represent that group and its members as *inherently deficient* in some sense (unhealthy, needy, irresponsible, powerless) simply by virtue of holding that identity (26, 33). Such deficit-based representations may be experienced as discriminatory, overlook positive attributes, minimise impacts of social or cultural determinants of health, or contribute to discriminatory attitudes in health care services.

b) Defining a PP in terms of existing illness (illness group), health service use (service user group) or inadequate quality of or access to mental health care services will tend to favour subsequent assumptions about improvements in the quality of, or timely access to, mental health care services as the 'right' policy response. Such assumptions stem from dominant biomedical views of metal health and illness and may serve to marginalise attention on opportunities for promotion and prevention, or action on relevant social determinants.

c) Understanding of the difference between risk groups and equity groups for the purpose of policy planning on PPs is important because: i) in light of evidence on health inequities, improving poor outcomes among *equity groups* holds the greater potential to reduce the overall burden of mental ill-health and suicidal distress; and ii) effective action to improve health outcomes among equity groups and reduce health inequities, necessitates action on structural or systemic inequalities in social determinants. However, this does not rule out the value of directing strategies toward risk groups as well.

d) Policies focused on suicide specifically identified a number of PPs also named in broader mental health policies. However, risk and protective factors related to suicide, and populations most affected by suicide, also differ in some important ways from those related to mental health and illness.

3.3.3 Recommendations

> ***Recommendation 10:*** **Definition/description of PPs in policy should aim to represent social determinants or service access as the problem (rather than 'deficient' group members) and acknowledge group strengths and capabilities.**
>
> ***Recommendation 11:*** **Stakeholders in mental health and suicide policy should recognise the potential for proliferation of named PPs and discuss consequences for effective policy.**
>
> ***Recommendation 12:*** **Stakeholders in mental health and suicide policy should recognise a difference between risk groups and equity groups and consider implications for effective action to improve mental health outcomes and reduce health inequities.**

3.4 Information or evidence used to identify PPs

3.4.1 Findings

Policy analysis: Information and processes used to identify PPs in the reviewed policies were sometimes well described, but in other cases not articulated. Twenty-four of the 62 policies published some form of (apparently) pre-conceived list, covering PPs similar to those named by the *National Mental Health and Suicide Prevention Agreement*. None of the lists in the policies were as comprehensive as the list published in the Agreement and there was significant variation in named groups between lists. The use of a pre-conceived list was equally common across both mental health and suicide prevention policies, and other public health policies considered in the analysis.

Sometimes, but not always, the naming of PPs was justified by reference to evidence. Most commonly, this was a secondary source of data on prevalence or (less frequently) incidence of mental ill-health or suicide within the group concerned. However, occasionally, burden of disease data was also used. For example:

> *"Males aged 85 years and over have the highest rates of suicide across Australia, although these suicides account for only 3% of all male deaths from intentional self-harm (ABS 2016)."* National Men's Health Strategy 2020-2030

> *"…for South Australians 24 years and under, mental illnesses are estimated to be the leading cause of burden of disease in our community (AIHW 2016)."* SA Mental Health Strategic Plan 2017-22

Other forms of evidence used to define or describe PP groups included data related to exposure to risk factors for mental ill-health, or rates of usage of health or social services. For example:

> *"Ninety per cent of young people experiencing homelessness have witnessed violence in their home, 60 per cent have been in OOHC, and 50 per cent have a reported mental health issue."* NSW Homelessness Strategy 2018-2023

> *"Aboriginal people who experience racism are at a greater risk of developing depression and anxiety and this continues to have a significant impact on Aboriginal peoples' decisions about when and why to seek health services and acceptance of, and adherence to treatment."* NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025

It was rare to find any use of secondary, qualitative research. However, instances where this was done indicate the potential value of these sources to inform strategies directed toward PPs. For example:

> *"A recent Australian research report highlights that multi-sectorial collaborations are required to improve access to evidence-based, culturally appropriate mental health and wellbeing services and suicide prevention and intervention activities for remote and rural Australians (Bishop et al 2017)."* NT Suicide Prevention Strategic Framework 2018-2023

When primary evidence was used, this tended to be qualitative data, and drawn from consultations rather than academic research. Infrequently, policies used primary quantitative data from survey findings. Overall, there was no consistent approach to identifying PP and there were no obvious differences in the type of data that was presented between mental health and suicide prevention policies.

Literature review: Articles examined in the literature review also mostly relied on secondary sources of prevalence or incidence data to justify PPs. Importantly, the review identified some studies providing evidence relevant to policy strategies for PPs. For example, evidence showing targeted mental health service responses were more efficacious that generic mainstream services for some PP groups (34).

Interviews: Interviewees identified problems in taking a 'laundry list' approach to identifying PPs.

> *"My reflection is that often, those lists are – I call it the laundry list, where people just apply the same list in all circumstances. … And we all know the groups that we should include. A lot of the time, that's right, because sadly, a lot of those groups are at risk across a bunch of different circumstances. And so, that list is not a bad place to start. But it's got to be a bit more considered than that."* National NGO

> *"The other issue as well is that we know that of the people who do die by suicide, 50% of them are not known to services prior to death. […] and I wonder, by refining and refining and narrowing down the people we're trying to target, I wonder if that's actually going to make that worse or better."* PHN representative

For some organisations whose work was specifically focused on a PP, being part of the list was important because *"we do need to be mentioned because otherwise we're just forgotten."* Interviewees also spoke about the potential value of evidence on PPs collected at a regional or local scale for policy planning, as a means to recognises difference in PP between regions and to tailor policy responses to localised needs.

> *"PHNs [Primary Health Networks} do need to understand the local community in which they operate and the population that makes up their area and direct funding to support priority populations within their region so that is written into the agreements and a key focus for them."* Federal health department.

> *"There's some parts of the country that have higher numbers of queer people as well, for example. Bankstown in NSW or Dandenong in Victoria have higher cultural diversity, so you would expect that both their numbers and also their community development efforts are gearing towards that. That's generally how we would assess [our services] as promoting access for those groups."* National NGO

In a similar vein, one interviewee described the limitations of a top-down approach to PPs limiting the scope of services to act flexibly to meet the needs of a particular population group:

> *"…priority populations and what health can do is really driven by a top-down approach and for us essentially the Commonwealth Department of Health and Aged Care, really influences that dramatically and that's only based on secondary data most commonly […] so it's not a true representation for our need but it's what is decided for us with minimal flexibility and being able to do much outside of that. So that's what I see is the biggest barrier to supporting priority populations."* PHN representative

Importantly, it was noted that a population group might be recognised as a PP for reasons other than higher prevalence or incidence of mental ill-health, suicide or suicide attempts compared to other groups, especially where barriers to health service use are identified. Furthermore, relevant prevalence/incidence data does not always exist for groups who might nevertheless be recognised as having particular needs.

> *"We recently submitted to a government process where they talked about disproportionately impacted populations, and [said…] Don't use that phrasing because … it's heavily statistical and the stats don't always exist for a lot of populations. So, you don't necessarily have the evidence as to whether or not some population is disproportionately impacted, even if you know that you should be paying attention to them. LGBTQI groups are a classic example of that. … But the other point is that just because a population isn't disproportionately impacted doesn't necessarily mean that they don't need targeted solutions. The classic example of this is a lot of CALD communities … rates of suicide vary as far as we can tell across different CALD communities. Some of them are disproportionately impacted, but some of them are not. Some of them actually have better than average suicide rates, as in lower. But then, there'll still be language and cultural barriers to support-seeking, and so you still need a targeted approach for that."* National NGO

3.4.2 Discussion

Some policy developers appeared to have undertaken comprehensive consultation processes, with policy documents outlining lists of stakeholders, breadth of consultation undertaken and community and service provider engagement strategies, including culturally safe practices for engaging with particular PPs. The inclusion of personal narratives and quotes from community and other stakeholders in policies was common and often helped move the policy narrative further towards understanding mental health and suicide prevention from a health equity perspective. The inclusion of stories allowed policies to present rich, real-life, human accounts of mental health and suicide ideation and experiences and illustrated the complexity and relevance of social determinants of mental health.

3.4.3 Recommendations

> ***Recommendation 13:*** **Stakeholder organisations identifying PPs should look for quantitative evidence on prevalence, incidence, and burden of disease compared to other groups. Other evidence relevant to PP group identification may include evidence on: exposure to risk factors; health or social service usage rates; barriers to health service use; or efficacy of services, programs or strategies to meet specific PP group needs**
>
> ***Recommendation 14:*** **Stakeholders should recognise the potential value of qualitative data for identifying PPs, understanding service access issues, and gaining insights into lived experience and determinants of mental health or suicidal distress.**
>
> ***Recommendation 15:*** **Evidence on PPs used in mental health or suicide prevention policy making should be able to be parsed to identify PP needs at a regional scale in order to inform tailored strategies at that scale.**

3.5 Which PPs are named in current policy & literature?

3.5.1 Findings

Policy analysis: For the purposes of assessing the relative extent to which a PP was *named* in the policies analysed, where a document named a PP once or multiple times, we counted this as 1 instance of naming. We identified PPs according to our own definition noted above (Section 3.3.1), and compared groups named against the list in the *National Mental Health and Suicide Prevention Agreement* (NMHSPA) (see Box 1 below).

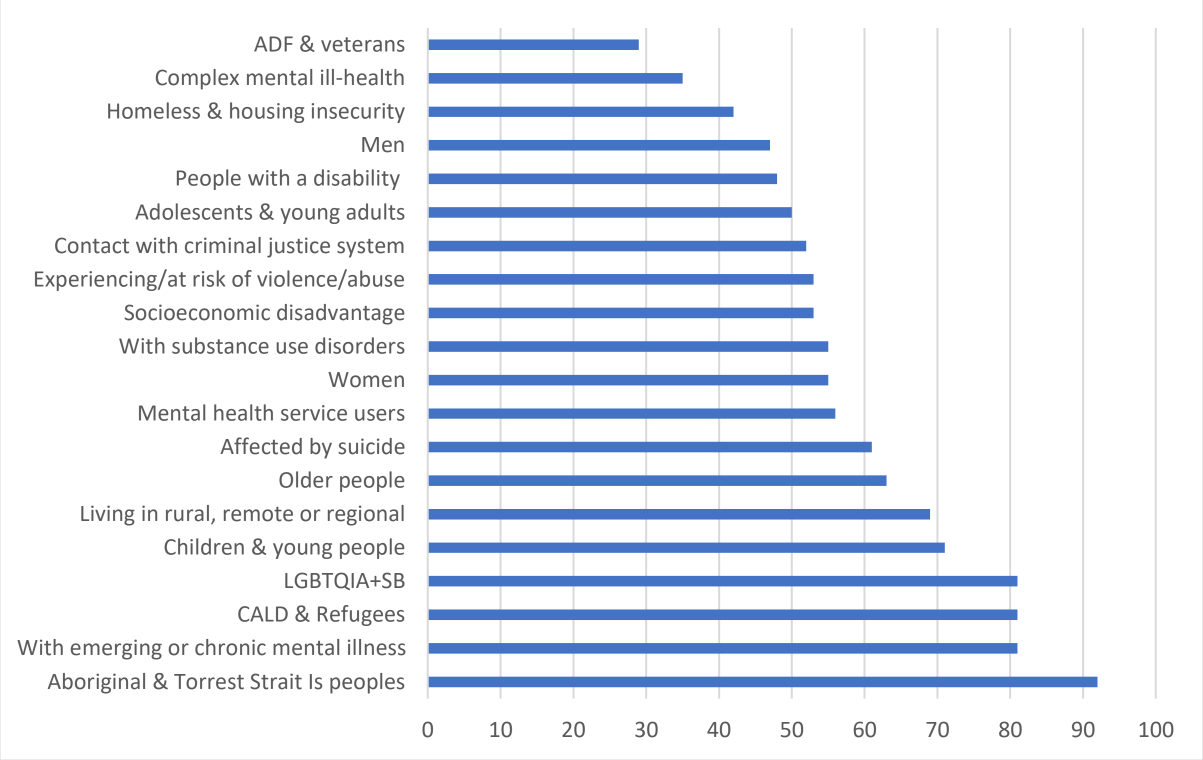
Box 1: PPs named in National Mental Health and Suicide Prevention Agreement (p. 25)

Implementation of initiatives under this Agreement or associated Schedules will consider and support the mental health and wellbeing of the following priority populations groups, at a minimum, noting that a person may fall into one or more of the below groups:

1. Aboriginal and Torres Strait Islander peoples.
2. LGBTQIA+SB people.
3. Culturally and linguistically diverse communities and refugees.
4. People experiencing homelessness or housing instability.
5. Children and young people, including those in out-of-home care.
6. Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander peoples).
7. People living in regional, rural and remote areas of Australia.
8. People experiencing or at risk of abuse and violence, including sexual abuse, neglect and family and domestic violence.
9. People with a disability.
10. Australian Defence Force members and veterans.
11. People experiencing socioeconomic disadvantage.
12. People who are (or were previously) in contact with the criminal justice system.
13. People with complex mental health needs, including people with co-occurring mental health and cognitive disability and/or autism.
14. People with harmful use of alcohol or other drugs, or people with substance use disorders.
15. People who have made a previous suicide attempt or who have been bereaved by suicide

