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A tool to help organisations and services identity Priority Populations in Mental Health and Suicide Prevention

Priority Populations in Mental Health and Suicide Prevention

A project supported by the National Mental Health Commission

make history.

This Tool should be used in conjunction with the **WORKBOOK - A tool to help organisations and services identify Priority Populations in Mental Health and Suicide Prevention.** The Workbook provides space to record your thoughts as you work with your colleagues to identify priority populations. The **glossary** on page 14 provides definitions of key terms used in the tool and a range of resource pages provide further information on some of the relevant concepts.

© 2023 Dr Matthew Fisher, Dr Toby Freeman, Dr Miriam van den Berg and Prof Fran Baum, Stretton Health Equity, Stretton Institute, University of Adelaide, Adelaide, South Australia, 5001. **This research was funded by the National Mental Health Commission.**

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Mental health and suicide are important public health issues that affect all populations. Mental health and wellbeing are strongly influenced by the social, economic, cultural, and environmental conditions in which people are born, grow, live, work and age. These are referred to as **social determinants of mental health and suicide**.

Favourable conditions, such as freedom from racism and discrimination, decent employment and stable housing, can support wellbeing, protect against mental ill-health, and aid recovery from illness. However, exposure to adverse, stressful life conditions at different life stages increases risks of mental ill-health or suicidal distress. Mental health or suicide risk is also affected by having/not having ready access to affordable, person-centred, culturally safe mental health care services or supports.

Inequalities in mental ill-health and/or suicide between population groups arise when particular groups don't have the access to the same opportunities for good mental health and wellbeing as other groups. Many of the reasons for these inequalities are social, economic, or cultural in nature and the terms 'social inequities' or 'health inequities' are commonly used to describe the resulting unfair differences in mental health or suicide.

Priority populations or **priority groups** are groups 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.

Identifying priority populations within the community can help organisations more effectively meet the needs of diverse groups, make programs and services more inclusive, better allocate resources and help reduce social inequities. This tool provides practical advice to government or non-government organisations working in the area of mental health and/or suicide prevention. The glossary on page 13 provides definitions of key terms used in the tool.

The aims of this tool are to assist organisations with:

- **Reflection** on their current approaches to mental health and suicide prevention.
- **Decision making** by thinking through a series of questions to help them identify priority populations.
  Planning by engaging with priority populations to promote mental health, reduce suicide risk, address social determinants of mental health, and improve equity.

Please note: In this tool, we use the term **'community'** to describe the **whole population** that your organisation works with, has responsibility for, or is able to influence. For most organisations, **priority populations will be sub-groups** within this whole community. For example, for a state government agency, their 'community' would be the whole population of their State. If your organisation is focused only on a specific group recognised as having particular needs related to mental health or suicide, this tool may still be used to consider priority sub-groups within *your* community.

Step 1: Do we want to identify priority populations?

Yes

Consider:

A priority population approach may involve:

- working with your community as a whole in a way that takes account of the needs of priority group/s
- implementing both whole-community (universal) and priority group strategies **OR**
- focusing work only on a priority group/s within your community

Continue to STEP 2

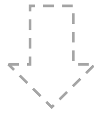
No

If you are not identifying priority populations, consider:

- How will you ensure your organisation's work is inclusive of everyone in your community?
- How will you take account of intersectionality to help people feel safe and included by your organisation or service?
- If different groups in your community have different needs, how will you ensure your organisation meets these needs equitably?
- How will you monitor how well your organisation or service is succeeding in being inclusive?

You may still like to review the questions in **STEPS 3** and **4** and read the resources provided.

Step 2: Do we know why we want to identify priority populations?



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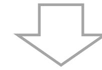


Some reasons may include:

… because of what we know about mental health and/or suicide in our community?

… because they have unique perspectives about mental health and/or suicide that we need to consider and address?

… to address inequalities in mental ill-health or suicide?

… to fulfill our organisational purpose?

… to plan our work or allocated resources?

… to be better advocates for change?

… to be accountable to the community and groups within it?

… to pursue a funding opportunity?

Use this opportunity to discuss the priority populations concept with your colleagues.

✎ **Record your thoughts in the workbook**

Consider these questions:

- Do we know what 'priority population' means?
- Is our area of interest: mental health and/or suicide prevention?
- Are we aware of the incidence of mental il-health and/or suicide and specific needs in our community?
- What are the goals/objectives we want to achieve?
- Do we understand if our work is mental health promotion, and/or primary, secondary and/or tertiary prevention?
- What are our organisation's values?
- Does the organisation have time and other resources necessary to work with priority populations?

✎ **Record your thoughts in the workbook**

Once you have identified why you want to identify priority populations, go to **STEP 3**.

Yes

☑ We understand what the term 'priority populations' means.

☑ We are clear about our goals in relation to mental health and/or suicide prevention.

☑ We recognise our role in mental health promotion, and/or primary, secondary and/or tertiary prevention.

☑ We have skills and knowledge needed to work with priority populations and we are willing to learn more from our community.

☑ We value working in partnership with our community.

GO TO STEP 3

STEP 3: Do we know how to identify priority populations?

Record your thoughts in the workbook

NO: Work your way through the following questions:

Q.1 Do we know our community, as a whole as well as the diverse groups within it? Have we engaged with our community? Have we listened to community voices? Do we understand the available mental health and/or suicide data* for our community? Do we understand the difference between risk groups and equity groups?

** data may include quantitative and qualitative data, as well as stories and informal sources of information*

YES: If you already know how to identify priority populations, you may still like to work through the reflective questions in this toolkit.

Yes

No

Visit resource page 1:

Community Engagement

Q.2 Do we understand how different groups in our community are affected by social, economic & cultural determinants of mental health and/or suicide?

Do we know which groups are denied the same opportunities as others to protect & improve mental health and/or prevent suicide?

Yes

No

Visit resource page 2:

Understanding social & cultural determinants of mental health & suicide

Q.3 Do we know how different stages of the life course affect mental health and/or suicide risk for different groups?

