



Diverse communities' mental health

**A Women's Mental Health
Alliance Position Paper**

January 2023

Introduction

The [Women's Mental Health Alliance](#) (the Alliance) welcomes the opportunity to make a response to inform the development of the Diverse Communities Framework and Blueprint for Action.

This position paper was led by Jo Farmer with input from the Women's Mental Health Alliance's Diverse Communities Working Group, which included representatives from the Australian Muslim Women's Centre for Human Rights, Gippsland Women's Health, Mental Health Complaints Commission, Mind Australia, Monash University, Multicultural Centre for Women's Health, Rainbow Health Australia, Safe + Equal, Victorian Legal Aid, Women's Health Goulburn North East and Youth Affairs Council Victoria.

We are happy to elaborate further on our submission or provide additional information upon request.

About the Women's Mental Health Alliance

The Alliance was established by Women's Health Victoria in 2019. It comprises over 45 organisations and individuals who provide expert advice to policy makers and health services on the mental health of women and girls, and undertake advocacy to ensure all women have access to evidence-based, gender-sensitive and trauma and violence-informed mental health support. The Alliance works to ensure the voices of women with lived experience are centred in policy, advocacy and service delivery. The Alliance brings together consumer and carer advocates, service providers, clinicians, women's health organisations, human rights bodies and researchers.

We include all women – trans and cis women – in our activities. While we centre women in our work, we also recognise the many shared experiences among women, gender diverse and non-binary people and our common interest in breaking down harmful gender norms and practices, and addressing structural inequalities and discrimination based on gender. We aim to work together with LGBTIQ+ organisations and advocates to support the mental health and wellbeing of LGBTIQ+ communities.

Our approach to this response

This response sets out the need for intersectional gender-responsive approaches to mental health and principals for working with diverse communities.

This response also provides recommendations around engaging with diverse communities, creating a community and service system that supports diverse communities, including cross cultural perspectives on mental health and wellbeing, workforce considerations, and funding and outcomes measurement.

Given the breadth of our membership, the Alliance believes that this response is more appropriate than directly responding to the Community Engagement Toolkit.

Summary of recommendations

This document outlines the Women's Mental Health Alliance's response to Recommendation 34 (see Appendix) of the Royal Commission into Victoria's Mental Health Services (hereafter the Royal Commission), and subsequent activity by the Department of Health to develop a Diverse Communities Framework.

The Women's Mental Health Alliance's recommendations are:

1. Reconsider the language used to better reflect the challenges people and communities face in interacting with the mental health system.
2. Implement mental health reform underpinned by the following principles: human-rights based, trauma and violence-informed, lived experience-centred, strengths-based and intersectional.
3. Support community-led organisations to develop best practice guidance for engaging with diverse communities, in particular women in these communities, and incorporate this guidance into their projects.
4. Build mechanisms to hold projects to account for their engagement with diverse communities, including meaningful partnerships, reporting to communities and feedback mechanisms.
5. Invest in, and support initiatives that aim to build capacity of people from diverse communities to take up leadership opportunities within mental health reform activities.
6. Invest in and support cross-government efforts to eliminate marginalisation, stigma and discrimination.
7. Support local and area mental health services to have whole-of-organisation knowledge of and the capacity to deliver trauma-and-violence-informed care. This knowledge includes different types of trauma, systemic inequities, and structural drivers of violence and trauma.
8. Invest in service and community level initiatives which promote cross-cultural perspectives on mental health and wellbeing.
9. Invest in initiatives to support the development of culturally safe workplaces and the retention of a diverse workforce.
10. Actively fund the costs of delivering accessible and inclusive services to diverse communities.
11. Fund the development of partnerships between mainstream services and community-led organisations.
12. Increase funding certainty for community-led organisations.
13. Build accountability mechanisms into funding and reporting arrangements.
14. Support a review into mental health and wellbeing data with the objective of improving the transparency of mental health access and outcomes for diverse communities.
15. Provide guidance to all reform projects on incorporating the lived experience, including that of diverse communities, into evaluations.

Context

The Royal Commission called for a mental health and wellbeing system that is safe, responsive, and inclusive of people from diverse communities.

Recommendation 34 calls for the Victorian Government to actively engage diverse communities in the planning, implementation and management of a new mental health and wellbeing system. It further suggests that the development of a responsive mental health system that promotes access and equity of outcomes is a legislative responsibility of the Secretary of the Department of Health and requires the Mental Health and Wellbeing Division to collect appropriate data.