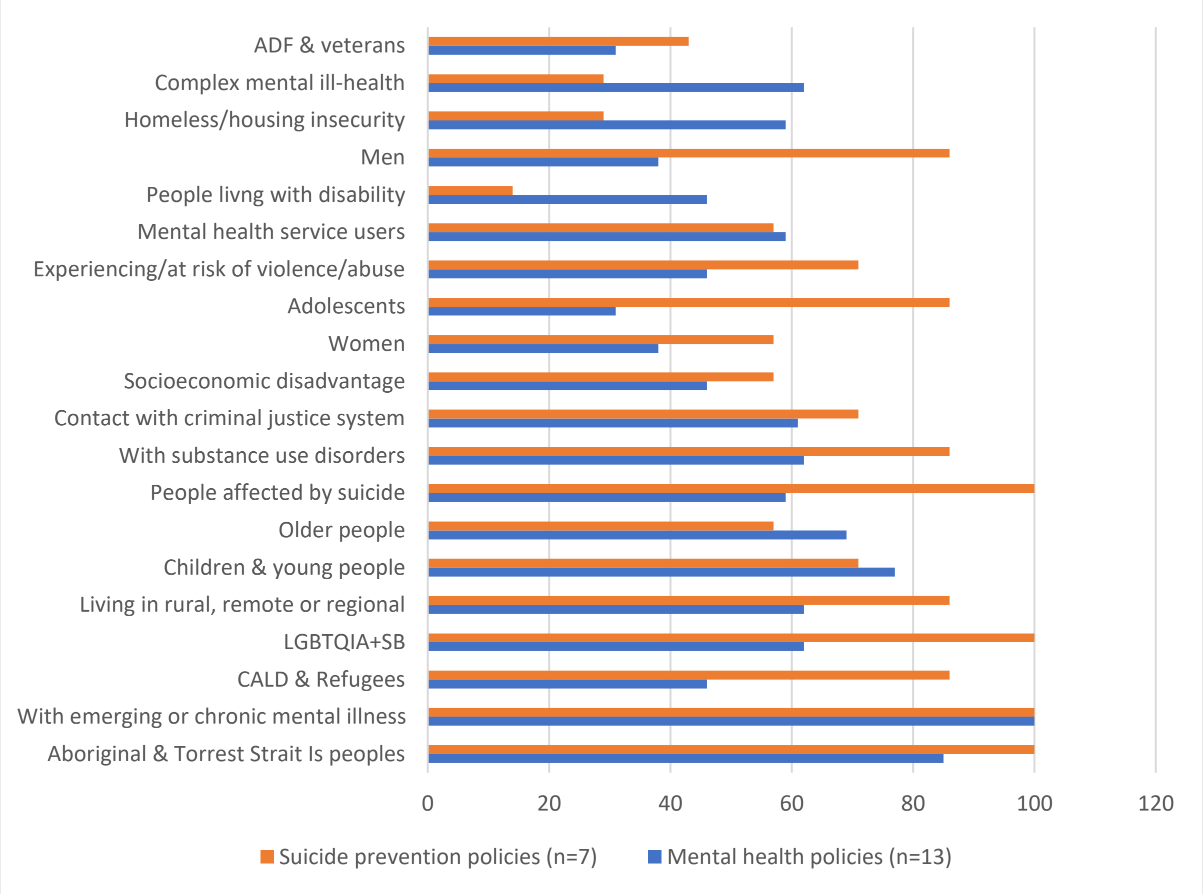
Across the 62 policies analysed, all of the 15 groups identified in the NMHSPA were named as PPs, but some far more commonly than others. The most commonly named PPs on this list were Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD) groups and refugees, LGBTIQ+ people, and children and young people (see Figure 3 below). However, the second most commonly named PP group we identified is not found on the NMHSPA list, namely people with existing or emerging mental illness. Notwithstanding the naming of many other PPs, we found this *illness group* definition (see Section 3.3.1) is a main criterion used to define a PP for the purposes of assigning policy action (see also Section 3.6). Similarly, we found that mental health service users – a *service user* group definition – were the ninth most commonly named PP. Groups named least often were ADF personnel and veterans, people with complex mental health needs, and people subject to homelessness or housing insecurity.

Figure 3: Proportion of policies (%) naming particular PP (n=62)



Part of our brief was to assess differences in PPs named between policies focused on improving metal health and those focused on preventing suicide. Interviewees reinforced the importance of not assuming the same groups are always relevant to both objectives, although there are commonalities. To do this we assessed differences in PPs named in policies specifically focused on mental health only (13 our of 62) and those specifically focused on suicide prevention only (7 out of 62). Figure 4 below shows the proportion of policies naming various groups, indicating that policies focused on suicide prevention gave greater attention to some PPs including CALD and refugees, LGBTIQ+, adolescents, men, and people living in regional, rural or remote locations.

Figure 4: Proportion of policies (%) naming PPs: mental health and suicide prevention policies



Findings shown in Figure 4 may suggest a lack of attention to suicide risk in some PP groups such as people living with a disability.

A large number of groups other than those named in the NMHSPA were also named as PPs in the policies analysed, reflecting the potential for naming of many PPs discussed in Section 3.3.1.

Box 2: Other groups named as PPs in policies

Occupation groups:

- Workers and workplaces
- Doctors, nurses, other health workers, medical students, health workers during COVID pandemic
- Farmers, other agricultural workers, dairy farmers
- Workers in male-dominated industries, construction, mining
- Security guards, police and former police, first responders
- Teachers
- Carers including those providing long term care without respite

Social, economic, or environmental circumstances:

- People exposed to conflict, emergencies, natural disasters or extreme weather events
- People experiencing overcrowding, homelessness or at-risk tenancies; public housing tenants
- People in ‘transition’ e.g. leaving inpatient mental health units, exiting prison, leaving school, moving from child to adult mental health services, moving from armed services to civilian life
- People who have experienced trauma, stigma or discrimination, or bullying
- New parents and single parents
- People with decreased mobility or loss of independence
- People experiencing grief and loss associated with the death of a partner or significant other
- People experiencing social isolation, loneliness, loss of purpose or loss of status
- Couples in relationship separation or arguments in the home
- People with gambling problems and their families

Health status:

- People with chronic health conditions, or co-morbid mental and physical illness
- People impacted by dementia related illness or traumatic memories

Groups related to suicide risk:

- People exposed to media reports on suicide
- People with access to lethal means

Sub-groups of PP

- **Asylum seekers** who have experienced torture, who are homeless, or who have transferred from detention centres in Australia and offshore
- **Aboriginal or Torres Strait Islander people** who have experienced historical trauma, who do not have strong connections to their culture or identity, are survivors of the Stolen Generation, are entering or leaving hospital
- **Women** who have experienced gender-based violence, are affected by Female Genital Mutilation
- **Men** aged over 85 years
- **Older people** at risk of elder abuse, residents of aged care facilities
- **Children and young people** whose parents have a mental illness or AOD problems, who have experienced multiple adverse life events, who are leaving school, with FASD, with disability or chronic illness, who have been exposed to natural disasters or community crises

Literature review: groups most often recognised as PPs in the journal articles analysed included: CALD people, migrants and refugees (15 articles); Aboriginal and Torres Strait Islander peoples (14 articles); LGBTIQ+ people (13 articles); Adolescents and young adults (11 articles); men (8 articles); women (7 articles); children and young people (7 articles); people subject to socioeconomic disadvantage (6 articles); people with existing mental illness (6 articles); and people involved in the justice system (5 articles). Some PPs named spanned more than one descriptor, e.g. CALD adolescents and young adults. The literature also pointed to priority populations that are increasingly at risk of mental ill health and/or suicidal distress, such as people who had experienced climate change-related severe weather events such as floods or bushfires (35), or people that have been continued to be under-recognised as being at greater risk, such as neurodiverse people (36).

Interviews: Interviewees were generally supportive of naming PPs in policy, but also described some potentially problematic issues that arise. In a process of naming multiple PPs one can in effect end up naming most or all of the entire population. Also, naming PPs can result in service responses which assume wrongly that the mental health risks or needs of people identified with a particular group are related uniformly and only to that aspect of their life circumstances or identity. Finally, naming of PPs perceived as relevant to mental health issues may fail to properly identify PP groups whose needs are more specifically related to suicide.

> *“We had this problem where we were doing something on domestic and family violence and the links to suicide prevention. Obviously, in that context, women are a significant priority group, but we wanted to maintain that men were still a priority group. And at that point, you’ve said, ‘The priorities are men and women. Oh, and anyone who’s gender diverse; so, everyone.’”* National NGO

> *“So, in the past, [we have] taken more of a priority population or cohort-specific approach to designing and delivering our work. … Then we started to reflect on the communities that we serve and what our role is […] and they might identify as a man, be from the LGBTQI community, and be a First Nations person. So, if we’re breaking some of the services and programs down into these really specific boxes, it forces people to identify with an aspect of their identity and doesn’t take into account the deep and broad experiences people have and deep and broad identities that people live with.”* National NGO

> *“Like I say, in lots of other circumstances, males are not a priority group. And a lot of the time, they get left off [a PP group list], especially if you’re talking about mental health and suicide prevention. The priority groups listed there often just don’t include men … In a mental health context, that may well be reasonable, but in a suicide-prevention context, it’s absolutely not reasonable.”* National NGO

3.5.2 Discussion

The frequent naming of people with existing or emerging mental illness, or users of mental health services, as PPs is not unexpected, given the lead policy role of Health agencies. However, it is also indicative of the dominant biomedical and clinical focus in policy and subject to the limitations of *illness group* and *service user group* definitions discussed in Section 3.3.1.

While policies commonly recognised social determinants of mental health and/or suicidal distress, and acknowledge health inequities, the naming of PPs did not demonstrate an explicit distinction between *equity groups* and other *risk groups*. Such a distinction is crucial in order to link naming of equity groups as PPs with requirements for policy action to address systemic social, economic, and/or cultural inequalities. For example, this would most obviously be the case for 'people experiencing socioeconomic disadvantage' PP group named in the NMHSPA. Over 3 million people live in poverty in Australia, including more than 750,000 children (37), and number experiencing socioeconomic disadvantage would be larger still. Any supposition that the mental health needs of this PP can be met adequately through remedial mental health care services, while their conditions of living remain unchanged, is profoundly unrealistic. The core policy problem to be addressed to improve mental health and wellbeing is exposure to socioeconomic adversity, not a lack of mental health services.

3.5.3 Recommendations

See Key Recommendation 2

Recommendation 16: **Identification of PPs should be cognisant of the difference between equity groups and other risk groups, and the potential for differences between PPs relevant to mental health policy objectives, and PPs relevant to suicide prevention.**

3.6 What range of actions are proposed, and which groups are they directed toward?

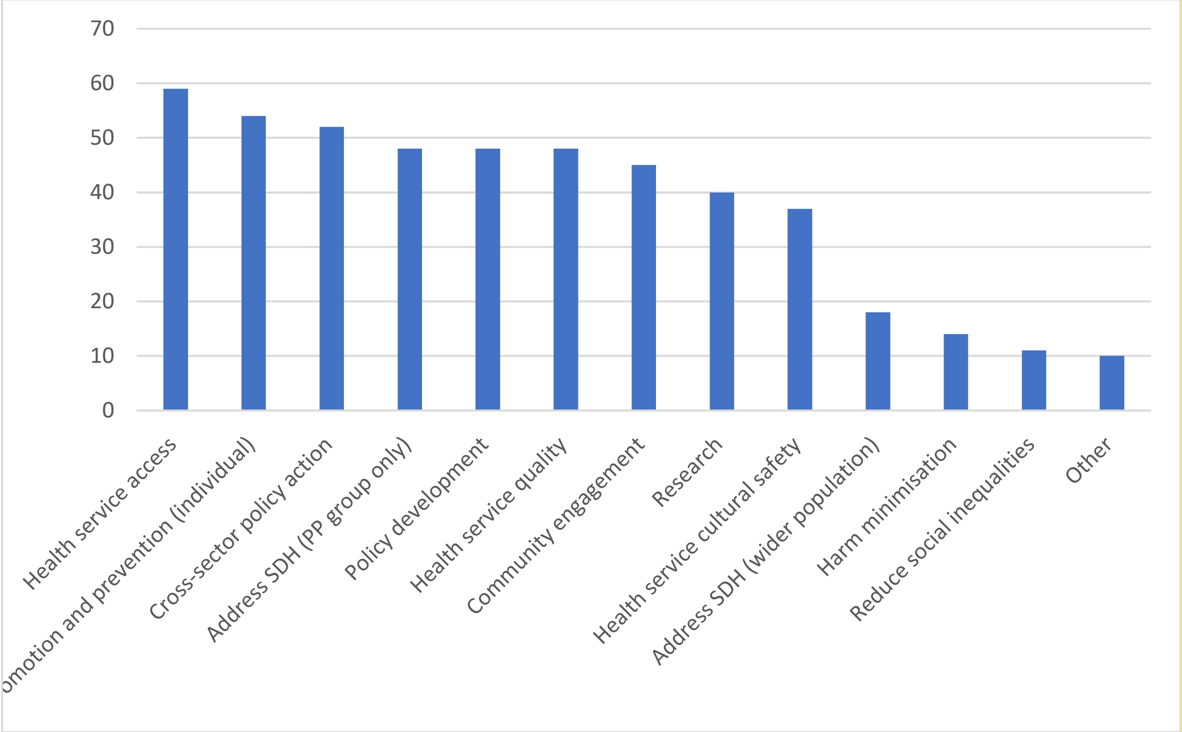
3.6.1 Findings

Policy analysis: In analysing each policy, we coded each proposed policy action directed toward a PP according to 13 types of action: Research, Policy development, Community engagement, Health service quality, Health service access, Health service cultural safety, Promotion and prevention, Harm minimisation, Cross sector policy action, Address SDH (PP group only), Address SDH (wider population), Reduce socioeconomic inequalities, and Other. These categories were based on previous research by Fisher and Baum (14). For example:

> **Research:** *"The Longitudinal ADF Study Evaluating Resilience (LASER-Resilience) is investigating those psychological and behavioural attributes that contribute to psychological resilience by studying new members as they adjust and progress in their military career."* Defence Mental Health and Wellbeing Strategy 2018-2023
>
> **Policy development:** *"Develop the Human Services Outcomes Framework (HSOF) application for homelessness, including introducing cross-agency requirements for reporting on homelessness outcomes."* NSW Homelessness Strategy 2018-2023
>
> **Health services quality:** *"Educate the health workforce about signs and risk factors of gender-based violence, and how to offer support to accessible, inclusive and responsive services."* WA's Women's Health and Wellbeing Policy
>
> **Health service access:** ***"****Improving the accessibility of mental health services including expanding use of new technologies like telehealth and telepsychiatry."* NT Mental Health Strategic Plan 2019-2025
>
> **Address SDH (PP group):** *"The NSW Government's Work and Development Order Scheme reduces financial stress for the most disadvantaged people."* Strategic Framework for Suicide Prevention in NSW 2018-2023:

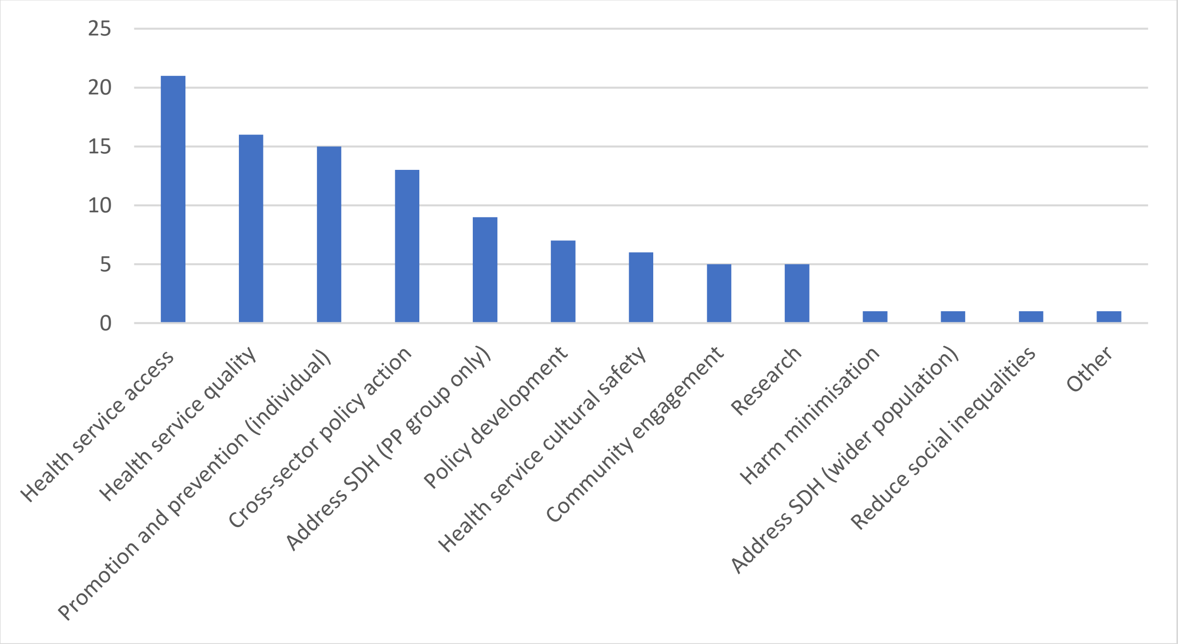
In each instance, we then cross-coded each identified action according to a list of 21 PP groups, including all those named in the NMHSPA. Summary analysis allowed us to assess the extent to which different kinds of policy action were proposed, and the extent to which proposed actions in general or specific kinds of action were directed toward different PP groups, across the whole data set. Around 2,400 policy actions were identified across the 62 reviewed policies. We assessed these firstly according to the number of policies containing each type of policy action, shown in Figure 5 below:

Figure 5: Number of policies containing types of proposed action



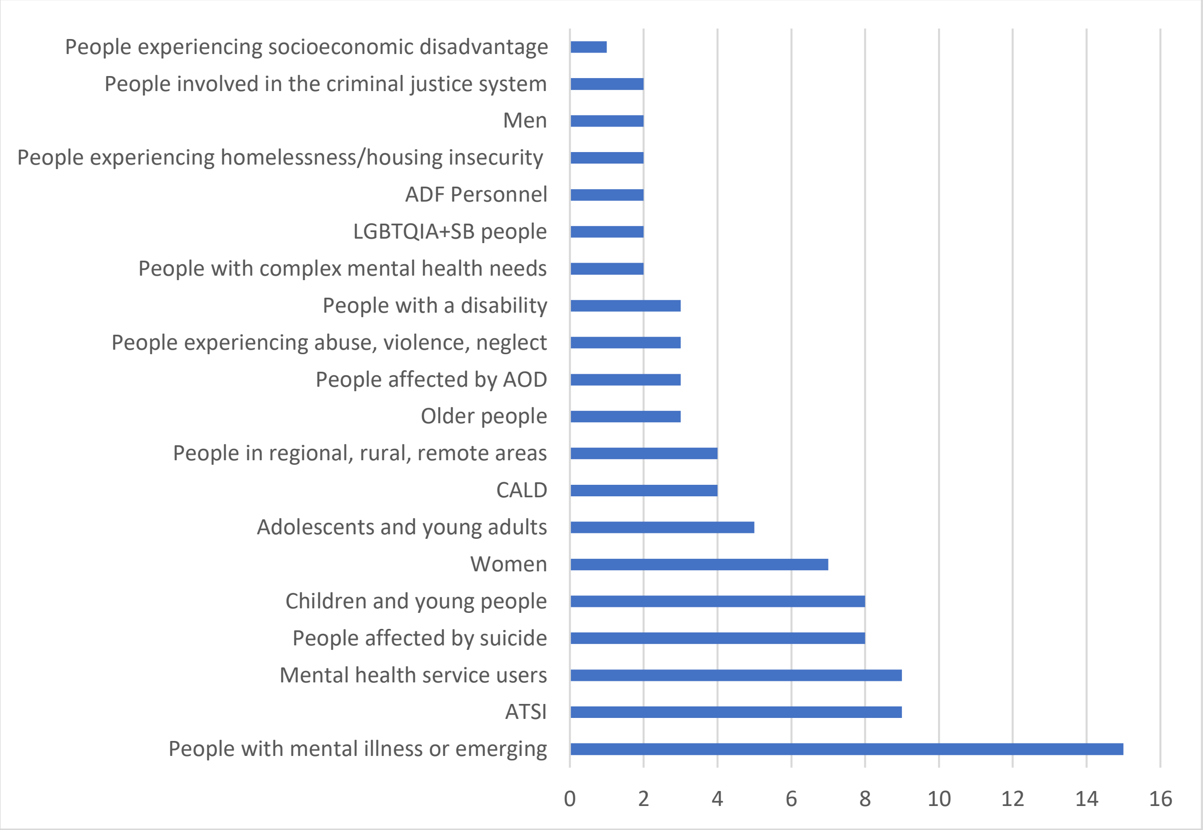
As shown, actions aimed at improving service access and at individual promotion/prevention were identified in the most policies (59 and 54 out of 62 respectively). Actions in areas such as cross-sector policy and community engagement were also found in a majority of policies. We then assessed frequency with which different types of policy action were proposed across the whole data set, calculated as a percentage of the total number of actions. Results are shown in Figure 6.

Figure 6: Frequency of types of action across all policies (%)



This shows that actions focused on improving access to or quality of mental health care, including service directed toward people affected by suicide, and individualised mental health promotion and illness prevention strategies were proposed most frequently. Thirdly, we assessed the proportion of all actions (n=2,409) aimed at particular PP groups as shown in Figure 7.

Figure 7: Proportion of all actions aimed at particular PP (%)



Together, the results show mental health services as the primary focus of policy actions proposed, and people with existing or emerging illness, and existing mental health service users, as two of the three groups toward whom the most actions are directed. We see this as reinforcing our view that mental health and suicide prevention policy and practice adopts a predominantly biomedical approach operationalised in delivery of remedial mental health services.

Literature Review: In the reviewed literature, it was less common for authors to outline suggested strategies to reduce inequities in mental health or suicide for priority populations, as the main focus generally was on justifying the need of the population. Where articles did make recommendations, they were usually individual health promotion or prevention strategies (such as tailoring health education resources and prevention strategies to the needs of the priority population), or health service access recommendations (such as ensuring mental health services are comfortable and acceptable to the priority population and improving referral pathways to mental health services for the priority population). Only six articles suggested addressing social determinants of health, such as addressing LGBTIQ+ discrimination in schools, restricting firearm availability for farmers, reducing alcohol availability, and increasing Aboriginal and Torres Strait Islander people's power and control over their lives.

Interviews: Data from our interviews with experts in the sector also reinforced our claim about the predominantly biomedical and clinical orientation of current mental health and suicide prevention policy. Participants also argued that this approach has particular, negative implications for members of PP groups.

> *"We're really looking at the theme of human rights and mental health particularly looking at the change in World Health Organisation definitions of mental health and their descriptions of what mental health services should do … and really trying to I guess through that lens, seeing mental health services as very narrowly medical, in general. And so, there's an enormous gap in terms of what people need to get on with their lives and what mental health services aspire to give in their services."* State/Territory NGO
>
> *"Having done a Master of Public Health, that's my mindset. What can we do to promote and protect people's health. What can we do to respond? In the mental health field, it feels like almost all our eggs are in the response and treatment basket when you look at policy and particularly when you look at funding decisions, and it felt like this was a big gap. But I think it's a gap that affects all populations, but clearly, is going to affect the populations who are more likely to experience multiple or more risk factors than others."* National NGO

In terms of the service models provided several interviewees raised concerns about 'standard' medical models of care that end up being a poor fit for particular PPs or are not flexible enough to be inclusive of a variety of needs.

> *"We say priority populations, but is that what is reflective in how we design and develop services? Do we prioritise or do we actually prioritise a homogenous model and then try and specialise or integrate or develop, often a bit late or a bit inadequately."* National NGO
>
> *"My understanding is if you design services with inclusion in mind, you create better services for everyone because the reality, most people don't fit into a homogenous model."* National NGO
>
> *"You can say all the things that will create an inclusive environment for Aboriginal and Torres Strait Islander communities, but if we aren't then investigating clinicians and practitioners and leaders and what we're actually bringing into that space that might actually block any meaningful change before it gets there just because of […] the implicit bias that we might be holding or the way that particular ideas and perspectives are privileged, then I think it's really challenging."* National NGO

Further to findings from the policy analysis, interviewees described how being named as a PP in policy does not necessarily result in actual investment in programs of services to meet the needs of that group; or is not followed up with considered planning for 'best fit' programs or services most likely to improve outcomes.

> *"The reality is that in the majority of national strategies where we are highlighted as a priority population, nothing happens. And so we sit there and we have conversations and we say, 'On the one hand you see us as a priority but then on the other hand, there is no investment in us, there's no program spend and there's no oversight.' ... and we don't really see any change in our health."* National NGO
>
> *"So, people have been told, 'These are your priority population groups,' for example, PHNs. But there's no acceptance in the mainstream around what those methodologies might be for implementation to enable a different outcome."* PHN representative

Finally, as several interviewees pointed out, if policy effort is directed primarily toward mental health services for diagnosed forms of mental ill-health, this is likely to miss the significant proportion of those who attempt suicide or die by suicide, who have not previously attended a mental health service.

3.6.2 Discussion

Evidence from our policy analysis and interviews supports our contention that mental health and suicide prevention policies adopt a predominantly biomedical and clinical approach. While we endorse and support access to primary, secondary and tertiary mental health services for PP groups, we see this biomedical orientation in policy as a barrier to action to address social and determinants of mental health and suicide, and a barrier to mental health promotion and illness prevention, because it positions both problem and solution wholly within the individual's biology, psychology, and behaviour, and positions its action *after* illness has already occurred. These weaknesses in policy have negative implications for PP groups (and equity groups in particular) because members of those groups will often stand to benefit most from effective policy action on determinants of health to reduce socioeconomic inequalities, reduce exposure to systemic stressors, and increase access to determinants of positive mental health and wellbeing (8).

Another significant finding is that some groups which figure prominently as PPs named in the *National Mental Health and Suicide Prevention Agreement* and other policies nevertheless appear to attract relatively little attention in terms of proposed policy actions (Fig. 7). For example, this appears to be especially true in relation to LGBTIQ+ people and people experiencing socioeconomic disadvantage. This is a significant finding for several reasons. It provides evidence that there is *no necessary connection* in policy between being named as a PP and commitments to actions to address the needs of that group. In a few instances, groups treated as PPs were not named, as with the focus on perinatal mental health in the National Mental Health and Suicide Prevention Agreement and associated bi-lateral agreements with States and Territories. This finding was also reinforced in analysis of individual policies. If such a connection is not reliable it undermines the whole rationale of naming PPs in the first place. The paucity of actions directed toward people experiencing socioeconomic disadvantage is troubling, because such disadvantage is a major determinant of mental ill-health across multiple PP groups. It may be indicative of the fact that many of the policy mechanisms needed to address socioeconomic inequalities sit outside the Health sector.

However, notwithstanding the points above, our findings also indicate a body of actions on promotion and prevention, on social determinants, and on cross-sector action. We will examine these in more detail in sections to follow.

3.6.3 Recommendations

See key recommendation 1

Recommendation 17: **Stakeholders in the mental health and suicide prevention sector should examine ways to reassess policy and practice, to include but extend beyond biomedical conceptions and practices.**

Recommendation 18: **Policy makers should recognise populations affected by climate change/extreme weather events as a PP group and plan 'best fit' strategies to meet their needs.**

3.7 Responses to Aboriginal and Torres Strait Islander social and emotional wellbeing

3.7.1 Findings

Policy analysis: As reported above, Aboriginal and Torres Strait Islander peoples were found to be the most frequently named PP in the policy documents analysed. Selected policies included policies specific related to Aboriginal and Torres Strait Islander social and emotional wellbeing in several jurisdictions. In our analysis of all actions proposed in policies against PP groups, the second largest groups of actions were directed toward Aboriginal and Torres Strait Islander peoples.

Policy statements and actions proposed frequently recognised a principle of Aboriginal and Torres Strait Islander leadership in policy development and delivery.