Do we know how key transition stages in life affect mental health and/or suicide for different groups?

Yes

No

Visit resource page 3:

Life-course approach to mental health and suicide prevention

Q.4 Do we understand that people may belong to more than one priority group (intersectionality) and that this may expose them to overlapping forms of discrimination?

Yes

No

Visit resource page 4:

Understanding Intersectionality

Q.5 Do we understand opportunities for mental health promotion and prevention of ill health?

Thinking about our community as a whole or particular groups within it…Do we know how to take a strengths-based approach to our work? Are there opportunities to strengthen mental health promotion, recovery and/or suicide prevention efforts? Do we know how to work with our community to co-design actions?

Yes

No

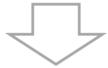
Visit resource pages 1 & 5:

Community Engagement

Mental Health Promotion and Prevention

Q.6 Do we understand local knowledge?

Do we know who we need to work with to be true to local knowledge and foster pathways for self-determination? For example, are there systems of knowledge embedded in Aboriginal & Torres Strait Islander cultures or other cultures that we need to be aware of?

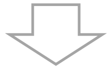


Yes

No

Visit resource page 6:

Cultural Knowledge



Q.7 Do we understand the wider social factors at play?

Are there policies and social movements that are affecting our community's mental ill-health and/or suicide rates? Do we understand who has the power to make things better for our community groups? Do we need to advocate for change in other parts of the system?

Yes

No

Visit resource page 7:

Policy and Advocacy

Q.8 Do we know how we can take an equity approach to mental health and/or suicide prevention?

Do we understand what we can do to help reduce mental health and/or suicide inequities?

Yes

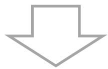
No

Visit resource page 8:

Understanding mental health and suicide from an equity perspective

Q.9 Are we best placed to work with the priority populations we are considering?

Are there other organisations that might be better placed to work with these groups – in the case of Aboriginal & Torres Strait Islander peoples, would it be more appropriate for an Aboriginal Community Controlled Health Organisation (ACCHO) to lead the work? Have we got working relationships with our selected priority groups? Do we understand their lived experiences? Are we committed to the principles of co-design?



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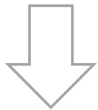
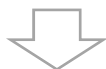




No

If your organisation is not best placed to work with the identified priority populations, think about how you can best support those organisations working with these groups.

Visit resource pages 1, 7 & 9

Community Engagement, Policy and Advocacy, Partnerships

Having reflected on the above questions,

you should now be able to choose priority populations in your community to work with.

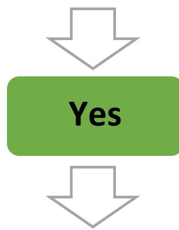
ALSO CONSIDER:

- ☑ We have established trust with your chosen priority populations or is there more to do before commencing action planning?
- ☑ How can you work effectively in partnership with priority populations?
- ☑ How can you be accountable to the groups you have identified by developing effective actions to help reduce mental ill-health and suicide inequities?

GO TO STEP 4: ACTION & EVALUATION PLANNING

STEP 4: Now that we have selected priority populations, are we ready to plan actions to reduce mental ill-health and suicide inequities?

✎ Record your thoughts in the workbook



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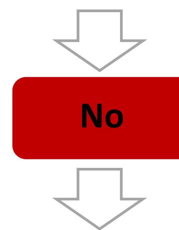
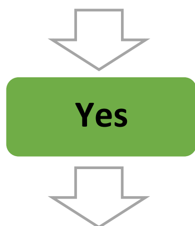


No

Return to Step 3

Q. 1 If we have chosen Aboriginal and/or Torres Strait Islander peoples as a priority population, do we understand what this requires?

If you have not chosen this group, continue to Q. 2



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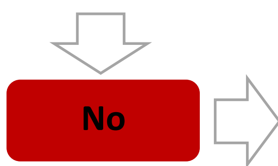
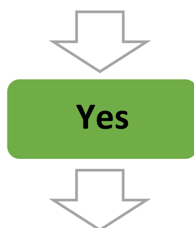


No

Visit resource page 10:

Supporting Aboriginal & Torres Strait Islander Social and Emotional Wellbeing

Q.2 Are we sure that our current practices are not contributing to the challenges faced by equity groups? Is there anything about our current practices that impacts negatively or harms equity groups?



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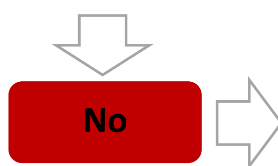
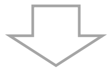


No

Visit resource page 8:

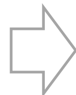
Understanding mental health and suicide from an equity perspective

Q. 3 Is our approach to 'work with' rather than 'work on' our priority groups? Are we working with members of our selected priority populations to co-design our strategies? Is power shared and transparent? Are there clear governance arrangements?



Yes

No



Visit resource page 1:

Community Engagement

Q. 4 Do we know what our goals and objectives are? Are our goals and objectives acceptable to our community and/or priority populations? Do our goals and objectives reflect a health equity approach? Are they measurable?

Yes

No

Visit resource page 11:

Health Equity Planning

Q. 5 Do we know what strategies for action—focusing on social, cultural and economic determinants of mental health and/or suicide—are needed for our community and/or priority populations? Given our capacity and scope, how can we act on the underlying causes of mental ill-health or suicide, while also meeting immediate needs? How can we improve accessibility and inclusiveness? How can we prevent lifestyle drift?

Yes

No

Visit resource page 2:

Understanding social & cultural determinants of mental health & suicide

Q. 6 Do we know what specific actions are needed to ensure our plan is inclusive of the spectrum of needs across our community, including our priority populations? Do we understand important concepts like culture and language, social hierarchies and power relations, and systems as they relate to priority populations, which can help us understand health complexities and inform our action plan?

Yes

No

Visit resource page 12:

Working with Priority Populations

Q.7 Do we know who we need to work with? Do we know who we need to work with to be true to local knowledge and foster pathways for self-determination? Do we need to partner with other organisations or sectors outside of health?

