

WORKBOOK

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

This Workbook should be used in conjunction with **A tool to help organisations and services identify Priority Populations in Mental Health and Suicide Prevention.** It provides space to record your thoughts as you work with your colleagues to identify priority populations. The [**glossary**](#_Glossary) on page 12 provides definitions of key terms used in the tool and a range of resource pages provide further information on some of the relevant concepts.

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**Step 1: Do we want to identify priority populations?**

**🖊 Record your thoughts below**

**YES – Refer to Step 1 in the tool and record your thoughts below:**

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**Continue to STEP 2**

**NO - We are not going to identity priority populations, but we know how to:**

* Ensure our organisation’s work is inclusive of everyone in your community.
* Take account of [intersectionality](#_Glossary) to help people feel safe and included by our organisation or service.
* Ensure our work or service aims to meet the differing needs of diverse groups in our community equitably.
* Monitor how well our organisation or service is succeeding in being inclusive.

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

**🖊 Record your thoughts below**

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**Before proceeding to STEP 3, complete this checklist.**

We are confident that:

* We know what ‘priority population’ means.
* We are clear about our goals in relation to mental health and/or suicide prevention.
* We are aware of the incidence of mental il-health and/or suicide and specific needs in our community.
* We recognise our role in [mental health promotion, primary, secondary and/or tertiary prevention](#_Glossary).
* We have the time and other resources necessary to work with priority populations.
* 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.

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**Continue to STEP 3**

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

**🖊 Record your thoughts below**

**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? \**data may include quantitative and qualitative data, as well as stories and informal sources of information*
* Do we understand the difference between [risk groups](#_Glossary) and [equity groups](#_Glossary)?

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**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?

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**Q.3 Do we know how different stages of the** [**life course**](#_Glossary) **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?

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

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**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?

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**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 and Torres Strait Islander cultures or other cultures that we need to be aware of?

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**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](#_Glossary)?

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**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](#_Glossary)?

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**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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**The next steps we need to take to resolve our views on the questions in Step 3 are:**

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**The priority population(s) we have chosen are:**

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**Before proceeding to STEP 4 complete this checklist.**

We are confident that:

* We have established trust with our chosen priority populations.
* We know how to work effectively in partnership with priority populations.
* We are committed to being accountable to the groups we have identified by developing effective actions to help reduce mental ill-health and suicide inequities.

**Continue to STEP 4**

**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 below.**

**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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**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](#_Glossary)?

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**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?

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**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](#_Glossary) approach?
* Are they measurable?

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**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](#_Glossary)?

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**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](#_Glossary) as they relate to priority populations, which can help us understand health [complexities](#_Glossary) and inform our action plan?

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**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?

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**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?

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

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**Complete this checklist.**

We are confident that:

* 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.

**The next steps we need to take in the short-term are:**

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| 1.2.3. |

**The next steps we need to take in the longer-term are:**

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| 1.2.3. |

**You have now completed the tool.**

**Please consider revisiting the questions at a future date to reflect on your choices and consider your progress.**

## **[Glossary](#_Glossary_Workbook)**

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| **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](https://preventioncentre.org.au/wp-content/uploads/2021/10/Systems-Thinking-A4-Poster_Aug18.pdf). |
| **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.](https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1) |
| **Health Inequalities** | The differences in health between different groups. An equalityapproach 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.](https://www.who.int/docs/default-source/documents/social-determinants-of-health/hiap-ppt-module-2-part-2.pptx?sfvrsn=6097ae24_2) |
| **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](https://nest.greenant.net/index.php/s/6TKx6EfiC3KiC3F). |
| **Intersectionality** | Describes how multiple social aspects of identity, such as gender, race, class and sexual orientation, intersect or interact with each other. [Read more](https://www.mindaustralia.org.au/intersectionality-and-its-value-mental-health-care). |
| **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](https://apps.who.int/iris/rest/bitstreams/1353953/retrieve). |
| **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.](https://academic.oup.com/jpubhealth/article/32/2/148/1610540) |
| **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](https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response). |
| **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](https://preventionunited.org.au/how-prevention-works/what-is-prevention/). |
| **Priority Population** | Groups of people defined according to a shared characteristic (e.g., socioeconomic status, gender, Indigeneity, ethnicity, sexual orientation, age, location, occupation) who:1. 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.
2. Are identified by an organisation working in mental health and/or suicide prevention as a specific focus of their policy and/or practice.
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| **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.](https://www.publichealthontario.ca/-/media/documents/F/2015/focus-on-priority-populations.pdf) |
| **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](https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf). |