The Recommendation also notes the role of communities and community-led organisations in designing and delivering mental health information and awareness campaigns, and support to navigate the mental health and wellbeing system. Specific sub-recommendations are also made to provide recurrent funding to Switchboard Victoria, and digital technologies supporting language services.

Multiple diverse communities are mentioned in the accompanying section of the Royal Commission report, including:

- younger people
- older people
- Aboriginal and Torres Strait Islander peoples
- people living in rural and regional Victoria
- LGBTQIA+ people
- people from migrant and refugee backgrounds
- people living with disabilities.

The mental health and wellbeing of diverse communities

As the Royal Commission extensively details,¹ people from various diverse communities are at greater risk of mental illness, self-harm and suicide compared to their peers in other communities. While there have been recent improvements in the collection of reliable prevalence data on mental illness, self-harm and suicide in Australia,² data collection in relation to people from diverse communities needs strengthening.³ Despite this, studies published in 2020 have found:

- Among Victorian LGBTQIA+ young people (aged 16-17 years):
 - 82% experienced high or very high levels of psychological distress, more than three times the rate of a comparable general population study;
 - 59% had considered suicide in the previous 12 months, more than five times the comparable general population; and
 - 9% had attempted suicide, again three times the comparable general population.⁴

¹ RCMHS (2021) [Final report: Volume 3: Promoting inclusion and addressing inequities](#). Royal Commission into Victoria's Mental Health System, Melbourne.

² SPA (2022) [Unfinished business: implementation of the National Suicide Prevention Adviser's final advice](#). Suicide Prevention Australia, Sydney and ABS (2021) [National Study of Mental Health and Wellbeing](#). Australian Bureau of Statistics, Canberra.

³ SPA (2021) [Culturally and linguistically diverse populations: policy position statement](#). Suicide Prevention Australia, Sydney.

⁴ Hill AO, et al. (2020) [Writing Themselves in 4: The health and wellbeing of LGBTQIA+ young people in Australia :Victoria summary report](#). ARCSHS, La Trobe University, Melbourne.

- More than a third (36%) of people in Australia with “severe or profound disability” reported that they had mood disorders, compared to 9% of those people without disability.⁵

In addition to higher prevalence of mental distress, there is evidence that many people from diverse communities experience multiple barriers to accessing mental health support, including:

- failure of services to be culturally safe and provide culturally relevant and appropriate understandings of and responses to mental health;⁶
- racism and discrimination when accessing services, including actual or anticipated experiences of stigma and discrimination;⁷
- not being respected, listened to or involved in the decisions that affect their mental health care and treatment, a lack of physical access and a recurrent focus being on their disability, rather than their health concerns;⁸
- language and communication barriers;⁹
- knowledge and awareness of services;¹⁰
- location and accessibility issues, including visa status¹¹ and physical service access;¹²
- social stigma around mental health issues and service access.¹³

The poor experiences that many people from diverse communities have had accessing services means that there is likely considerable work to be done by services and the mental health system overall to re-establish trust before service experiences and outcomes will realistically improve.

However, it is also important to recognise that diverse communities bring many strengths. Out of both a sense of community and necessity in the face of a service system that does not meet their needs, many communities have formed strong social networks that support their health and wellbeing needs. Any response by the service system must not assume it is

⁵ ABS (2020) [Health of people with disability](#). ABS, Canberra.

⁶ Victorian Transcultural Mental Health (2021) [An integrated approach to diversity equity and inclusion in mental health service provision in Victoria: a position paper](#). VTMH, Melbourne.

⁷ Sullivan C, Vaughan C, Wright J (2020) [Migrant and refugee women's mental health in Australia: a literature review](#). School of Population and Global Health, University of Melbourne, Melbourne;

Carman M, Rosenberg S, Bourne A, Parsons M (2020) [Research Matters: Why do we need LGBTIQ-inclusive services?](#) La Trobe University, Melbourne

⁸ Australian Federation of Disability Organisations, Disability Resources Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia (2019) [Joint Submission to the Royal Commission into Victoria's Mental Health System](#). Melbourne.

⁹ Sullivan C, Vaughan C, Wright J (2020) [Migrant and refugee women's mental health in Australia: a literature review](#). School of Population and Global Health, University of Melbourne, Melbourne.