Yes

No

Visit resource page 9:

Partnerships

Q.8 Do we know how we can monitor and evaluate our work from a health equity perspective? If our resources are limited are there simple ways we can monitor our work? Do we need to partner with another organisation to help us with evaluation? Is our approach culturally safe, inclusive and respectful?

Yes

No

Visit resource page 13:

Monitoring & Evaluation

Q.9 Do we have the knowledge, skills and resources to progress our action and evaluation plan?

Yes

No

Visit resource page 14:

Capacity Building

Implement your action and evaluation plan.

☑ We know how to make our work more inclusive so as to help reduce mental ill-health and /or suicide inequities.

☑ We know how to be accountable to the priority groups we have identified.

☑ We value working in partnership with our community.

You may find Participation Action Research resources helpful.

See the Participatory Action Research Toolkit for ideas.

Glossary

Complex Systems	The recognition that mental health and suicide are affected by many different factors, which collectively may be thought of as a **system**—a group of interacting and interrelated things that form a complex and unified whole. Read more.
Equity Group	A risk group defined according to demographic criteria associated with increased risk of mental ill-health or suicidal distress, where risk factors associated with the population *include* exposure to structural or systemic socioeconomic or cultural disadvantage. Examples would include people subject to low socioeconomic status (socioeconomic inequality), women (sex discrimination, gendered violence), Aboriginal and Torres Strait Islander peoples (colonisation, racism, incarceration), LGBTQI+ groups (discrimination based on sexual orientation) or people who are unemployed (discrimination, socioeconomic inequality).
Health Equity	Is achieved when everyone can attain their full potential for health and wellbeing. Health outcomes do differ between groups, however, health inequities are the differences in health outcomes and their risk factors between groups that are socially produced, avoidable and unfair. Read more.
Health Inequalities	The differences in health between different groups. An equality approach involves providing equal services, resources and treatment, regardless of need or outcome. This differs to an equity approach which recognises that some groups need more support or resources to achieve the same health outcomes as others. Read more.
Mental Health Promotion	The process of using public policy and other structural mechanism to enable people to increase control over, and to improve, their health, through a wide range of social and environmental actions. Read more.
Intersectionality	Describes how multiple social aspects of identity, such as gender, race, class and sexual orientation, intersect or interact with each other. Read more.
Life-Course Approach	Recognises that the experience and impact of **social determinants** varies across life, and influence people at different ages, gender and stages of life in particular ways. A life-course approach involves actions to address health inequality appropriate for different stages of life. Read more.
Lifestyle Drift	When policy starts off recognizing the need for action on upstream **social determinants of health** only to drift downstream to focus largely on individual lifestyle factors. Read more.

Mental Health	A state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn and work well, and contribute to their community. Read more.
Primary, Secondary, Tertiary Prevention	The three levels of prevention: Primary prevention—actions aimed at avoiding ill health; secondary prevention—actions aimed at early identification to improve the chance of positive health outcomes; and tertiary prevention—actions aimed at reducing the impact of ill health. Read more.
Priority Population	Groups 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 or suicide 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.
Proportionate Universalism	A strategy that aims to benefit the whole population or community (universal population) but that focuses effort and resources proportionate to need, to reduce inequities. Read more.
Risk Group	A group 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).
Social Determinants of Mental Health & Suicide	The social, economic, cultural and political factors that influence mental health and suicide rates. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces, wealth and power imbalances and **systems** shaping the conditions of daily life. Read more.

RESOURCE PAGES

Resource page 1: Community Engagement

Community engagement is an **important** strategy for pursuing health equity. Engaging with communities who have inequitable health outcomes, or inequitable access to health care can support an organisation to understand the community's experience, understand what is driving these inequities, and support the community to pursue their needs and goals. Community engagement also fosters appropriateness, acceptability, and accessibility in policy and service/program delivery. Listening to community is especially important for **Aboriginal and Torres Strait Islander peoples** given the context of their struggle for self-determination, and to counter systemic and institutional racism. Community engagement in priority populations may occur through **population-specific strategies**, such as an Aboriginal and Torres Strait Islander advisory group, or through working towards **inclusivity** of priority groups in broader engagement activities and structures. Either way, considering **equity in terms of who is participating** is crucial. It may be valuable to seek out **community leaders** such as Elders or faith leaders or grass-roots **representative organisations**.

There are **different goals** of community engagement such as provision of information, consultation to design a new program or initiative, or more ongoing collaboration where power is shared. There can be structural approaches to community engagement, such as establishing community advisory groups. There are different **frameworks** to guide choosing community engagement goals and methods. One popular one is IAP2's Public Participation Spectrum, which describes a continuum of Inform, Consult, Involve, Collaborate, and Empower. More structural approaches to community participation that involve power sharing have more potential to redress health and health care inequities.

Lived Experience has become common terminology in the mental health field and is related to community engagement. A lived experience approach emphasises that people with first-hand experience of mental ill health or mental health service use should be consulted, and accorded power through participation structures to promote **lived experience leadership**.

Co-design has become a very popular term in this space. While it initially referred to a specific method developed in the UK in 2005-06, now it is often used to encompass collaborative approaches that seek community involvement in policy or program design.

In the mental health field in Australia, there are lived experience leadership and consumer **organisations** such as Lived Experience Australia and the National Mental Health Consumer & Carer Forum.

Useful links and resources

1. IAP2's Public Participation Spectrum
2. Loughhead, M., et al, 2020, Lived experience leadership for organisational and systems change: a scoping review of concepts and evidence, University of South Australia and Lived Experience Leadership and Advocacy Network SA, Adelaide.
3. NSW Health: Library of Co-Design Resources
4. The Australian Centre for Social Innovation (TACSI): Unpacking Co-Design

Resource page 2: Understanding social & cultural determinants of mental health & suicide

The term 'social determinants' of mental health and suicide refers to social, economic, or cultural factors that influence mental health or suicidal distress. Some such factors are protective of mental wellbeing and reduce risk of suicide. Other factors increase risks of mental ill-health or suicidal distress. Thus, in policy or research, social determinants may also be described as "protective factors" or "risk factors".