> *"The Federal Government must be led by Gayaa Dhuwi (Proud Spirit) Australia, and Aboriginal Community Controlled Health Organisations (ACCHOs), in identifying emerging evidence-based therapies and interventions that work for Aboriginal and Torres Strait Islander peoples and communities."* National NGO policy statement

> *"There is an expectation that health services partner and work collaboratively with Aboriginal people with lived experience of a mental health issue as well as carers and families to co-design services and systems of care."* NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025

> *"Work with Aboriginal and Torres Strait Islander communities through local decision-making bodies, as part of the implementation of Local Thriving Communities reform."* Every life The Queensland Suicide Prevention

> Plan 2019–2029
>
> *"Child and family mental health and wellbeing supports for Aboriginal and Torres Strait Islander communities should be delivered by Aboriginal Community Controlled Organisations wherever possible."* National Child Mental Health and Wellbeing Strategy

We found that policies also recognised a number of other issues important to Aboriginal and Torres Strait Islander social and emotional wellbeing, including: improved workforce capacity for culturally safe mainstream services; building the Aboriginal and Torres Strait Islander workforce; desire for strength-based strategies and avoidance of deficit discourse; implementation of localised strategies; and recognition of social and cultural determinants of Indigenous health and wellbeing. For example:

> *"Lead a cross-agency initiative to promote a more strengths-based approach to Aboriginal and Torres Strait Islander Queenslanders, underpinned by the Tracks to Treaty agenda, that includes celebrating culture, supporting self-determination and reducing negative discourse towards Aboriginal and Torres Strait Islander peoples."* Every life The Queensland Suicide Prevention Plan 2019–2029
>
> *"Develop cultural understanding amongst health professionals to work safely and effectively with Aboriginal and Torres Strait Islanders children and families, and provide greater support for Aboriginal Health Workers to engage in child mental health focused ongoing education and training."* National Child Mental Health and Wellbeing Strategy
>
> *"The Aboriginal Health Council of Western Australia (AHCWA) delivers the Family Wellbeing Program across Western Australia. … As part of the Family Wellbeing Program, AHCWA delivers a culturally appropriate version of the Certificate II in Family Wellbeing to Aboriginal Communities."* WA Suicide Prevention Framework

Interviews: Interviewees also recognised an essential principle of Aboriginal and Torres Strait Islander leadership in policy development and delivery

> *My view is really that – what I hear Aboriginal people saying is, "Don't do stuff for us. Let us lead the way. We'll ask you for the support we need or the guidance we need or the resources we need."* National NGO
>
> *"We have quite a good relationship with Gayaa Dhuwi, the Proud Spirit organization. …We rely on our Aboriginal and Torres Strait Islander members to provide us with guidance on what needs to happen in their area. We're quite strong on making sure that what we say is what they're saying."* National NGO
>
> *"There are three [of our services] run by ACCHOs … And we're actually in the process of working with one of the primary health networks … to look to increase the number of ACCHOs running [our services]."* National NGO

Interviews also spoke to on-going issues of data on health inequities affecting Aboriginal and Torres Strait Islander people and how this intersects with deficit-based thinking in policy:

> *"Aboriginal and Torres Strait Islander [peoples] have been 'at risk', 'vulnerable' and 'priority populations' depending on the current term. Particularly with that group there is a sense of problem, problem, problem, problem."* National NGO
>
> *"So, in terms a deficit discourse, that's how governments structured the program. If you try and secure resources to be able to do undertake a good response, you have to provide evidence that shows the deficit – the gap. So, a lot of how you apply for resourcing is predicated on that sort of evidence.* National NGO

3.7.2 Discussion

We support the leadership role of the Gayaa Dhuwi (Proud Spirit) Organisation (38), the Aboriginal community-controlled health sector and other Aboriginal and Torres Strait Islander advocacy and workforce organisations around Australia.

3.7.3 Recommendations

> ***Recommendation 19:* All stakeholders should continue to support and fund Aboriginal and Torres Strait Islander leadership in policy development and delivery for Aboriginal and Torres Strait Islander social and emotional wellbeing.**

3.8 Intersectionality

Intersectionality has been defined as "the interconnected nature of different demographic characteristics and experiences, such as race and gender. Human lives cannot be reduced to single characteristics and experiences cannot be accurately understood by prioritising any one single factor" (39). This is highly relevant to PPs in the context of mental health and suicide prevention policy, emphasising that the definition of PPs do not describe wholly discrete and separate groups, but rather that people identified and/or identifying with any one PP are likely to identify with other population groupings as well, such as, for example, a young gay man living in a rural community fits (at least) three of the PP categories named in the NMHSPA (See Box 1). In this sense, intersectionality is likely to be the norm rather than the exception.

Method of epidemiological analysis used to identify defined population groups as at relatively higher or lower risk of mental ill-health or suicide compared to other groups *describe real phenomena occurring at a population level* and provide essential information for policy makers about needs, distribution of health risk and outcomes, and determinants of mental health. However, unless designed to do so, they do not necessarily describe the more complex, 'intersectional' reality of individual lives.

3.8.1 Findings

Policy analysis: Several policies identified that people belonging to more than one PP group may experience additional layers of complexity that influence their mental health and wellbeing, and suicidal ideation. However, while there were examples of intersectionality throughout the policies, only five policies explicitly used the term, one of which identified intersectionality as a policy pillar:

> *"Gender equity and intersectionality. The Policy highlights gender as a key determinant of women's health and wellbeing. Gender intersects with other factors influencing health outcomes such as race, ethnicity, religion, culture, Aboriginality, immigration status, disability, geographical location, socioeconomic circumstances, age, sex characteristics and sexuality. Achieving gender equality often requires gender specific programs and policies to address existing inequities. By considering the needs of women and men, a more targeted approach to improving the health and wellbeing of the whole community can be undertaken and greater results will be achieved."* WA Women's Health and Wellbeing Policy.

The policy goes on to say: "Intersectionality is taking an approach that considers the complexity of a person's lived experience. It considers the multiple forms of discrimination that can be experienced as they relate to a person's identity (or many identities), and how systems and structures interact to reinforce the discrimination" (p. 36). Examples of intersectionality, while not often named as such, were common throughout the policies analysed:

> *"Young refugees are six times more likely to become homeless than other young people. The temporary, transitory, and often overcrowded nature of accommodation common to newly arrived migrants and refugees qualifies as many as 33 per cent as homeless at some point after arriving in Australia."* NSW Homelessness Strategy 2018-2023

> *"There are a range of diverse groups within the veteran and ex-service community, including various cultural backgrounds, ethnicities, religions, same sex partnerships and single parents."* Veteran Mental Health Strategy 2013-2023

> *"Vulnerable young people who are at higher risk of poor health and wellbeing include those who: are Aboriginal; are homeless or at risk of homelessness; are sexuality and/or gender diverse (LGBTI); are entering, in, or exiting Out-of-Home Care; are under justice supervision; are refugees or newly arrived*

> *migrants; have physical or intellectual disabilities; have a chronic or complex condition, including mental health disorders; are a young carer; have experienced family, domestic, intimate partner or peer violence; live in rural and remote areas; are pregnant and/or parenting."* NSW Youth Health Framework 2017-2024
>
> *"Human health is dependent on planetary health. Environmental issues, such as extreme weather events and significant changes in climate systems, have had, and will continue to have, an impact on the health and wellbeing of all Australians. This is particularly true for rural and remote communities, including Aboriginal and Torres Strait Islander people, who have close cultural, spiritual, and social connections to the land."* National Preventive Health Strategy 2021-2030

Literature review: Intersectionality was also described in a number of journal articles reviewed, and some of these raised a key issue regarding the implications of policy naming PPs and planning strategies to meet the needs of those groups. As described earlier (in Section 3.5.1), the concern is that the identification of a PP can lead to policy action which assumes wrongly that the mental health risks or needs of people identified with a particular group are related uniformly and only to that aspect of their life circumstances or identity. Thus, salient differences within the PP can be overlooked:

> *''Young people' are identified as a target population in the majority of drug strategy documents; however, references to 'young people' are overwhelmingly gender-neutral, and the differences between young men and women are rarely discussed (this de-gendering of 'young people' in the NDS is also noted by Moore et al., 2015)."* (40)

A positive example of considering intersectionality in the literature is a Three Rivers University Department of Rural Health report (41) summarising evidence around social isolation, loneliness, and mental health. This report considered priority populations such as Aboriginal and Torres Strait Islander people, older people, and LGBTIQ+ people, but also considered evidence for people at the intersection of these identities, with sections on, for example, 'Older LGBTI people", "Mental health issues for older Aboriginal people", and "Sexual minorities in CALD communities".

Interviews: All of the people interviewed for the research spoke to the issue of intersectionality. Their reflections highlighted five perspectives on the issue which relate to the ways PPs are recognised and addressed in policy and practice.

1. That organisations should not assume members of a PP have uniform needs related only to that aspect of their lives, but rather expect and respond to diversity of need within that group.
2. A person who might identify themselves with multiple PPs may also be subject to multiple and potentially compounding forms of discrimination and/or disadvantage, placing them at greater risk of ill-health or distress (compared to the risk associated with exposure to just one of those risk factors).
3. Parcelling out policy funding according to assumed, 'neat' distinctions between PP may not be effective.
4. Recognition of intersectionality provides a compelling argument for inclusive, person-centre services, which treat users as whole people with their own particular combination of life circumstances rather than a) just a unitary identity, or b) just a collection of 'disease' symptoms.
5. There may be a tension between advocacy to get the needs of a particular PP recognised by policy makers, and recognition of intersectionality.

Several interviewees also spoke about how their own organisations were acting to take account of intersectionality.

> *"And then there are those issues for those intersections, so more of those sorts of issues in relation to people with disability, people from CALD backgrounds, who have that multi-layer discrimination that they live with. So, for white cisgendered people who are lesbian, gay, bisexual, there's still those issues of course right? But then we do see those more exacerbated when we start looking at intersections with that and with trans and gender diverse people."* National NGO

> *"And then the other reason for [our choice of] those four [priority groups] is the intersectional lens on each of those, because they compound in terms of both risk and reluctance to help-seek. And the other aspect from each of those areas is around services needing to ensure thought is given to the inclusion of people in each of those groups or more than one of them."* National NGO

> *"It's a two-edged sword. Because people doing their own advocacy or advocacy for their families, or whatever, they recognise that, yes, if people are being identified as a priority population, they're finally being seen. But, of course, the double-edged sword is what happens then? Can they then escape that definition and all that comes with that? As I was saying, the system tends to keep people in that definition."* Researcher

> *"Just the other day, we met with an organisation that represents First Nations, LGBTQI+SB community people and so just drawing in the relevant areas and making sure that intersectionality is recognised and supported. I think also the national agreement speaks to a person-centred approach to care and so, understanding the needs of an individual person and meeting those unique needs, addresses that intersectionality too."* Federal health department

> *"I think, so now often we include that term, and we often do a line about it, that people experience many of these challenges, and they can be exacerbated. But I think we haven't moved beyond acknowledging it. And there's that tension between acknowledging needs of particular groups that are different but also acknowledging that people can belong to multiples of these groups."* National NGO

One interviewee spoke to the need to recognise diversity of need within Aboriginal and Torres Strait Islander populations, and avoid assumption of a uniformity of needs:

> *"My point with the equity diversity issue was that Aboriginal people, for example, are rural remote, English is not a first language, and they're Indigenous. I don't mind that different 'user groups' get identified because again [without that] we'd run the risk of assuming - that how the service or program or access is provided assumes a whole lot of similarities that aren't true. It's not the best use of resources. It doesn't get to where it needs to go."* National NGO

One major organisation in the sector has responded to intersectionality by moving away from population specific models of service toward a model of universal but inclusive services, taking account of a variety of needs.

3.8.2 Discussion

The phenomenon of intersectionality in mental health and suicide prevention points to a number of lessons for policy makers, representative groups, and service providers in relation to PPs:
a) Intersectionality supports the value of inclusive person-centred mental health care services.
b) Individuals or group facing exposure to multiple intersecting risk factors may face compounding effects on mental ill-health or suicidal distress.
c) Organisations naming and seeking to support PPs should expect and prepare to accommodate diversity of need within that population.
d) There is significant potential to improve outcomes across multiple PPs by addressing major common risk factors such as socioeconomic disadvantage.

3.8.3 Recommendations

> ***Recommendation 20:*** **Stakeholders in the sector should understand intersectionality and seek to address it in their responses to priority populations.**

3.9 Mental health promotion, illness prevention and suicide prevention

Health promotion has been defined as "the process of enabling people to increase control over, and to improve, their health" (42). According to Margaret Barry, "Mental health promotion is concerned with achieving positive mental health and well-being at an individual, community, and population level." She goes on to say that "Alongside strategies for strengthening individual's skills and competencies, mental health promotion also focuses on improving the social, physical, cultural, and economic environments that determine the mental health of populations and individuals" (43). Effective mental health promotion and illness prevention has significant, under-utilised potential to improve mental health outcomes and reduce suicidal distress in Australia (44).

Strategies for prevention of mental ill-health or suicidal distress can be divided into three categories:
1. **Primary prevention** aims to prevent people developing mental ill-health, or suicidal distress by preventing or reducing exposure to risk factors (determinants).
2. **Secondary prevention** aims to detect early signs of mental ill-health or suicidal distress and prevent it getting worse.
3. **Tertiary prevention**, directed toward people with existing mental illness or at high risk of suicide, aims to improve quality of life, aid recovery, manage symptoms, and prevent acute episodes.

3.9.1 Findings

Policy analysis: Many policy actions coded as 'promotion and prevention' in our analysis were secondary or tertiary prevention strategies. Two kinds of secondary prevention actions were common:
a) Strategies to improve individuals' personal skills or behaviours related to mental health, such as health literacy, help-seeking, self-care or reduced alcohol or drug use.
b) Strategies to improve access to early intervention mental health services.

