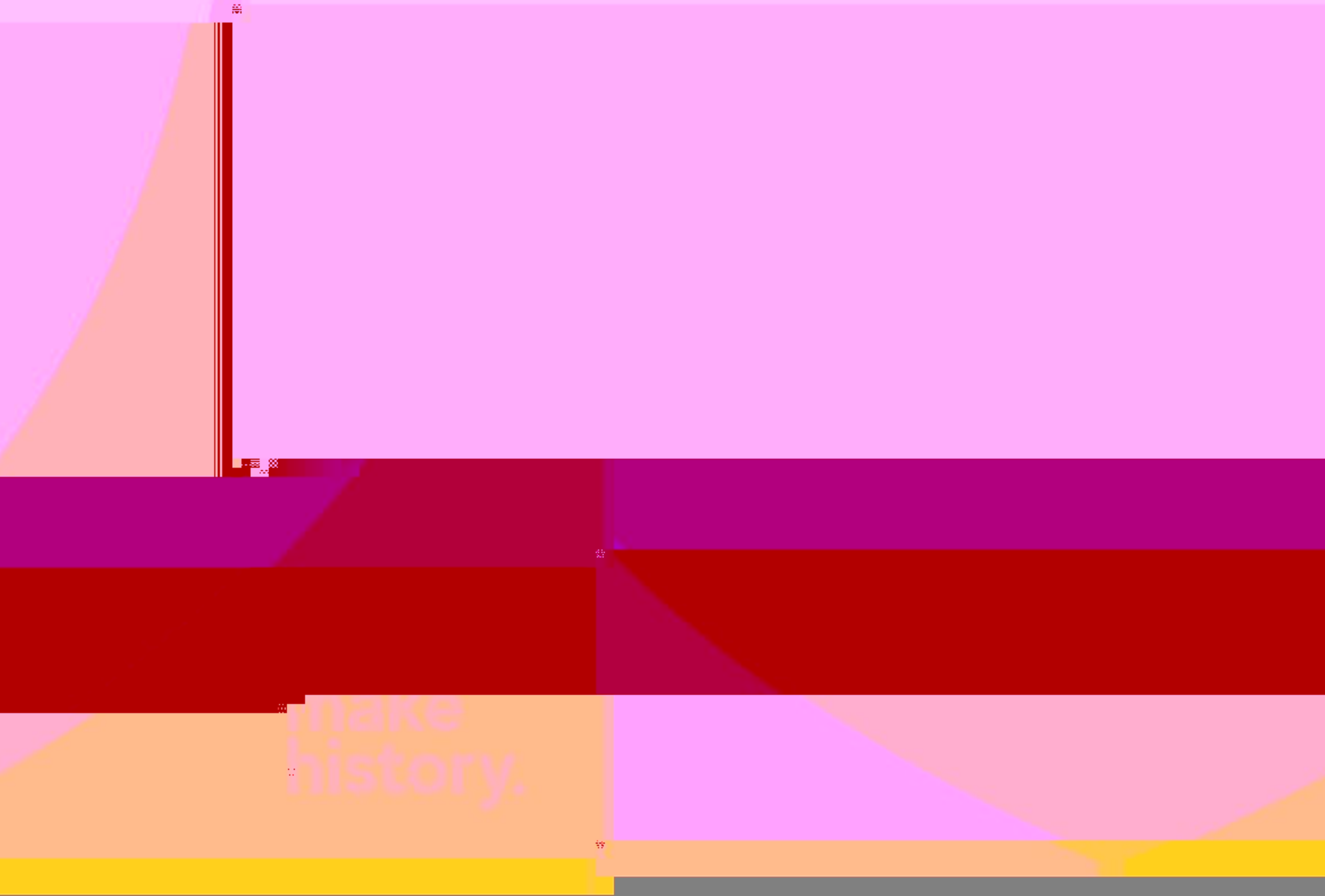
PRIORITY POPULATIONS IN MENTAL HEALTH



Priority Populations in Mental Health and Suicide Prevention

Research Report

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 It

- 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.
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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

Recommendation 6:

Recommendation 18: Policy makers should recognise populations affected by climate changeкeÈúꞮeme øeaűheꞮ eØenűă aă a PP gꞮ2ǳLJ and LJlan ѱbeăű fiűꝽ ăűꞮaűegieă ű2 meeű űheiꞮ needăφ

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 strategieă ădzch aă SAꝽă ădzicide LJꞮeØenűi2n 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.