- **Protective social determinants include** adequate income; secure employment; higher level of education; secure, affordable housing; and social support.
- **Harmful social determinants include** financial distress; unemployment or insecure employment; workplace stress; racism and discrimination; insecure housing; exposure to adverse family conditions in childhood; and stigma.
- **Determinants related to suicide include** financial insecurity; childhood trauma; family violence; long-term unemployment; displacement; limited education; isolation and loneliness; and alcohol and other drug use.
- **Chronic stress** is a key mechanism by which determinants affect mental health.
- **The key determinants** affecting mental health or suicidality may **vary** from one priority population group to another.

Social & cultural determinants of Indigenous mental health

First Nations peoples in Australia continue to maintain strong cultures and communities working to assert rights, achieve self-determination and promote social and emotional wellbeing; despite the adverse impacts of colonisation, racism, and socioeconomic inequality. Aboriginal and Torres Strait Islander leaders, researchers and policy makers recognise a range of social and cultural determinants which are especially relevant to First Nation peoples' social and emotional wellbeing in Australia.

- **Protective determinants include** connection to culture and strong cultural identity; connection to and care for country; connection to family and kinship; secure employment and housing; and access to community-controlled health services.
- **Harmful social determinants include** ongoing impacts of colonisation including intergenerational trauma; exposure to racism; interactions with discriminatory child protection or justice systems; poverty; unemployment; poor housing and sanitation; and lack of access to culturally safe health care services.

Useful links and resources

- World Health Organisation: Social Determinants of Health – Overview
- World Health Organisation (2014) Social determinants of mental health
- AIHW: Determinants of health for Indigenous Australians
- Calma, T., Dick, D. (2007) Social determinants and the health of Indigenous peoples in Australia – A human rights based approach
- Dudgeon, P., et al, (2014) Working together: Aboriginal and Torres Strait Islander mental health and wellbeing – principles and practice
- Beyond Blue. Factors affecting LGBTI people

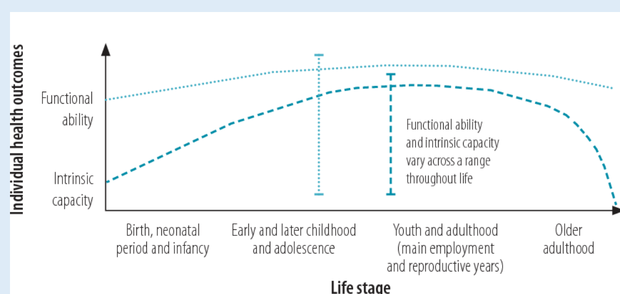
See also: Understanding mental health and suicide prevention from an equity perspective

Resource page 3: Life course approach to mental health and suicide prevention

A life course approach recognises that the different stages of life (i.e. preconception, infancy, early years, childhood, youth, adulthood, older age) affect mental health and wellbeing, both in terms of *intrinsic capacity* (the internal attributes we are born with) and *functional ability* (what we are able to be or do) (see figure below, WHO). It recognises that at each stage of life, our functional ability is heavily influenced by social, cultural and other environmental factors, and that a wide range of protective and risk factors influence mental health and wellbeing.

Creating healthy public policies that address the social determinants of metal health and suicide, creating environments that improve the conditions of daily life, and promoting social and cultural norms that are important for mental ill-health and suicide prevention, will help reduce inequities across the life course trajectory, and improve population mental health and wellbeing.

By taking action to protect, promote and improve mental health and wellbeing that respond to the specific stages of life, we can reduce inequities within and between generations.



Putting a life-course approach into practice

Understanding how a life-course approach relates to particular priority populations can help organisations and services improve many aspects of their work/service delivery. Putting it into practice may involve:

- Investing in strategies to support good parenting and early child development can reduce risk of children experiencing mental ill-health later in life
- Identifying important transition periods for priority populations to protect and promote mental health and prevent suicide (e.g. for women in the perinatal stage, children entering adolescence, men commencing work in high-risk occupations; people exiting prison).
- Recognising opportunities to create supportive environments for health and wellbeing, and improving conditions of daily life for priority groups (e.g. improving housing security, supporting young people to find employment, providing opportunities for social inclusion for elders).

Useful links and resources

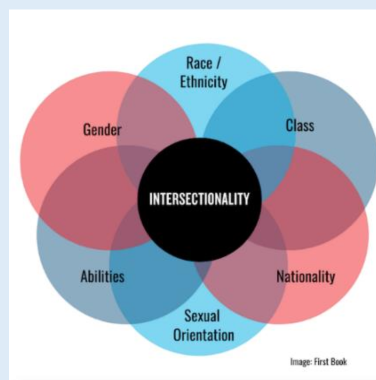
- Life Course Centre: The Life Course Approach
- Public Health England: Prevention – a life course approach
- World Health Organisation: A life-course approach: from theory to practice

See also: *Understanding social & cultural determinants of mental health & suicide*

Resource page 4: Understanding Intersectionality

Intersectionality refers to the way in which multiple social aspects of identity, such as gender, race, class and sexual orientation, intersect or interact with each other. It encompasses the idea that people often identify with more than one group.

Intersectionality is an important concept to understand for reducing mental health and suicide inequities, because identity labels can affect mental health and suicidal distress.



While we all have a personal story, certain identities are at greater risk of marginalisation—for example, First Nations communities, LGBTIQ+AB communities, people with a low income and people with disabilities. There may be unique stresses associated with each identity, often related to systems of power, that lead to discrimination and oppression.

For example, media reports that marginalise transgender people can create barriers to accessing mental health services.

Read this article, which explains further: **Negative Media Coverage as a Barrier to Accessing Care for Transgender Children and Adolescents**.