One can observe that both these approaches carry suppositions of emerging mental illness, consistent with secondary prevention, and neither recognises or addresses reducing exposure to social, cultural, economic, or environmental risk factors. For example:

> *"NSW Health is funding the delivery of Mental Health First Aid across NSW to improve mental health literacy and equip people with the skills they need to provide appropriate support to people experiencing mental health problems."* Strategic Framework for Prevention of Suicide in NSW 2018-2023

We identified very few whole-of-population mental health promotion or primary prevention strategies. However, a range of strategies directed toward at-risk PP groups did aim to improve exposure to protective factors such as social support and/or reduce exposure to risk factors. For example:

> *"Work with partner agencies to support and provide health promotion information, programs and services, and create healthy environments for young people in line with state and local priorities that support healthy living, physical and mental wellbeing, health literacy, harm and demand reduction, sexual and reproductive health, and injury prevention."* NSW Youth Health Framework 2017-2024

Interviews: Interviewees emphasised the need for a systemic approach combining both universal (whole of population) and targeted (PP) mental health promotion and illness prevention strategies. Some argued the value of equipping people with life skills while others highlighted to importance of addressing social-environmental risk and protective factors. Most agreed that current policy focus and resources are predominantly directed toward remedial and clinical responses to illness, conditioned by a biomedical and clinical view of mental health; meaning that policy support for promotion and prevention is relatively weak and limited. However, some government interviewees described funded promotion and prevention programs delivered by key NGOs. Some interviewees addressed the issue more systemically, arguing a need for a much stronger promotion and prevention 'infrastructure' including policy, a lead national agency, revised funding models, and research to shift policy thinking and highlight relevant issues in public debate. Some interviewees' comments reflected the individualised, secondary, or tertiary prevention focus of written policies:

> *"One of the messages … in our Mental Health Promotion is to actually remind people that they're in charge of their own life. … a large part of mental health is how you live your life with the condition. So, that the*

> *medical part can be really valuable – it can be a lot, can be a little – but then the bigger part is how do you pick yourself up again and get on with your life.”* State/Territory NGO
>
> *“Our approach - and women are admitted to this very structured program for five days - is to increase their care-giving capabilities, so really to get them to understand the babies' needs better and then learn the skills of making sure the baby does have enough sleep, that feeding is separated from going to sleep, that they understand the babies' needs for cognitive stimulation and play, and week after week for more than 25 years I see women transformed by that approach.”* Researcher

Others emphasised the importance of promotion and primary prevention addressing environmental risk and protective factors:

> *“I think in terms of the health equity priority populations, there's the funding for prevention is woefully inadequate still. We estimate … that less than 2% of the mental health budget is directed towards prevention activities.”* National NGO
>
> *“There are different ways to talk about resilience or strengths versus tackling risk, promoting protective factors versus tackling risk factors. Individual focused efforts versus settings and social policy. Clearly both are required. We do need to support individuals … to learn certain self-care skills or build their mental health literacy, whatever it is. Absolutely important. But the truth is it probably gets weighted towards those things, the interventions, partly because they’re easier to study and research.”* National NGO
>
> *“I think about mental health promotion in terms of applying something like the Ottawa Charter of health promotion to the mental health space. How do you provide individuals with the skills they need to manage or enhance their mental health? How do you create mentally healthy environments, like workplaces, homes, and communities? How do you create community action around mental health? How do you advocate for mentally healthy public policies? How do you integrate mental health promotion into the services that we deliver?”* National NGO
>
> *“We do work on the prevention of infectious disease. We do work on the prevention of injury. We do work on the prevention of cardiovascular diseases and cancers, diabetes. … We’ve got an authorising [policy] environment. We’ve got particular funding pools or funding mechanisms. We’ve got key players. We’ve got a workforce. I call that a system. I call that a health promotion/public health system, but in mental health, we only have a mental health care system, but not a mental health promotion system.”* National NGO

Some interviewees also raised problems with funding models leading such as short-term and insecure funding of programs, and prescriptive PHN funding restricting capacity to respond flexibly to local priority needs:

> *"We see in the disability field, this constant repetitive grant rounds for two years of funding, it’s like ‘please stop doing that because it’s a waste of money’, you get programs that start and then they don’t quite finish and then they start a new one. They’ve started to look at three- and five-year funding, which I think is much better.”* National NGO
>
> *“…we do have a focus on alcohol and people who have substance use disorder and then at times, depending if funding permits and this is where it’s often just very influenced by policy, but eating disorders is a known priority in our region as well. It’s difficult for us to address that without it being dedicated funding [for] things like that as well. So, there’s some priorities that it is a priority for us but we can’t or we are limited in our ability to address."* PHN representative

3.9.2 Discussion

In general, the understanding of ‘promotion and prevention’ exhibited in policy appears to be weighted toward improving the skills or motivation of at-risk individuals or groups to cope more effectively with their conditions or to seek early treatment. Like a biomedical frame, this stance also constructs both problem and ‘solution’ within the individual and is a barrier to understanding of the potential for and importance of promoting mental health promotion and primary prevention through action on risk and protective factors (i.e., determinants of mental health). This bias is characteristic of

Australian health policy in general (14, 45), and may be reinforced by research focused on devising and trialling behavioural interventions. Interview data indicates that the biomedical focus of mental health and suicide prevention policy 'pushes' resources into remedial clinical services and restricts policy support and resources for an effective system of mental health promotion and prevention.

While we recognise the potential value of skill-building or help-seeking programs for members of PP groups, a predominant policy focus on such programs reduces the overall potential for promotion and prevention strategies to improve mental health outcomes, reduce suicidal distress and promote wellbeing.

3.9.3 Recommendations

> ***Recommendation 21:* Sector stakeholders should support calls for development of a mental health promotion system in Australia, informed by the Ottawa Charter for Health Promotion.**
>
> ***Recommendation 22:* Mental health promotion, illness prevention and suicide prevention strategies should encompass: a) both whole-of-population and targeted PP strategies; b) actions on health promoting environments and reducing risk factors, as well as on skills and behaviours; c) actions at all three levels of prevention.**
>
> ***Recommendation 23:* Localised, community-driven strategies such as SA's suicide prevention networks warrant consideration for additional policy support, funding and expansion.**

3.10 Role of health services

Access to available, affordable, appropriate, and culturally safe primary, secondary and tertiary mental health care services is important for members of PPs, who are at greater risk of mental ill-health than other comparable groups. The make-up of the mental health and suicide prevention services sector in Australia is highly complex, and has been analysed in detail in several recent, major reports (3, 5, 6). Here we will limit our reporting and discussion to specific issues related to PPs as revealed in our research. Like many areas of health policy, responsibilities for mental health care services in Australia are split between the Federal and State/Territory governments. State/Territory governments fund and manage clinical mental health service directly, with support from the Commonwealth. State and Federal governments jointly and separately fund various NGOs to deliver services. The Federal government funds limited access to psychiatry and psychology services on referral through Medicare, and also fund Primary Health Networks to commission mental health services within their respective regions. Access to some forms of mental health care has been subject to significant, structural inequalities in access related to differences in socioeconomic status or geographic location (46).

3.10.1 Findings

Policy analysis: Within the policies analysed, policy actions directed toward mental health service access, quality and/or cultural safety for PPs featured prominently and covered a very wide range of specific measures. Just some examples follow:

Access:

> *"Addressing the critical lack of after-hours support for people in suicidal crisis outside of emergency departments (EDs) and anonymous helplines, especially in rural and remote settings."* WA Suicide Prevention Framework 2021-2025
>
> *"Expand treatment and prevention services for crystal methamphetamine, in particular ice, dependence in eight centres across Queensland – Logan, Townsville, Rockhampton, Gold Coast, Charleville, Cunnamulla, Weipa and Cooktown."* Qld Aboriginal and Torres Strait Islander Mental Health Strategy.
>
> *"Establishing one new Headspace site to increase access to youth mental health services."* Bilateral Schedule on Mental Health and Suicide Prevention: South Australia

Quality:

> *"Build capacity through appropriate professional development opportunities relating to identification, assessment, treatment and response to suicide for GPs, frontline workers, health, mental health and primary care staff."* WA Suicide Prevention Framework 2021-2025
>
> *"Incentivise existing service providers (including GPs, maternal child and family health nurses and allied health), with a focus on practitioners in rural and remote areas, to complete training in children and family mental health assessment and treatment."* The National Children's Mental Health and Wellbeing Strategy
>
> *"As part of a comprehensive approach to crisis care reform, trial new and innovative crisis care options that include or are led by peer workforces."* Every life The Queensland Suicide Prevention Plan 2019–2029

Cultural safety:

> *"Develop a mental health cultural capability training module and mandate its inclusion in the induction for clinical staff, nurses, allied health staff, Queensland Ambulance Service and administrative staff, with a refresher course to be undertaken every five years."* Qld Aboriginal and Torres Strait Islander Mental Health Strategy.
>
> *"Co-funding, on a 50:50 basis, the establishment and ongoing operation of an Aboriginal Mental Health and Wellbeing Centre … to improve access to culturally appropriate, multidisciplinary mental health and wellbeing services for Aboriginal and Torres Strait Islander peoples and improve service integration."* Bilateral Schedule on Mental Health and Suicide Prevention: South Australia
>
> *"Recommendation: Fund the co-design of culturally appropriate mental health services and suicide prevention programs, which would be jointly implemented by CALD community organisations to address stigma, target vulnerable groups and increase utilisation of mental health and suicide prevention services in cross-generational CALD communities."* NGO submission to a government enquiry

Stepped care models: Stepped care is defined by the Australian Government as 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the individual's needs' (47). Stepped care approaches have become increasingly common in response to health problems including mental health, largely as a perceived means to enhance service efficiency and cost-effectiveness. Stepped-care frameworks were referenced in 21 of the 62 reviewed policies, with a clear emphasis on mental health and suicide-related health care and treatment. The framework was often referenced in the context of meeting the needs of individuals and delivery of person-centred care. For example:

> *"A stepped care approach promotes person centred care which targets the needs of the individual: Rather than offering a one size fits all approach to care, individuals will be more likely to receive a service which more optimally matches their needs, does not under or over-service them, and makes the best use of workforce and technology. A stepped care approach also presumes early intervention – providing the right service at the right time, and having lower intensity steps available to support individuals before an illness develops or gets worse (Department of Health, 2019)."* Mental Health and Suicide Prevention Regional Plan Central and Eastern Sydney 2019-2022

There were few examples of policies where health equity and PPs other than those with emerging or existing mental ill-health were considered within the stepped care framework. Examples were provided by the *WA Primary Health Alliance Mental Health Strategy 2020-2023* (WAPHAMAS) and *NT Mental Health Strategic Plan* (NTMHSP). The WAPHAMAS is comprised of six elements, one of which is the concept of place and place-based decision making. While the focus on services remains, there is additional consideration for the social services that people may require as well as infrastructure needs for particular PP. Tasmania's *Rethink Mental Health Plan 2020* provided a similar approach, including a "services focus on underserviced groups and priority populations" as one of the 10 principles of stepped care.

The NTMHSP has six priority areas, one being: Priority 6: Equity, sustainability, and a stepped care approach. Within this priority, although there is still a focus on mental health services, the outlined commitments move beyond service efficiency and targeted care. For example, one action is to provide:
"Career development pathways for Aboriginal and multicultural workers, including fostering leadership within services to promote recruitment and retention of Aboriginal staff and the development and implementation of culturally appropriate programs and services." Northern Territory Mental Health Strategic Plan 2019-2025.

Literature Review: The peer reviewed literature identified concerns with access, quality and cultural safety for different priority populations.

Access concerns included recommendations for community outreach to improve priority population access to mental health services, intersectoral collaboration to intervene early with priority populations and support their access to services, the need to establish trust with priority population communities, and inequities in health care access for people living in rural and remote areas of Australia.

Quality concerns included wanting to ensure "that people in justice settings receive care of an equivalent standard to that provided in the community" (48, p. 31), outlining best practice in gender affirming care, and developing models to provide quality emergency mental health care to act as alternatives to the Emergency Department.

Cultural safety concerns included Western perspectives of mental health dominating the provision of mental health care, which may be inappropriate for Aboriginal and Torres Strait Islander peoples, language as a barrier to mental health help-seeking, and lack of tools in other languages. For example, Blignault (34) noted "Where Arabic-speaking mental health professionals are employed, as is the case at St George Mental Health Service, they face a scarcity of linguistically and culturally appropriate clinical tools." (p. 553)

Interviews: Interviewees spoke to a range of issues affecting or relevant to access to affordable, appropriate, and safe, person-centred mental health care for PP groups:

1. Access to both mainstream (universal) and group-specific (targeted) health services:
   "We do fund both mainstream services and through Headspace … which are expected to develop cultural competency and safety to service the needs of First Nations populations, but we also fund targeted programs for example, with NACCHO, we're working with them to establish 31 First Nations-led services across the country … I think they are good First Nations examples, but we do that with all of the priority population groups. Trying to build the cultural competency of mainstream as well as delivering specialist services so that people have choice and that's what we hear from our stakeholders too, in terms of what they want to see delivered." Federal Department of Health

   "There is a role, an important role for designated services but we also need generalist services to be able to pick up and work with people. I mean, I'm very lucky for example. I have a really amazing GP who is a member of our community, she's got a massive caseload of lesbians and trans men, she's able to refer us. If I'm sent to a specialist by her, I know I'll get a specialist who's really good." National NGO

2. A biomedical, disease-focused approach to mental health care as a potential barrier / need for person-centred care:
   "The lived experience messages that we get are that the services often miss the mark … Someone goes to the emergency department, and they're assessed for their medical issues … when the trigger could have been the anniversary of someone's death or a bust-up with a long-term partner … And it's just that thing of working with people as people and asking those questions." State/Territory NGO

   "The difficulty in health and mental health is that [PPs are] generally not part of the conversation. Like say state funded services, at the moment with those they deal with whoever is coming through the door, they're

not touting for business. If you've got low numbers of Aboriginal people turning up to your service, it's kind of like we're still full and there's a limited care factor I suppose for that." State/Territory NGO

"I think for people with the suffering that goes with daily life, in a way, and with day-to-day experiences, I think really with them we should be taking a much more comprehensive approach that understands the importance of psychosocial contributors, and psychosocial needs as people get better." Researcher