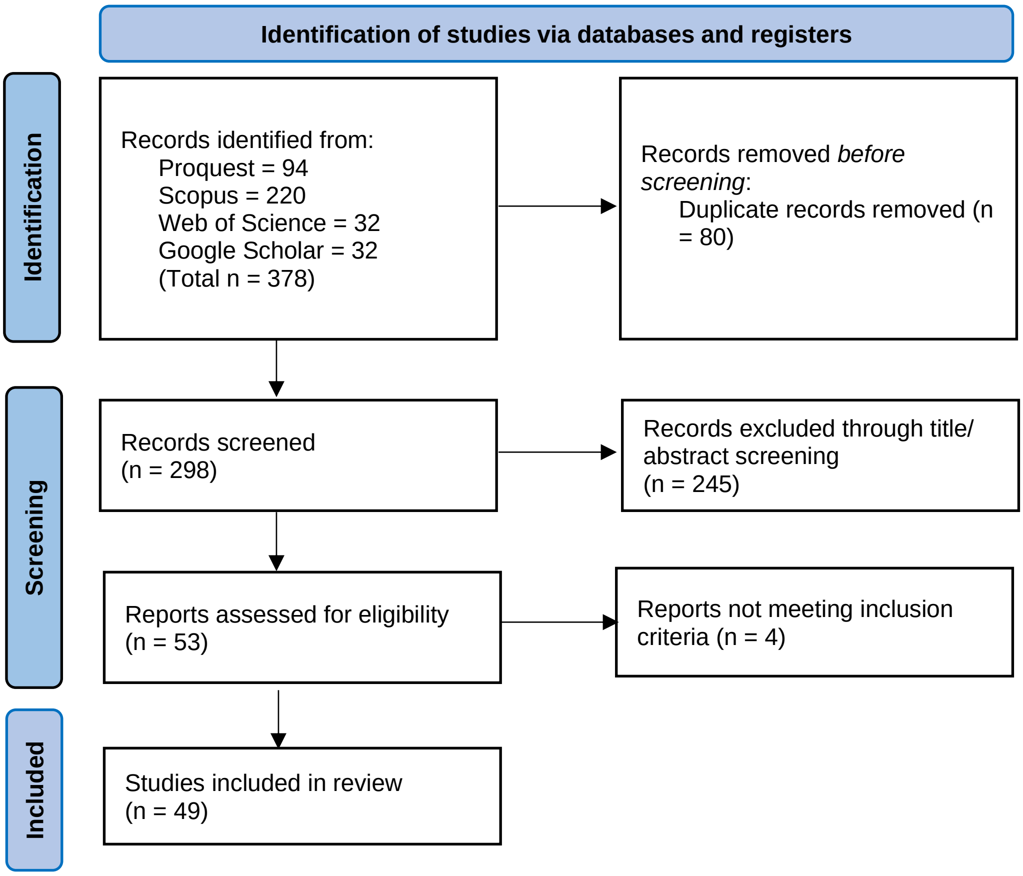
Recommendation 25: Support innovative service mod 0.000008871 0 59[(i)2 11.04 Tf1 0 0 1 191.66 386.23r6nT

r delivery

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 of PPs named, and proportions of actions directed at each of the PPs. Policy quotes were extracted to illustrate these findings in further detail.

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.



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.

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.

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 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 embedde 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

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*

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 ad*

“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.”

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 [illegible] mental ill-health, suicide [illegible] 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.

[illegible]ed by [illegible] organisation [illegible] mental health/suicide prevention as a specific [illegible]eir policy and/or practice.

[illegible]ndicates that *definition* of a PP for the purposes of policy requires terms to defi[illegible] coupled with terms to define need or risk within that group. Our analysis of po[illegible] academic literature reveals a broad range of possible ways in which PPs may [illegible]ain terms available and in use to define groups, and terms to define risk or need ar[illegible] 1 below. A potential for wide-ranging and diverse of PP definitions arises in part [illegible] more of the terms in column 1 can be used to define a group and may be combined [illegible]re of the terms in column 2. Notwithstanding this potential diversity, definitions of PP [illegible]d in our analysis can be usefully summarised in four categories which we describe as [illegible] 'service user groups', 'risk groups' and 'equity groups'.

[illegible]PPs are defined primari[illegible] or emerging mental ill-health.