Putting Intersectionality into Practice

Understanding how intersectionality relates to particular priority populations can help organisations and services improve many aspects of their work/service delivery. Putting it into practice may involve:

- Engaging with specific priority population groups to learn more about their perspectives—and reflecting on your current practices and being open to change.
- Adopting an inclusive approach at all levels of the organisation or service, using principles of practice related to **person-centred care**, **cultural safety**, **trauma-informed practice** and taking a **strengths-based approach**.
- **Co-designing** programs and services with priority populations.
- Addressing stigma and discrimination within the organisation/service.

Useful links and resources

- Health Consumers NSW: **Intersectional needs explained**
- LGBTIQ+ Health Australia **Fact Sheet: Intersectionality and Youth Mental Health**
- National Collaborating Centre for Determinants of Health: **Public Health Speaks: Intersectionality and Health Equity**
- National Mental Health Commission: **National Stigma and Discrimination Reduction Strategy** & **Enabling diverse participation**

See also: *Community Engagement*, *Understanding social & cultural determinants of mental health & suicide*

Resource page 5: Mental Health Promotion and Prevention

Mental health promotion:

- ***Aim*****:** To promote healthy behaviours, mental health & psychological wellbeing
- ***Target*****:** The population at large (universal) or an at-risk group (selective)
- ***Examples*****:** Create health promoting environments (e.g., walking trails); Facilitate/resource community actions (e.g., community gardens, social support networks, sporting groups); Support school to employment transition; Develop positive parenting skills; Promote skills to manage stress.

Primary prevention:

- ***Aim:*** To prevent people developing a mental health problem or illness, or suicidal distress by preventing or reducing exposure to risk factors
- ***Target*****:** The general population or an at-risk group
- ***Examples***: Regulation of tobacco or alcohol; Prevent bullying or discrimination in schools; Prevent exposure to workplace stressors (e.g., excessive workload, long working hours, insecure employment)
- ***Re suicide prevention***: Proactively address exposure to risk factors (e.g., financial distress, loss of relationship, long-term unemployment); Reduce access to means; Limit media discussion of suicide.

Secondary prevention:

- ***Aim****:* To detect early signs of mental ill-health and prevent it getting worse
- ***Target***: Groups at higher risk of mental ill-health or suicidal distress, or with signs of emerging illness
- ***Examples***: Screening programs through primary care; Reduce stigma and create supportive environments for acknowledgment of mental distress; Mental health first aid; early help-seeking; Service systems for early access to treatment
- ***Re suicide prevention***: Postvention services for people bereaved by suicide; Ensure safety of people taken into custody and eliminate access to means.

Tertiary prevention:

- ***Aim****:* To improve quality of life, manage symptoms, prevent acute episodes
- ***Target***: People with chronic mental illness
- ***Example***: Build skills for self-management; Implement recovery strategies; Provide support for carers; Address housing needs or access to employment.
- ***Re suicide prevention***: Reduce access to means in acute care settings.

Addressing **social determinants of mental health** is relevant across the whole promotion and prevention spectrum. A **strengths-based approach** to working with a priority population group *resists* thinking about group members in deficit-focus terms (ill, in need, lacking, problematic) and actively aims to recognise group strengths (shared culture, communal practices, organisation, resilience, creativity) and develop strategies that build on those strengths.

Useful links and resources

- **Prevention United** website.
- **Suicide Prevention Australia** website.
- VicHealth, Carbone, S. (2020**)** **Evidence review: The primary prevention of mental health conditions**
- Mental Health Commission of NSW: **Strengths model implementation in community mental health services**

Resource page 6: Cultural Knowledge

Cultural knowledge involves developing an understanding of the cultural characteristics, norms, beliefs, symbols and attitudes that are unique to priority population groups. Cultural knowledge involves gaining local insight into what is important to particular groups and how they interpret the world around them—including how they understand mental health, wellbeing and suicidal distress. Cultural characteristics may be related to race or ethnicity, or other aspects of identity.

An example of the value of developing cultural knowledge relates to Aboriginal and Torres Strait Islander communities' approaches to suicide prevention, which draw on aspects of local knowledge about social and emotional wellbeing. Comprehensive community engagement processes, focusing on self-determination and employing decolonising practices have been shown to be important for mental health initiatives. Read more about what mental health might mean to Aboriginal and Torres Strait Islander communities **here**.

Cultural knowledge may also be relevant for groups defined by other aspects of identity. For example, **Rural Alive and Well** is a program that uses an outreach model to address early intervention suicide prevention in rural and remote communities. It is based on research findings, for example, that farmers are **less likely to access mental health care**, but are at greater risk of poor mental health.

Cultural knowledge is sometimes incorporated into discussions about **cultural competence** and **cultural safety**. Cultural competence is about your ability to engage with people who come from different cultural backgrounds. Cultural safety involves a deeper understanding about how to move from knowing to action, with an emphasis on shifting power imbalances. This article is worth reading and includes definitions of the various terms: Definitions and Concepts of Related Terms: **Why cultural safety rather than cultural competency is required to achieve health equity.**

Understanding cultural knowledge can help organisations and services improve many aspects of their work/service delivery for priority populations. Putting cultural knowledge into practice may involve:

- Effective engagement with priority populations—being open to learning and practicing **deep listening**.
- Relinquishing poorly informed assumptions and unconscious biases.
- Reflecting on current practices and shifting these in the direction of power-sharing, self-determination and enabling local ownership.
- Building organisational capacity to offer **culturally safe** practices and services.