"And one of the things I say that we need is just for everyone to become a bit kinder […] if we had people that we're just a bit kinder, a bit more curious, didn't make assumptions, just those basics around how we engage with people, it would make things very different." National NGO

"So, in the lived experience area, people put all of their life bits together, and it makes sense. They get up in their day, and they carry all of themselves around with them, every day. If you know what I mean? But as soon as they engage with systems, they only look at the parts." Researcher

3. Barriers to accessing clinical services; Emergency Departments as entry points:
   "Most of the services that are delivered by the NGOs are psychosocial supports. Often though the models mean that people can't access them directly … the state government funded services you get referred through Community Mental Health, which means essentially, you've been through a pathway of going to the Emergency Department at least once and then you get referred to the Community Mental Health team … they're really good services, it's just you could have spent years kicking around emergency departments before you get access." State/Territory NGO

4. Potential benefits of localised responses to service planning:
   "[Our service centres] would all do it a little bit differently and it does depend on where they are. What we do in our model integrity check …[is ask] how they promote access for the priority groups and then there's no fixed answer for that. But we can check their data and so the national mean for LGBTIQA+ young people at centres moves between 26 and 29, 30%. But some centres are up at 45, 50%. And so, if you've got a centre that's got 10%, then it's basically the model integrity framework would look into that … and there's some more qualitative conversations that happen with 'what is it that you're doing to engage your local population?' National NGO

   "Look, I'm completely convinced that local solutions are essential because I don't think we can presume that what happens in Toorak in Melbourne is the same as what happens in Mallacoota, and I think communities have shown that, when given the opportunity, they can identify well what it is that's needed." Researcher

   "The fact that we've got the number [of local Suicide Prevention Networks] that we do is a really good sign, and it highlights that there are a lot of people who want to support efforts at a local level, which is about preventing suicide or promoting those protective factors in communities … what also is terrific is that mental health or the suicide-prevention literacy that is developed in that awareness and that skill-building that's happening within communities." State health agency

5. The potentially valuable role of Primary Health Networks (PHNs) to tailor services to local needs:
   "There is also a focus through the funding we provide through PHNs for mental health services. PHNs do need to understand the local community in which they operate and the population that makes up their area and direct funding to support priority populations within their region so that is written into the agreements and a key focus for them." Federal health department

   "So when you think about culturally and linguistically diverse and that category of priority pops, there is a huge amount of diversity, and we know that, like the south Brisbane PHN has a large Pacifica population and so they're able to target supports as well as some of the Melbourne PHNs do more work to support LGBTQA+ communities. Yeah, absolutely that's their role and does work so that they can target more specifically the needs of priority populations in their region." Federal health department

   "There's a new program …, which is an investment across all PHNs to employ a suicide prevention and coordinator or a leader role and then to co-design activities with some funding to prevent suicide in local

communities. That's part of the previous suicide prevention trials, which operated in 12 PHNs across the past six or seven years." Federal health department

But also, questions raised about the current position of PHNs in the national health system:
"And I've often seen that as a big gap in the system and what I believe the original intention of Medicare Local and then PHN was, was to do that health promotion […but] the commonwealth priority has moved more into commissioning of work, we've moved away from that health promotion, health literacy […] and that is not particularly anyone's role at the moment. A little bit of state government, a little bit of PHN but […] very little funding is rolled down for anyone to do it, no one is particularly responsible for it." PHN representative

"There's feedback from Aboriginal community-controlled health organisations that there is this systemic, historic racism that's built into the funding structures and that requires a change in the way funding is done. And I know it is actually the Department of Health's intention is to exclude PHN from that funding process, at least from the Commonwealth funding stream and allow self-determinants in how programs are designed and run and administered. […] So we are taking a step forward on that […] and we're intending to move to that even before the Department of Health do […] we want to just provide funding for our Aboriginal community-controlled health organisations and allow them to just design their own model." PHN representative

6. Role of people with lived experience: leadership, policy development and workforce

"We're just about to embark in the new year, well, probably from about March, on some co-design workshops across the country and nationally, and we're working … to recruit diverse lived experience, to try and get representation across those priority groups to participate in session to guide the way in which they want to see services and funding invested." Federal health department

"We know that potentially the people who are most in need or at least potentially have more risk factors, are not accessing the system, I think the workforce is something we also need to think about and look at. What is the diversity of the mental health workforce? … [can we] enhance the accessibility, diversity, inclusion of those workforces and potentially increase the uptake in under-served communities? National NGO

"So, I think it's about, ideally, it's about making sure that the people get to have their representation opportunity, they get to have discussions, have the relevant background. And if you're trying to get an understanding across a population, then that needs to include the whole population, which means including priority groups and people who are less likely to have a say." National NGO

7. New models of care

"I think it's really helpful to have accessible, and probably that now means online and virtual, evidence-based self-management packages - so if I've experienced this, how do I manage my emotions? So, if I lose a job or I lose a boyfriend, what might I experience and what might I do about it - that really provide solution-focused empathic support that is not about drinking a lot and thinking about harming yourself." Researcher

"And have you seen the Urgent Mental Health Care Centre when you're across that? … It's a thing of great beauty. It's a relatively new service. It's run by Neami National, and it's seen as an alternative to the emergency department. Ambulances can take people there and … generally, they'll take anyone who is in distress and the approach is to say, "Welcome," and you don't get that in a hospital. "Welcome, and what brings you here or what can we do for you? Tell us what's going on," and then take it from there. … They've got 50% of the team is people with lived experience and 50% roughly clinicians and it's an interesting service that aims to be holistic." State/Territory NGO

"We've also got a really burgeoning digital program, so looking at how we can leverage technology to connect with the community and to provide them the information they need, which is relevant to them when they need it." National NGO

3.10.2 Discussion

Considered in overview, our findings on mental health services highlighted several key issues for sector stakeholders to consider:

a) Persistent inequities of access to mental health services due to affordability or geographic maldistribution of services are likely to affect PPs disproportionately.

b) A predominantly biomedical approach to mental health care services is a negative for PPs by: acting as a barrier to services that appropriate and culturally safe; preventing person-centred care; restricting resources for promotion and prevention; and contributing to over-use of pharmaceutical 'treatments'

c) However, access to specialist clinical mental health services is required for PPs with more severe or chronic mental illness or other specific, treatment-related needs.

d) Stepped care models have value as a means to better match services to needs but retain a narrow focus on delivery of (a spectrum of) mental health care services as the primary method of mental health and/or suicide prevention policy.

e) Involvement of community members and people with lived experience in planning, service delivery and community-based promotion and prevention efforts has significant potential to improve access and health outcomes for members of PP groups.

f) While a principle of named PP groups having access to both universal and targeted services is strongly supported, other findings show this is not always achieved in current practice. Targeted services may also be subject to the fragmented and insecure funding found in other areas of primary healthcare policy (49, 50). Targeted services are not one-size-fits-all and should be tailored to meet PP group needs.

g) Primary Health Care policy in Australia is demonstrating the limitations of a narrow medical approach delivered via private GP services and calls have been made to shift to a model of Comprehensive Primary Health Care (CPHC) (49). A CPHC model is already practiced by Aboriginal Community-Controlled Health Organisations (ACCHOs) (51) and some Community Health Services. Stakeholder in the mental health and suicide prevention sector should consider the potential merits of this model as a vehicle for integrated, holistic primary health and mental health care in Australia. Some key stakeholders in the sector already recognise the value of a CPHC approach to mental health care (4).

3.10.3 Recommendations

***Recommendation 24:* Support PHNs and other localised methods of mental health service planning and delivery to enable services to be tailored to PP needs within regional locales.**

***Recommendation 25:* Support innovative service models to improve access to care, including nonhospital-based emergency mental health care with pathways for referral as needed.**

***Recommendation 26:* Where targeted services are desired by named PP groups, they should be funded and seen as an opportunity for peer support, promotion and prevention, group empowerment and action on determinants such as social support.**

***Recommendation 27:* Sector stakeholders should debate the potential value of a CPHC model for integrated primary care and mental health care, informed by lessons from the ACCHO sector and Victorian community health sectors.**

3.11 Social determinants of mental health and health equity

Evidence shows that a range of social, economic, cultural, and environmental factors – determinants of health – affect mental health and suicidal distress (52-56). These determinants include cost of living, rental or mortgage stress, unemployment, and insecure work. Inequalities in access to protective factors and in exposure to risk factors results in structural inequities in mental health outcomes in Australia (9) and other countries (57). Chronic stress arousal is a key pathway by which social conditions (acting as stressors) affect both mental and physical health outcomes (8, 54, 58-60). Stress arousal is a key mechanism mediating the impacts of racism and other determinants on Aboriginal and Torres Strait Islander peoples' social and emotional wellbeing (56). Social determinants of mental health are major causes of higher rates of mental ill-health or suicidal distress among recognised PP groups in Australia (55, 56).The specific determinants affecting mental health and/or suicidal distress vary significantly from one PP group to another. Climate change, extreme weather events and their social and economic sequalae are already acting as social-environmental determinants of mental health and their adverse impacts are only likely to increase.

3.11.1 Findings

Policy analysis: All of the reviewed policies acknowledged that the social contexts in which people lead their lives affect mental health and wellbeing, even if the term 'determinants' was not used. While *stress* was recognised widely in the policies as a factor involved in this relationship between social conditions and mental health or suicidal distress, interpretations of the terms varied and we did not identify any clear, explicit statements or models explaining the role of stress arousal (and chronic stress in particular) as a crucial mediator of adverse social-environmental impacts on mental health.

The term 'social determinants' was used 93 times across 27 of the 62 policy documents. More than a third of policies (39%, n=24) demonstrated minor recognition of SDH and limited discussion to broad, isolated statements of acknowledgement. For example,

> *"Strategy recognises a broader social orientation to mental health and wellbeing. Individuals need social supports, including from family, friends and carers, ex-service organisations, or health providers."* Veteran Mental Health Strategy 2013-2023.
>
> *"Suicide arises from a complex interaction between many vulnerabilities, risk factors and triggers in a person's life. However, suicide can also be influenced by gender, social and economic circumstances and differences between cultures and individual's experiences in society."* Tasmanian Suicide Prevention Strategy 2016-2020.
>
> *"The Parties recognise that the enablers of mental health and suicide prevention system reform are beyond the influence of the health system alone and span all aspects of where people live, work, learn and socialise."* Bilateral Schedule on Mental Health and Suicide Prevention: NSW.

However about two thirds of the policies (65%, n=40), acknowledged and discussed SDMH in more depth. For example:

> *"Suicide is often caused by situational events, not mental health conditions and this needs to be recognised and addressed in a holistic, not siloed, approach. In fact, in some regions and communities, addressing the social determinants that drive hopelessness and have a marked impact on an individual's social connections, mental health and suicidality is seen as the most pressing activity for suicide prevention in the near and long term. These social determinants include, but are not limited to, domestic and family violence, alcohol and other drug use, homelessness and overcrowding, unemployment, poverty, and hunger and require a whole of government response."* WA Suicide Prevention Plan.
>
> *"It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects."* National Strategic Framework for ATSI Mental Health and Social and Emotional Wellbeing 2017-2023.
>
> *"Housing and mental health have a two-way relationship. Having a safe and secure place to call home is a fundamental foundation for health and wellbeing. In turn, having good health and wellbeing helps people to sustain housing and access housing supports."* NSW Housing and MH Agreement, NSW Health and Department of Communities and Justice.
>
> *"The inequality between people with and without mental illness, and between different groups and*

> *communities, is unacceptable. These gaps show that there is much more to do to create a fair and inclusive society."* Victoria's 10-Year Mental Health Plan.

Despite recognition of SDH, there was also evidence of 'lifestyle drift' and 'health care services drift', where policies acknowledged SDMH but 'drifted' to behaviourist or health care strategies in their proposals for action (1, 14, 61). For example:

> *"We recognise that complex interactions of various political, social, economic and environmental conditions determine a person's health, experience of disease and mortality. But the pandemic (COVID-19) has shown us the importance and benefits of supporting healthy behaviours."* Victoria's Ageing Well Plan.

In some cases, there was a strong emphasis on building individual capacity to cope with life's challenges (rather than improving environments) and the term 'resilience' was frequently cited (299 times across 45/62 policies). For example, The *Defence Mental Health and Wellbeing Strategy 2018-2023* states that one of the central components to Defence's approach to mental health and wellbeing is that training is designed to instil a "resilience that can help them in their career and throughout life". The Strategy goes on to define resilience as:

> *"The capacity of the individual, team and organisation to recover quickly, resist, and possibly even thrive in the face of direct/indirect stressors and adverse situations."* Defence Mental Health and Wellbeing Strategy 2018-2023.

Such statements risk diluting the complexity surrounding poor mental health and suicide ideation and shifts the emphasis away from a social determinants approach towards a restricted focus on individual coping.

However, a significant number of proposals for policy action on SDMH were coded in the analysis (see Section 3.6.1). Such proposals included actions on determinants such as: stigma, discrimination, housing and homelessness, financial distress, social isolation/relatedness, access to education, access to employment and access to digital technology. For example:

> *"Increase Aboriginal and Torres Strait Islander participation rates in tertiary courses. Encourage the development of specialist Aboriginal and Torres Strait Islander mental health courses."* National Strategic Framework for ATSI People's Mental Health and Social and Emotional Wellbeing 2017-2023.

> *"Support and encourage financial institutions, including telecommunications and energy companies, to offer information on a full suite of Commonwealth and state supports for their customers who are experiencing financial hardship. Provide access to education and accommodation for young people through a Youth Foyer social impact investment, to be evaluated for expansion."* NSW Homelessness Strategy 2018-2023.