[illegible]alians who ex[illegible] also require targeted and ongoing [illegible]ese inclu[illegible]lex mental illness, borderline [illegible]disorde[illegible]tal illnesses, substance use [illegible] oth[illegible]

[illegible] are defined primarily in terms of [illegible]nsumers') of mental [illegible]

[illegible]ition' is used to describe the process of planning, [illegible]ing from a paediatric [illegible]vice to an adult health care service. There is increas[illegible]ver this period young [illegible]articularly at risk of suboptimal medical follow u[illegible]nt adherence, [and] [illegible]vice costs resulting in poorer health outcomes." WA Y[illegible]018-2023

[illegible]s are defined according to demographic criteri[illegible] increased risk of [illegible]h or suicidal distress, where known risk factors as[illegible] population *do not* [illegible]re to structural or systemic socioeconomic or cult[illegible]s. Examples would [illegible]

Definition of groups	Definition of risk/need
	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:
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	*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

> *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

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.

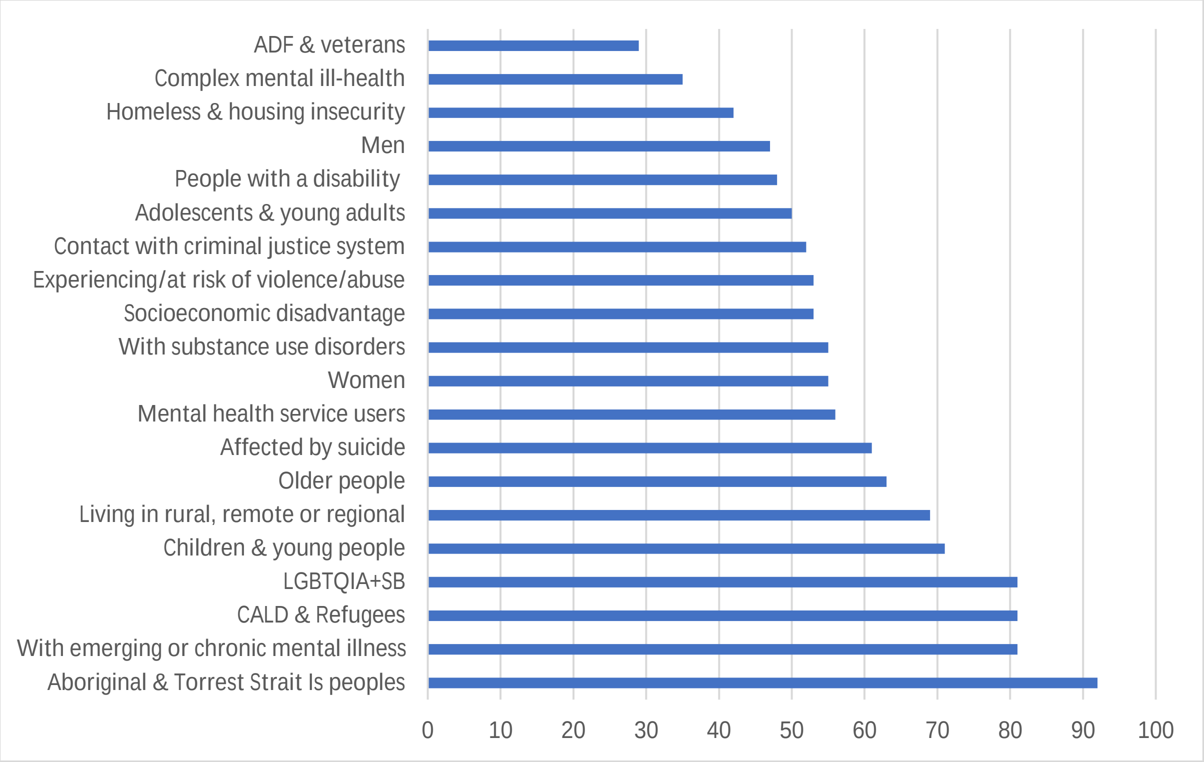
a) Defining a PP solely according to a demographic criterion associated with elevated risk of mental ill-

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*

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.



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.

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:

Aing each type of policy act actoo

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.

Together, the results show mental health services as the primary focus of policy actions proposed, *“We’re really looking at the theme of human rights and mental health particularly looking at the change in*

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.

> 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.

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

> *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 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.

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 form s n e that [illegible] b e si

> *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 n*

“And then the other reason for [our choice of] those four [priority groups] is the intersectional lens on each of those

level.” She goes on to say that “Alongside strategies for strengthening individual’s skills and

> *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* [illegible]

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.

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.

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

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

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

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 conditions (acting as stressors) affect both mental and physical health outcomes (8, 54, 58-60)

"[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

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

b) Health and other social service agencies to coordinate services.
c) Health and other policy sectors to facilitate improved access

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).

> *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.

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

> *“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

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

15. Deacon B, McKay D. The biomedical model of psychological problems: A call for critical dialogue. *Lancet*. 2015;16:231-

			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				