Useful links and resources

- Conversations Matter: **Supporting Culturally and Linguistically Diverse (CALD) communities to talk about suicide.**
- Mental Health Commission of NSW: **Aboriginal Communities**
- NSW Health: **How can I support a LGBTIQA+ person with a mental health condition?**
- Women's Health Victoria: **Towards a gendered understanding of women's experiences of mental health and the mental health system.**

See also: *Community Engagement*, *Understanding Social & Cultural Determinants of Mental Health & Suicide, Capacity Building*

Resource page 7: Policy & Advocacy

Mental health and suicide prevention policies provide important frameworks for action to reduce mental ill-health and suicide inequities. Policies may be specific to mental health and/or suicide prevention (e.g. **Fifth National Mental Health and Suicide Prevention Plan 2017**); while others may focus on social determinants of mental health and wellbeing, such as housing (e.g. **NSW Homelessness Strategy 2018-2023**). Policies aimed at a particular priority population group may provide deeper insights into important social and cultural determinants of health for that particular group (e.g. **National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023**). Non-government organisations often develop policies as 'position statements' as part of their advocacy efforts. An example can be found at **Beyond Blue Policy and Advocacy**. The World Health Organisation describes advocacy for health as a "combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme." Advocacy can help translate policy into action.

Numerous organisations are utilising **lived experience** participation to inform advocacy, as well as other aspects of their work (e.g. service design, peer support). People with lived experience have personal experience of mental ill-health and/or suicide attempts and/or suicidal distress, and can provide valuable insight what it's like to live with or recover from mental ill-health, care for someone with mental ill-health and navigate the service system. They may also provide personal understanding of marginalisation, oppression and discrimination, and insights into changes to social status and inclusion.

Putting policy and advocacy into practice

- Developing an understanding of the policy development process and u how politics and policies interact
- Understanding the mental health and suicide prevention policy environment, including specific policies relevant to your selected priority populations
- Holding governments to account for important policy commitments that could help reduce mental health and suicide inequities (e.g. develop an understanding of relevant data, monitor progress against commitments, ask questions, advocate)
- Working in partnership with other organisation and sectors, and implementing a **Health in All Policies** approach
- Developing position statements on important policy issues and making advocacy part of your workplan

Useful links and resources

- Public Health Ontario: **Eight Steps to Building Healthy Public Policies**
- Parham, J., 2007: **Shifting mental health policy to embrace a positive view of health: a convergence of paradigms**
- Black Dog Institute: **Lived Experience**
- Reich, M., 2002: **The politics of reforming health policy**

See also: *Partnerships*

Resource page 8: Understanding mental health and suicide prevention from an equity perspective

Risk of mental ill-health and suicide prevention is partly shaped by social determinants. Housing insecurity, job insecurity, food insecurity, discrimination, and poverty create a chronically stressful environment that raises risk of mental ill-health and suicidal distress. This creates a social gradient in health, where people in the poorest areas of Australia are over twice as likely to suffer from mood problems, and are almost twice as likely to die from suicide or self-inflicted injuries before they turn 75 compared to people in the richest areas of Australia (see Figure 1).

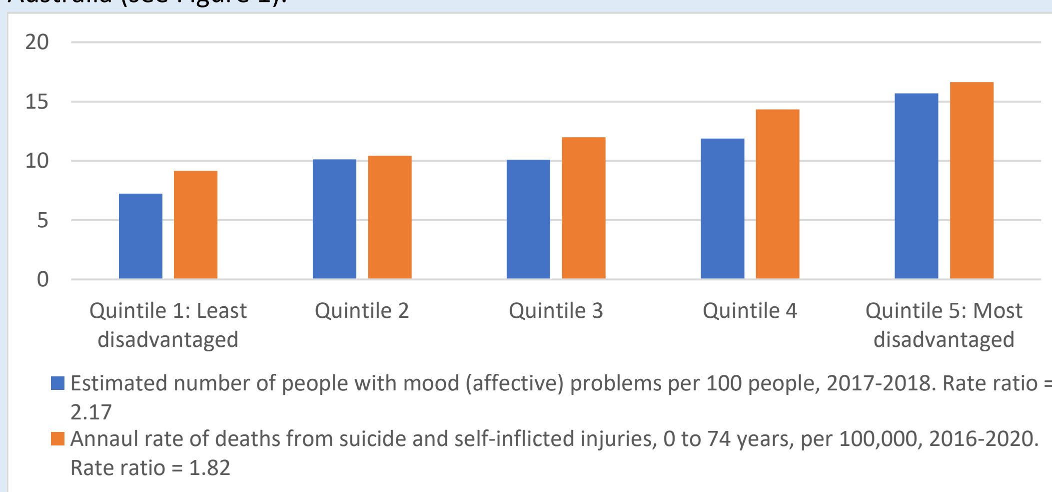


Figure 1. Social gradient in mood (affective) problems and deaths from suicide and self-inflicted injuries (0-74 years) in Australia. Source: https://phidu.torrens.edu.au/social-health-atlases/graphs/monitoring-inequality-in-australia

These inequities in outcomes are driven by inequities in social determinants of health and health service access. Inequities have been increasing over time, with the gap between the richest and poorest on both these measures growing larger over recent decades. Taking an equity perspective is crucial, because otherwise mental health or suicide prevention efforts risk increasing these inequities if those with less resources or less socioeconomic status miss out on benefitting.

As well as socioeconomic inequities, discrimination and exclusion create increased risk of mental ill health and suicidal distress for groups such as LGBTQIA+ people, Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse people.

Useful links and resources

- Public Health Information Development Unit (PHIDU): **Social Health Atlas**
- AIHW: **An overview of Indigenous mental health and suicide prevention in Australia**
- LGBTIQ+ Health Australia: **LGBTIQ+ Mental Health and Suicide Prevention Strategy**

See also: Health Equity Planning, Understanding social & cultural determinants of mental health & suicide

Resource page 9: Partnerships

Partnerships are central for improving mental health and preventing suicide among priority populations. Working in partnership in this context means working in partnership with population groups, as well as with other organisations and different sectors.

Vic Health describes different types of partnerships for health promotion and illness prevention, including ***networking***—which involves the exchange of information for mutual benefit; ***coordinating***—exchanging information and altering some activities for a common goal; ***cooperating***–which involves resource sharing; and ***collaborating***—which extends partnerships to include capacity building for mutual benefit.