> *"To improve mental health outcomes for LGBTQIA+ people, protective factors should be put in place which include stronger promotion within the broader community of the importance of respecting, recognising and accepting the personal identity of LGBTQIA+ people and the right to equality and non-discrimination under the law."* Tasmania's Rethink Mental Health Plan 2020:

> *"Address the drivers of violence against women; reduce problem gambling harm and improve financial literacy."* Strong Futures SA Youth Action Plan 2020-2022:

> *"The NSW Government's Work and Development Order Scheme reduces financial stress for the most disadvantaged people. Work and Development Orders are made by Revenue NSW to allow eligible people who have a mental illness, intellectual disability or cognitive impairment, are homeless, are experiencing acute economic hardship, or have a serious addiction to alcohol, drugs or other substances, to satisfy their fine debt through unpaid work."* Strategic Framework for Suicide Prevention in NSW 2018-2023.

> *"Ensuring there is secure and affordable housing and promoting "housing first" approaches to addressing homelessness."* ACT Mental Health and Suicide Prevention Plan 2019-2024:

> *"Mental health policy addresses social and emotional wellbeing for Aboriginal and Torres Strait Islander*

> *people, including the importance of connection to land, spirituality, ancestry and family and community."*
> National Preventive Health Strategy 2021-2030

A more extensive analysis of the policies' various responses to SDMH indicated that the concept of, and the body of evidence on, 'social determinants of mental health' was interpreted for the purposes of PP policy actions in three main ways, with quite different implications for policy makers.

a) ***Evidence on SDMH is used simply as information about relative risk in order to define PP groups where (nevertheless) the presumptive 'right' action is to improve access to, or quality of, mental health services or supports.*** In these instances, SDMH can be acknowledged while proposals for action continue to support the predominantly biomedical status quo.

b) ***Proposed actions on SDMH are directed only toward people with chronic mental illness, or other, relatively small PP where prevalence of mental ill-health is high.*** Where policies did propose actions to actually address social or environmental factors affecting mental health, this form was most common. Such actions are welcome and important but, by their nature, may only meet the needs of a relatively small group.

c) ***Proposed actions address SDMH affecting broader groups and/or influencing inequities in mental health.*** This form of proposed action was least common, and sometimes involved aspirational statements rather than concrete proposals.

It is understandable that policy actors in mental health and suicide prevention might limit responses to SDMH to the a) and b) forms above because these may most seem feasible within their institutional constraints. However, it actions consistent with c) that have the far greater potential to actually address the scale of mental ill-health and suicidal distress, improve mental health and reduce health inequities.

Despite this critique, recognition of SDMH in the policies analysed was also a significant rationale for arguments and strategies identified in the policies, for adoption of an inter-sectoral or whole-of-government approach to mental health and/or suicide, which we discuss in the next section.

Literature review: In the academic literature, the identification of PPs was almost always accompanied by an outlining of the SDMH that drive the need of that population, such as discrimination, socioeconomic disadvantage, or social exclusion. For example, Blignault and colleagues (62) write:

> *"Refugees, fleeing war and conflict in their country of origin, have experienced violence and loss and the psychological impact of an often uncertain and prolonged journey [13]. Their distress is often exacerbated by social, economic, and legal circumstances in the new country [14]."(62, p. 2)*

This is important because describing these SDMH makes it clear that the problems causing the health inequities lie in external structures and factors, and the experiences of members of the priority population, rather than locating the problems within the priority population, such as blaming their behaviour, beliefs, skills, or health literacy. However, articles often began by outlining the SDMH for a priority population, but then fell back on describing strategies to increase access to mental health services.

Interviews: All interviewees recognised SDMH and/or of suicide and reflected on implications for policy and practice to improve outcomes for PPs and reduce inequities. Some highlighted determinants as risk factors, to be addressed through access to services or supports. Others highlighted the pressing need for effective action on determinants alongside metal health care services. Others described current policy/service weaknesses in addressing systemic inequities in health and in use of mental health services.

> *"[W]e want to have an increasing focus on the social determinants of suicide prevention […] When the Centrelink officer recognizes that this person has been turned down for their special loan to deal with particular circumstances […] But that means this person is in crisis, and that this is a thing that we should be targeting them for support."* National NGO
>
> *"We've so got to do all of that work because if we're not developing young people in a way that's going to give them the protective factors, that's going to support them in the social determinants of health, well nothing is going to change. We've got to look at housing, we've got to look at employment, we've got to look at education, we have to look at all of those things, the impacts of drug and alcohol, smoking […] all of this stuff has to be looked at."* National NGO
>
> *"…we talk to our members, and they identify top priority social determinants around housing, employment, social participation, early childhood, stigma and discrimination, and they're all kind of like mainstream things. And then within that, we acknowledge that there's different needs or people, priority populations that experience that to a disproportionate level."* National NGO
>
> *"The feelings of despair among women who are pregnant are usually those that are associated with the two things that we know are the toxic ingredients: feeling trapped in an impossible predicament that also involves humiliation. … And for women in pregnancy, this is predominantly associated with being in a relationship characterised by violence."* Researcher

Interviewees reflected on how governments can address SDMH more effectively to improve mental health outcomes and reduce inequities. Suggestions focused on promotion and prevention strategies involving broader PP groups such as children and young people and people subject to socioeconomic disadvantage.

> *"The next step is that I think schools are extraordinarily well placed to be mental health promoting institutions, and we know that schools' policies about inclusion, about valuing every child, about providing learning opportunities for every child, about providing every child with opportunities to experience mastering success … these can really set people up for a better course through life. So, I'd have a big investment, really, in zero to 18, some of which is based at home and some of which is based in schools."* Researcher
>
> *"People from disadvantaged backgrounds have a higher prevalence of practically every mental health condition because of their financial and social circumstances and conditions of daily living. To me, they're a priority population, but they're not often called out as such, you know, low SES background. They would benefit most from a prevention focus. If we are serious and we start tackling risk and protective factors, then we're going to be able to improve their lives, as opposed to just more mental health care services, where the problem is, as we've seen with the Medicare rebate and psychological services, they don't get to access anyway."* National NGO

3.11.2 Discussion

Results from this research show that social determinants of mental health and/or suicidal distress (SDMH) are widely recognised in mental health and suicide prevention policy, and by leading experts working in the sector. However, despite this recognition, the overall orientation of policy and practice remains strongly biomedical and clinical in its approach, and policy actions to address SDMH are limited in scope. While positives strategies were identified to address key determinants such as housing, access to education and debt relief, it appears that these were often available only to people with a more severe or chronic form of mental illness. Such measures are to be applauded, but obviously do not address mental health impacts of housing insecurity, financial stress, or low levels of education on broader population groups.

Taken as a whole, our findings suggest that the predominantly biomedical and clinical service focus of Australia mental health and suicide prevention policy is unlikely to meet policy objectives without an equally strong commitment to action on social determinants of mental health, suicidal distress, and mental health inequities (SDMH). Such a conclusion is reinforced by recent analysis across several countries including Australia showing that, despite increased spending on mental health care services, the overall scale of mental ill-health has not decreased (11). While policy actions to improve access to appropriate mental health care services for PP groups is a worthwhile response to inequities in mental health and suicide; in and of itself, it will not be sufficient to significantly reduce these inequities.

Recognition of SDMH is essential for PPs because makes it clear that the problems causing the health inequities lie primarily in the social, economic, or cultural conditions to which members of the PP have been exposed, rather than locating the problems within the PP, such as resulting from their behaviour, beliefs, or lack of relevant life skills or health literacy. Framing problems in terms of SDMH suggest very different health promotion strategies to framings that focus on individual deficits or clinical need.

Given that mental health and suicidal distress are inter-related with other population health concerns such as alcohol and other drug use, obesity and overweight, and tobacco smoking; there are strong reasons for stakeholders in mental health or suicide prevention policy and services to link with policy makers, NGOs or researchers working in the broader field of health promotion and public health, with a view to combined advocacy on the need for policy action of SDMH and health equity.

Many of the PP groups already recognised in national mental health and suicide prevention policy also represent population segments wherein effective action on SDMH could occur, to promote mental health, prevent illness and reduce health inequities. Actions related to large population groups have potential to address need across a number of PPs. For example:

Aboriginal and Torres Strait Islander peoples: e.g., action on determinants of Indigenous social and emotional wellbeing such as racism and unemployment and protective factors such as connection to culture and country; policy support for Indigenous leadership in policy, service and programs.

People living in regional, rural, and remote areas: e.g., land restoration, small business development, protections against impacts of climate change. Localised, community-engaged actions such as Suicide Prevention Networks, or Men's Sheds have significant potential to address determinants such as social support.

Children and young people: e.g., universal programs to support effective parenting and improve home environments from birth.

People experiencing socioeconomic disadvantage: e.g., addressing poverty and reducing socioeconomic inequalities through welfare measures, proportionate universal investment in public education, housing reform to ensure access to secure affordable housing.

People affected by climate change and extreme weather: e.g., effective, urgent policy action to reduce Australia's use and export of fossil fuels.

3.11.3 Recommendations

***Recommendation 28:* All stakeholders in mental health and suicide prevention policy – including PP groups – have common, urgent interests in effective, preventative policy action on social, economic, cultural and environmental determinants of mental health and should work toward a united approach to advocacy on this issue.**

***Recommendation 29:* Planning for policy action should aim to recognise and address specific social determinants of mental health and/or suicidal distress affecting different PP groups.**

3.12 Whole-of-government and/or inter-sectoral policy action

3.12.1 Findings

The idea of a whole-of-government approach to mental health and suicide prevention is a existing commitment of the Commonwealth under the *Fifth National Mental Health and Suicide Prevention Plan* (2) and the *National Mental Health and Suicide Prevention Agreement* (20). Recognition of a need for whole-of-government policy approaches or collaboration between policy sectors to address population health and health equity extends readily from recognition of SDMH (63). In that context, some government have applied frameworks such as 'Health in All Policies' intended to encourage 'non-Health' sectors to recognise and address the health impacts of their own policy settings (64). Policy commitments to whole-of-government policy approaches or intersectoral collaboration matter for PPs because they hold the potential to address SDMH, which affect members of PPs groups and give rise to health inequities.

Policy analysis: In principle statements of a need for whole-of-government approaches to mental health and/or suicide prevention were identified frequently in the policies analysed. For example:

> *"Shifting minds is everyone's business. It recognises and values the unique and different contribution of all sectors and sections of the community. It is built on whole-of-government and whole-of-community commitment and leadership well beyond the health sector to drive reform and improve mental health and wellbeing across the population."* Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023

> *"NSW supports the eight priority areas of the Fifth Plan, including 'Priority Area 2: Suicide Prevention'. The priorities align with the NSW Government's decadelong, whole-of-government enhancement of mental health care – a response to the Living Well: A Strategic Plan for Mental Health in NSW 2014–2024."* Strategic Framework for Suicide Prevention in NSW 2018–2023

Some governments have formalised a whole-of-government approach in legislation, and for example with the *South Australian Suicide Prevention Act 2021*. In our analysis, we also identified a wide range of proposals for, or existing examples of, collaboration between Health and other policy sectors or between levels of government. For example:

> *"The Parties agree to continue to support the development, implementation and monitoring of joint regional mental health and suicide prevention plans between WAPHA, the Mental Health Commission, Area Health Services, the Local Health Districts, consumers, carers and service providers."* National Mental Health and Suicide Prevention Bilateral Agreement WA

> *"The Mental Health Co-Response Program (MHCR) … is a joint initiative between the WA Police Force, the MHC and Health Service Providers."* WA Suicide Prevention Framework 2021–2025

> *"Coordinated mental health related policies, service delivery models, interagency processes and infrastructure between government departments and across sectors to support partnerships and integration, such as common referral pathways, appropriate discharge support and prompt follow-up for people experiencing mental illness and/or those who have attempted suicide and their families and carers."* SA Mental Health Strategic Plan 2017-2022

> *"Expand responses to people involved in the criminal justice system through better coordination across mental health, AOD, justice, housing, disability, employment and psychosocial supports."* Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023

Our overall assessment of policy in this area would be to observe that concepts of whole-of-government or intersectoral approaches to mental health and/or suicide prevention are interpreted in a wide variety of ways, which may or may not have anything to do with addressing SDMH. Possibilities within this range of interpretations relevant to PP groups included cooperation between:

a) Different parts of the health system to undertake mental health service planning or facilitate movement of patients between services.

b) Health and other social service agencies to coordinate services.
c) Health and other policy sectors to facilitate improved access of ‘other’ agencies’ service users or staff to mental health care services.
d) Health and other policy sectors to address determinants of health such as housing, employment, debt, or psychosocial support affecting people with existing mental illness or other high-risk groups.

Thus, it would appear that the concepts of whole-of-government approaches and/or intersectoral collaboration for promoting mental health and preventing suicide can be operationalised in ways that do not address SDMH at all or do so only in quite limited ways. In either case, this falls well short of the kinds of approaches that are required to address SDMH systemically in order to improve overall population health outcomes and reduce inequities. This finding is in keeping with other research on intersectoral action in Australian health policy (65). Variations in interpretation noted above may mean that government agencies can ‘tick the box’ of whole-of-government or intersectoral approaches without challenging their own status quo practices. However, at the same time, it must also be recognised that some SDMH are being addressed by policy in ‘other’ sectors to a greater extent than can be recognised in Health sector policy documents; simply because they are part of the regular business of those sectors.

Interviews: Most of the interviewees we spoke to strongly supported principles of whole-of-government action or intersectoral collaboration, largely as an extension of their recognition of SDMH. However, at the same time, some also recognised the problem that, while the principle is right, Australian governments may be falling short of putting it into effective practice, to really make a difference to health outcomes. One person spoke a need to think beyond an intervention or service provision mentality, to consider broader policy and legislative settings able to contribute to health promotion environments.

> *“If we work from a risk factor perspective and we say, “All right, the risk factor is child abuse and neglect.” Now, which government department? Technically, I think that’s DSS or department of social services … so you’re going to need to get them to look at this issue. When you talk about access to green and blue space or tackling climate change, you’re going to have to get the environment minister involved in that. When you talk about cost-of-living pressures, presumably that’s the prime minister and the treasury …You want each government department to think about it. What age group do I deal with? What setting or platform or mechanism do I have to reach people or to change things in? What’s the risk factor that’s most prevalent that I am responsible for that I can influence would be the thinking model that they could use, but everyone, technically, has got something to offer.”* National NGO

> *“I think there’s a lack of coordination across government… that definitely makes a whole of government approach challenging and so I’m hoping that the Victorian model of having a mental health promotion advisor who’s responsible for state-wide coordination across departments and really pushing that whole of government approach, that’s an interesting prototype to see what dividends that pays. The ‘Health in All Policies’ approach kind of makes sense, or health and all portfolios approach or whole of government approach. It definitely makes sense in theory, but I think it lacks coordination. It lacks even a universally applied approach. It’s not an intentional approach right now, it’s more of a concept.”* National NGO

> *“The other thing that’s relevant – again, coming from a health promotion/public health perspective. We know that it’s not just programs that solve problems. There are ways we can change legislation or regulations or implement social or public policies that create mentally healthy communities. Obviously, the Obesity Policy Coalition’s big push is to ban junk food marketing or to limit junk food marketing. Now, that’s not a program, that’s a regulatory issue. I don’t think we’ve looked at what are the sorts of legislation, regulatory policy approaches to mental illness prevention.”* National NGO

3.12.2 Discussion

Analysis of our findings also brought out several other issues related to concepts and practices of whole-of-government or intersectoral policy approaches to mental health promotion or suicide prevention, as these may affect PP groups:

a) In order to significantly improve mental health outcomes and improve health equity in Australia, whole-of-government approaches must aim to address risk and protective factors (determinants) affecting the population at large, as well as those affecting specific PP groups.
b) Emphasis on the role of government agencies may marginalise the essential role of community-based organisations and actors, including people with lived experience and community mental health or suicide prevention networks, as important participants in holistic approaches to mental health promotion and SDMH.
c) Local governments in Australia have significant potential to contribute action on SDMH and mental health promotion within their respective communities.
d) Current literature provides policy makers with a range of frameworks to inform and guide whole-of-government approaches to preventative mental health policy, taking account of SDMH, including Health-in-All-Policies (64, 66) and mental health promotion (43, 67-69).

3.12.3 Recommendations

***Recommendation 30:* Stakeholder in the sector should seek to hold governments to account, to operationalise principles of whole-of-government or intersectoral approaches in ways that address social determinants of mental health and suicidal distress.**

***Recommendation 31:* Policy actors should give consideration to holistic mental health promotion frameworks following the principles of the Ottawa Charter for Health Promotion (43, 69), Health in All Policies (70), and Health Cities (71) as tools for conceptualising inter-sectoral approaches.**

3.13 Data needs

3.13.1 Findings

Literature Review: Ellen and Biddle (72) indicate that it may be necessary to identify priority populations even in the absence of good data. For example, they write: “Although CALD populations have been identified as a priority population for suicide prevention in Australia, it is not possible to discern CALD status within Australian National Government held suicide and self-harm monitoring data … Lesbian, gay, bisexual, transgender or intersex (LGBTIQ+) communities are also in the position of having been identified as priority populations but are not currently identifiable within national data assets” (72, p. 7). Some articles on populations such as CALD and LGBTIQ+ concluded with a call for better data, e.g.: “Australian AOD [alcohol and other drug] treatment services do not routinely collect data on sexuality or gender identity. As a result, the treatment needs, experiences and outcomes of LGBTQ people remain largely invisible.” (73, p. 40).

Interviews: Interviewees’ comments on data needs were broadly consistent with findings of the literature review, namely that national data sets and/or other forms of data collection related to health outcomes and/or service use in mental health and/or suicide do not necessarily collect demographic data suited to on-going assessment of outcomes or service use within currently recognised PP groups.

> *“Another reason why for [LGBTIQ+ people] to be a priority population is so important is because when we get those strategies, and we get a government that is not supportive … at least we are sitting in the strategies as a priority population so they can’t totally ignore us. And so, from that perspective, it’s very vital and it’s also vital because we’re not in data, we’re not in minimum data sets, you can’t do data linkage on LGBTIQ+ people. And so, because we’re not in the data, we’re often missed out.”* National NGO

> *"For LGBTQI+, there's a set of definitions around gender identity or sexual identity that you'd need to include so that you can then cut the data in a particular way … The same will be true when you look at Indigenous versus non-Indigenous, female versus male or non-binary, LGBTI versus heterosexual. I think we need to ask the right questions about people's identities and geographic location, for example, but then we need to collect sufficient quantity of data to allow those analyses to be undertaken in a statistically significant fashion."* National NGO

Other comments relate to lack of sufficient data within PHN regions for appropriate understanding of PP group outcomes or needs at that scale.

> *"The data on suicides and suicide attempts is getting better, but certainly, particularly at that PHN level, they need to know not only what are the groups that exist in their community, but how those groups fare in regard to suicide deaths and attempts. And particularly with attempts, that data is pretty patchy."* National NGO

One interviewee described a lack of data collected by clinical mental health services that would show the extent to which members of particular PP groups are using their services:

> *"In terms of data, what you find is data is not collected very much [in mental health services] but when it is, if you look at the percentage of Aboriginal people in NGO services in South Australia, it's tempered by that referral process. If Community Mental Health don't have a lot of Aboriginal people in their caseload, then they won't be referring them."* Sate/Territory NGO

Another person described a lack of connection between data collection and actual usage to inform policy and practice:

> *"Every woman is filling out a depression questionnaire at least three times in her - now, it's not implemented perfectly but nevertheless contributing a lot of data, and what we hear both here and internationally is usually nothing's done with it. So someone fills this in. It might be that if they have a very high score they're asked to see their GP, but we have very poorly developed strategies of where someone should be sent or what they should be given. It's not systematised. It's not documented. So medical records in this area are completely haphazard as to whether someone's been sent to get extra help or not."* Researcher

Finally, an interviewee also raised the issue of older data failing to fully reflect present circumstances:

> *"So while we have really strict guidelines of how we can use funding and other strict models that have come in from Department of Health, which may be based on good evidence five years ago, it's not the need right now so we need that flexible funding to respond appropriately."* PHN representative

3.13.2 Discussion

Findings from this research indicate that, while organisations such as AIHW are playing an important role and improving practices to include consideration of PP groups, national-level data gathering on mental health, suicide and suicide attempts is not yet able to be full analysed according to relevant PP group data. University-based studies as identified in our literature review and as mentioned by interviewee participants obviously also form potentially important sources of data for understanding PP groups. As per Section 3.4, evidence relevant to identifying PPs and developing appropriate policy responses may include quantitative data on health outcomes, exposure to risk or protective factors, and health service or social service usage, relative to other comparable groups; and changes in these over time. Qualitative data may also inform understanding of lived experience perspectives on service access or social determinants.

Methods used in this research do not provide enough information for us to make any specific recommendations related to data gathering relevant to mental health and/or suicide prevention policy. More generally, we would warn against too-simple assumptions about an evidence-to-policy relationship where quantitative data on outcomes within a PP group leads to an ‘adequate’ solution in the form of mental health care services or behaviourist strategies to improve resilience, help-seeking, or self-care.

3.14 Conclusion & acknowledgments

For a range of reasons explained in this report, we conclude that recognition of PPs in mental health and suicide prevention policy can contribute to improved access to inclusive, person-centred services which meet a variety of needs, improved mental health outcomes, prevention of suicide, promotion of mental health and wellbeing, and gains in health equity. However, for such outcomes to be realised more fully, recognition of PPs must be tied to public investment and tailored strategies to meet the needs of those groups, while governments also pursue whole-of-population strategies to promote mental health and psychological wellbeing (8, 68, 74) and address social determinants of mental health and suicidal distress across the life course. The persistently high and increasing rates of mental ill-health and suicidal distress in Australia (9) and implications for harms to social equity and cohesion, workforce participation, family and child health, and healthy aging show that this whole-of-government and whole-of-community effort must be of the highest priority.

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APPENDIX 1: Documents include in policy analysis.

Jurisdiction	Type of policy (determined by title)				
	Mental Health Policies (n=10)	Suicide Prevention Policies (n=6)	Mental Health & Suicide Prevention Combined (n=19)	Priority Population Policies (n=21)	Other Public Health Policies (n=6)
Australian Government (n=10)			1. Fifth National Mental Health and Suicide Prevention Plan 2017 2. National Mental Health and Suicide Prevention Agreement 3. Prevention, Compassion, Care - National Mental Health and Suicide Prevention Plan 2021	1. National Strategic Framework for **Aboriginal and Torres Strait Islander** Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 2. **Veteran** Mental Health Strategy 2013-2023 3. **Defence** Mental Health and Wellbeing Strategy 2018-2023 4. National **Women**'s Health Strategy 2020-2030 5. National **Men**'s Health Strategy 2020-2030 6. National Strategic Framework for **Rural and Remote** Health	1. National Preventive Health Agreement 2010-2030
Non-government organisations and other agencies (n=7)					
Australian Non-Government Organisations (n=4)	1. National Mental Health Consumer & Carer Forum: Submission in response to the Productivity Commission Inquiry into Mental Health		1. Suicide Prevention Australia: Submission to the Select Committee on Mental Health and Suicide Prevention Inquiry March 2021. 2. Mental Health		

			Australia: Submission to the Select Committee on Mental Health and Suicide Prevention 2021. 3. Beyond Blue Submission: Select Committee on Mental Health and Suicide Prevention 2021.		
Other agencies (n=3)	1. National Mental Health and Wellbeing Pandemic Response Plan		1. National Mental Health Commission: Vision 2030 for Mental Health and Suicide Prevention in Australia	1. The National **Children**'s Mental Health and Wellbeing Strategy	
Australian States and Territories (n=37)					
ACT (n=3)	1. ACT Office for Mental Health and Wellbeing Work Plan 2019-2021		1. ACT Mental Health and Suicide Prevention Plan 2019-2024 2. Bilateral Agreement between the Commonwealth and the Australian Capital Territory on Mental Health and Suicide Prevention		
NSW (n=7)		1. Strategic Framework for Suicide Prevention in NSW 2018-23	1. Bilateral Agreement between the Commonwealth and New South Wales on Mental Health and Suicide Prevention	1. NSW **Aboriginal** Mental Health and Wellbeing Strategy 2020-2025 2. NSW **Housing** and Mental Health Agreement 2022 3. NSW **Youth** Health Framework 2017-24	

				4. NSW **Homelessness** Strategy 2018-2023 5. NSW Plan for Healthy **Culturally and Linguistically Diverse Communities** 2019-2023	
NT (n=3)	1. NT Mental Health Strategic Plan 2019-2025	1. NT Suicide Prevention Strategic Framework 2018-2023	1. Bilateral Agreement between the Commonwealth and the Northern Territory on Mental Health and Suicide Prevention		
QLD (n=4)	1. Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023	1. Every life: The Queensland Suicide Prevention Plan 2019-2029	1. Bilateral Agreement between the Commonwealth and Queensland on Mental Health and Suicide Prevention	1. Queensland Health **Aboriginal and Torres Strait Islander** Mental Health Strategy 2016-2021	
SA (n=4)	1. SA Mental Health Strategic Plan 2017-2022		1. Bilateral Agreement between the Commonwealth and South Australia on Mental Health and Suicide Prevention	1. Strong Futures – SA **Youth** Action Plan 2020-2022	1. SA State of Public Health Plan 2019-2024
Tasmania (n=6)	1. Rethink 2020 A state plan for mental health in Tasmania 2020-2025	1. Tasmanian Suicide Prevention Strategy (2016-2020)	1. Bilateral Agreement between the Commonwealth and Tasmania on Mental Health and Suicide Prevention	1. **Youth** Suicide Prevention Plan for Tasmania (2016-2020) 2. Health and Wellbeing for **Women** Action Plan 2020-2023	1. Healthy Tasmania Five Year Strategic Plan 2022-2026
Victoria (n=5)	1. Victoria's 10-year Mental Health Plan	1. Victorian Suicide Prevention Framework 2016-2025	1. Bilateral Agreement between the Commonwealth and Victoria on	1. Victoria **Police** Mental Health Strategy and Wellbeing	

			Mental Health and Suicide Prevention	Action Plan 2017-20 2. **Ageing** Well Action Plan - An action plan for strengthening wellbeing for senior Victorians 2022–2026	
WA (n=5)		1. WA Suicide Prevention Framework 2021-2025	1. Bilateral Agreement between the Commonwealth and WA on Mental Health and Suicide Prevention	1. WA **Women**’s Health and Wellbeing Policy 2. WA **Lesbian, Gay, Bisexual, Transgender, Intersex** Health Strategy 2019-2024 3. WA **Youth** Health Policy 2018-2023	
Local Government (n=3)					
Murraylands & Riverland Local Government Association (SA)					1. Regional Public Health and Wellbeing Plan 2022-2026
City of Geelong (Vic)					1. Our Community Plan 2021-2025
Shire of Augusta Margaret River (WA)					1. Public Health Plan 2020-2024
Primary Health Network (n=5)					
Primary Health Network/Alliance (Perth, Perth North and Country WA)	1. WA Primary Health Alliance Mental Health Strategy 2020-2023				
WA Primary Health Alliance	1. Mental Health Framework 2021				
Primary Health Network NT, Aboriginal Medical Services Alliance NT			1. Joint NT Mental Health and Suicide Prevention		

(AMSANT) and NT Government Department of Health (NT Health)			Foundation Plan 2021-2022		
Northern Queensland Primary Health Network (NQPHN), Torres and Cape Hospital and Health Service (TCHHS), Cairns and Hinterland Hospital and Health Service (CHHHS), Townsville Hospital and Health Service (THHS), and Mackay Hospital and Health Service (MHHS)			1. Joint Regional Wellbeing Plan for Northern Queensland: Mental health, suicide prevention, and alcohol and other drugs 2020		
Central and Eastern Sydney Primary Health Network, Sydney Local Health District, South Eastern Sydney Local Health District, St Vincent's Health Network and the Sydney Children's Hospital			1. Mental Health & Suicide Prevention Regional Plan Central and Eastern Sydney		