Partnerships are important when working with priority population groups, for example, where goals relate to improving cultural safety, building capacity, engaging with community, understanding intersectionality and undertaking co-design. Partnerships between Health agencies or services and organisation in other sectors can support taking action on social determinants of mental health.

Partnerships can have many benefits but can also be challenging, so it's important to be open to learning and adapting approaches.

An example of a partnership approach to working with a priority population is the Migrant and Refugee Health Partnership. Establish in 2016, the partnership *"brings together health professionals and the community to address systemic barriers to health access for migrant and refugee communities."* Visit the **Migrant & Refugee Health Partnership website** for more information.

Putting Partnerships into Practice

Working in partnership can help organisations and services improve many aspects of their work/service delivery. Putting partnerships into practice may involve:

- Planning—asking questions such as: why does the organisation/service need partners; who are the potential partners; what are we offering them and what could they offer us; are there any risks or ethical issues to consider; will there be resource implications; what type of partnership would work best (e.g. networking, coordinating, cooperating, collaborating)?
- Open conversations—particularly in relation to expectations, overcoming differing perspectives, ownership of outputs and outcomes, and branding.
- Partnerships should be reviewed or evaluated using participatory approaches such as this **Partnerships Analysis Tool**.
- Being brave enough to engage with sectors outside of the mental health or suicide space. For example, **Doorway** is a collaborative project to uses the private rental market to provide housing for people who are affected by mental ill health.

Useful links and resources

- Hope Corbin, J., 2017, **Health promotion, partnerships and intersectoral action**
- NSW Health: **Community mental health service partnerships**
- Vic Health: **Partnerships Analysis Tool**
- Hope Corbin, J., et al 2018, **What makes intersectoral partnerships for health promotion work? A review of the international literature?**

See also: Community Engagement

Resource page 10: Supporting Aboriginal & Torres Strait Islander Social and Emotional Wellbeing

Aboriginal & Torres Strait Islander social and emotional wellbeing encompasses the social, emotional, spiritual and cultural wellbeing of a person. It also recognises that connection to country, family and community are integral for wellbeing.

Mental health and mental illness are considered by many Aboriginal & Torres Strait Islander people to be medical terms that focus too much on problems and do not properly describe all the factors that make up and influence wellbeing.

The **National Strategic Framework for Aboriginal &Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing** has nine principles: **1.** Health as holistic **2.** The right to self-determination **3.** The need for cultural understanding **4.** The impact of history in trauma and loss **5.** Recognition of human rights **6.** The impact of racism and stigma **7.** Recognition of the centrality of kinship **8.** Recognition of cultural diversity **9.** Recognition of Aboriginal strengths.

The Framework is intended to guide and inform Aboriginal & Torres Strait Islander peoples' mental health and wellbeing policy and action in Australia.

Understanding Aboriginal & Torres Strait Islander social and emotional wellbeing can help organisations and services improve many aspects of their work/service delivery. Putting it into practice may involve:

Considering whether your organisation is best placed to work with Aboriginal & Torres Strait Islander organisations and communities to provide programs or services; e.g. have you developed strong, enduring and trusting relationships with a community or communities? Have you thoroughly addressed racism and built cultural safety within your organisation?

- Engaging with Aboriginal and Torres Strait Islander health peak bodies and other organisations in your jurisdiction to listen and learn.
- Embracing the Gayaa Dhuwi Declaration which focuses on Aboriginal & Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of social and emotional wellbeing for Aboriginal & Torres Strait Islander peoples.
- Supporting funding and control of mental health and suicide services for Aboriginal & Torres Strait Islander peoples by Aboriginal Community Controlled Health Organisations (ACCHOs)
- Embedding culturally safe practice into service and program design and delivery

Useful links and resources

- Dudgeon, P., et al (eds), 2014: Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice
- Indigenous Mental Health and Suicide Prevention Clearinghouse: Social and Emotional Wellbeing
- Department of Health Victoria: Aboriginal & Torres Strait Islander Cultural Safety

***See also**: Understanding Social & Cultural Determinants of Mental Health & Suicide*

Resource page 11: Health Equity Planning

There are different approaches to setting goals or objectives for health equity to consider.

Targeted strategies. Instead of addressing the needs of the community in general, targeted strategies are specific to particular priority populations, aiming to support their particular needs around mental health and suicide prevention. Examples include tailored health promotion outreach strategies, or services developed specifically to cater to particular priority populations, such as Aboriginal and Torres Strait Islander peoples. Targeted strategies need to be co-designed to ensure acceptability and avoid stigma (see 'Community Engagement').

Proportionate universalism. Proportionate universalism means working to improve the health and wellbeing of the whole population, while placing proportionately more effort into supporting those lower down the social gradient (see 'Understanding mental health and suicide prevention from an equity perspective) or groups who experience discrimination, exclusion, and other barriers. If strategies do not place more effort into reaching those with less socioeconomic resources, then efforts are likely to be more beneficial to those who have the resources to access help, and make changes to their life. This would exacerbate inequities in mental health and suicide.

Considerations will differ depending on whether your organisation is aiming to provide health care services, and/or engage in health promotion and advocacy on social determinants of mental health and suicidal distress. For service provision, consideration of equity is likely to focus on equity in access to care, and outcomes from care, and may be more amenable to measurement. Health promotion and advocacy provide opportunities to address more fundamental drivers of inequities, but impact and outcomes are more difficult to measure.

Program logic modelling is one approach that can help organisations plan to contribute to addressing inequities. Program logic models aim to articulate the necessary resources and activities, the rationale for the selected approach, and its intended outcomes.

Useful links and resources

- Public Health Ontario: **A Proportionate Approach to Priority Populations**
- World Health Organization: **How to equity proof your policies and interventions**
- Health Scotland: **Proportionate universalism briefing**
- NSW Health: **Developing and Using Program Logic: A Guide**

See also*: Understanding mental health and suicide prevention from an equity perspective*

Resource page 12: Working with Priority Populations

In selecting a priority population and determining that your organisation is best placed to work with a group, it's critical to reflect on the shared characteristics of the population group. What makes a priority population are shared characteristics such as socioeconomic status, gender, Indigeneity, ethnicity, sexual orientation, age, location, occupation and so forth. It is these unique attributes that should inform your work with priority populations.

Ensuring you understand your selected priority populations' needs and how they view the world in relation to mental health, wellbeing and suicidal distress may involve doing further 'research', undertaking community engagement, seeking out cultural knowledge or building partnerships with other organisations.

There are many useful publications available to guide practice, unique to priority groups. For example, this resource, **Going upstream**, provides important information about promoting mental health of LGBTIQ+ people.

For some groups, you may need to rely more on local knowledge and employ strategies underpinned by the principles of self-determination.

Other important aspects of working with priority populations include recognising diversity with groups, as well as the impact of key determinants, including Indigenous, cultural or linguistic heritage, religious affiliation, geographic location, age and so forth.

Working with Priority Populations – Putting it into Practice

Understanding the unique characteristics of priority populations can help organisations and services improve many aspects of their work/service delivery. Putting this into practice may involve:

- Doing your homework: Understanding your chosen priority population's key characteristics, diversity, needs and priorities.
- Using an evidence-base. Find out about best practice approached for working with particular groups. For example, this resource—**Youth mental health service models and approaches, Considerations for primary care**—is about working with youth.
- Take an equity approach to your work—acting on the underlying factors that are contributing to inequities in mental health and suicide. One of the main reasons groups are categorised as 'priority populations' is 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.
- Co-design programs and services with priority populations.

Useful links and resources

- Mental Health Australia: **Co-design in mental health policy**
- NSW Mental Health Commission: **Priority populations: Resources for working with communities**
- Public Health Ontario: **Focus On: A Proportionate Approach to Priority Populations**

See also: Understanding Intersectionality, Partnerships, Community Engagement

Resource page 13: Monitoring and Evaluation

Monitoring and evaluation should be factored into all programs and aspects of service delivery on an ongoing basis. Monitoring involves keeping track of day-to-day activities to ensure you are 'on the right track'. Evaluation involves asking questions about the effectiveness of programs and services.

Evaluation may involve exploring:

- **Process** indicators to answer questions about the quality of activities, and how well a program or service is being implemented.
- **Impact** measures, which can identify the short-term effects associated with a program or service, and whether objectives are being met.
- **Outcomes**—the longer-term effects arising from programs or services, and whether goals are being achieved.

Sometimes evaluation may seem daunting but there are many useful resources available that can provide guidance. In some cases, you may want to engage with external expertise (like a university) to help you.

Participatory, reflective monitoring and evaluation practices are very useful when working with priority populations. Visit these websites: **Participatory Action Research Toolkit** and **Most Significant Change**.

Understanding how to monitor and evaluate activities can help organisations improve many aspects of their work/service delivery with priority populations. Here are some ways you can put this into practice:

- Before you can evaluate anything, you need to decide what you want to evaluate and why. Start by developing a goal and objectives, and then identify indicators that can help reveal how effective an activity has been.
- Consider your 'data sources'. Monitoring and evaluation doesn't have to mean endless paperwork, surveys or detailed research. There are many ways to capture the impact of something e.g. using personal stories, observations or social media. Here are some ideas from the arts sector: **Arts Based Evaluation**.
- Take the time to reflect on monitoring and evaluation findings, and ask yourselves, 'Do we need to do things differently'?
- Ensure there is some level of independence to your monitoring and evaluation. While approaches should be participatory, there may need to be some level of objective separation between those delivering a service, and those collecting feedback, for example.

Useful links and resources

- Department of Health (Victoria): **Measuring Outcomes in Mental Health Services**
- Health Pathways Community: **Evaluation Resources**
- NSW Health: **Program evaluation**
- Vic Health: **Planning, monitoring and evaluating mental health promotion**
- World Health Organisation (WHO): **Evaluation in health promotion: principles and perspectives**
- **Better Evaluation**

See also: Health Equity Planning, Cultural Knowledge

Resource page 14: Capacity Building

Capacity building in health promotion and illness prevention is **defined by the World Health Organization (WHO)** as "the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organisations; and the development of cohesiveness and partnerships for health in communities."

To work effectively with priority populations, organisations may need to build their capacity, for example, through staff training and skill development, seeking funding for additional staff and resources, developing organisational commitment for sustainable change, or forming partnerships to build capacity in specific areas, like evaluation and local knowledge.

Identifying existing strengths is an important part of capacity building, as is recognition that lack of capacity may be associated with wider structural issues such as politics and policies, funding models and systems of accountability.

Read about the Queensland Mental Health Commission's Mental Health and Wellbeing Capacity Building Project on **this webpage**.

Putting Capacity Building into Practice

Here are some ways you may be able to build capacity within your organisation or service:

- Before working with priority populations, it may be useful to do an 'internal audit' to identify gaps or areas within the organisation or service that could be strengthened. This resource may be helpful: **Indicators to help with capacity building in health promotion**.
- A willingness to share power and ownership is very important for working with priority populations. This may mean that your organisation is not best placed to work directly with a selected group. However, there are other important actions that can support the work of those with direct links to priority populations including advocacy, working collaboratively with other sectors, developing healthy public policy and reorienting other parts of the health system. All of these actions can help build capacity for change, even if your organisation is not directly working with priority groups. Partnerships are key to success.
- Building capacity should be part of a long-term plan to better meet the needs of communities. Short-term funding can be problematic if expectations are not met, and communities feel let down.

Useful links and resources

- DeCorby-Watson, K., et al, 2018: **Effectiveness of capacity building interventions relevant to public health practice: a systematic review**
- Vic Health: **Capacity Building for Health Promotion**
- The Lowitja Institute: **Deficit Discourse and Strengths-based Approaches: Changing the narrative of Aboriginal and Torres Strait Islander health and wellbeing**

See also: Partnerships, Cultural Knowledge