¹⁰ Sullivan C, Vaughan C, Wright J (2020) [Migrant and refugee women's mental health in Australia: a literature review](#). School of Population and Global Health, University of Melbourne, Melbourne.

¹¹ Perkins D, et al (2019) [The Orange Declaration on rural and remote health](#) *Australian Journal of Rural Health* 27:5; Sullivan C, Vaughan C, Wright J (2020) [Migrant and refugee women's mental health in Australia: a literature review](#). School of Population and Global Health, University of Melbourne, Melbourne;

¹² Australian Federation of Disability Organisations, Disability Resources Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia (2019) [Joint Submission to the Royal Commission into Victoria's Mental Health System](#). Melbourne.

¹³ Sullivan C, Vaughan C, Wright J (2020) [Migrant and refugee women's mental health in Australia: a literature review](#). School of Population and Global Health, University of Melbourne, Melbourne; Aisbett DL et al. (2007) [Understanding barriers to mental health service utilization for adolescents in rural Australia](#). *Rural and Remote Health* 7:624

starting from 'zero' but work with communities to build on their existing strengths, experiences and networks.

The need for intersectional gender-responsive approaches to mental health

Gender is a key social determinant of mental health.¹⁴ The prevalence, risk factors¹⁵ and experience of poor mental health among women and gender diverse people means they have different mental health needs, yet there are very few gender-responsive mental health programs and services in Australia or internationally. Gender-based violence and harassment have also been identified as “longstanding” issues in Victorian mental health services.¹⁶ Despite this, gender is not routinely considered as part of mainstream mental health policy or practice, and there is limited evidence about effective gender-responsive interventions.¹⁷ A gender-responsive approach to health identifies gender differences and inequalities in women, men, transgender, gender diverse and intersex people, and sets about addressing them.¹⁸

Sex and gender-based inequalities also intersect with other forms of inequality to influence the mental health of different groups of young women. Women with disabilities are subjected to dual discrimination and stereotyping on the basis of gender and disability, adversely affecting self-esteem and expectations.¹⁹ For Aboriginal and Torres Strait Islander women, the compounding effects of a history of colonisation and dispossession, intergenerational trauma, removal from family and community, racism and discrimination have a detrimental effect on mental health.²⁰ Migrant and refugee women experience structural, institutional and interpersonal forms of disadvantage that significantly impact their ability to experience good mental health, including racism, settlement stress and trauma, gender inequality and gender-based violence.²¹ Women and gender diverse people living in rural areas face barriers including stigma, isolation, confidentiality, lower choice of and access to services.²²

An intersectional approach recognises the multiple and overlapping identities that any individual holds, and that social and political systems contribute to experiences of marginalisation and discrimination. It is an analytical tool to help understand the impacts that policies and practices have on those within the community.²³

¹⁴ WHO and Calouste Gulbenkian Foundation (2014) [Social determinants of mental health](#) World Health Organization, Geneva.

¹⁵ Including: exposure to male violence, exposure to sexual harassment and gender-based discrimination, unequal caring responsibilities, sexualisation and objectification, sexist attitudes and norms (e.g., dismissing women's experience of physical pain) and unequal access to economic resources.

¹⁶ Mental Health Complaints Commissioner (2018) [The right to be safe: ensuring sexual safety in acute mental health inpatient units](#). MHCC, Melbourne.

¹⁷ Duggan M (2016) [Investing in women's mental health: strengthening the foundations for women, families and the Australian economy](#) Australian Health Policy Collaboration, Melbourne – (*AHPC Issues Paper*, 2016-02).

¹⁸ UNESCO (2017) [Gender-sensitive resources In Women make the news \[Webpage\]](#) United Nations Educational, Scientific and Cultural Organization, Paris.

¹⁹ Women with Disabilities Australia (2015) [Submission to the UN Committee on the Rights of the Child \(CRC\): development of the General Comment on the Rights of Adolescents](#). WWDA, Lenah Valley, Tas., p. 9.

²⁰ Suicide Prevention Australia (2016) [Suicide and suicidal behaviour in women: issues and prevention: a discussion paper](#). Suicide Prevention Australia, Sydney, p. 24.

²¹ MCWH (2020) [Policy brief: Immigrant and refugee women's mental health](#). Multicultural Centre for Women's Health, Collingwood, Vic.

²² Perkins D, et al (2019) [The Orange Declaration on rural and remote health](#) *Australian Journal of Rural Health* 27:5

²³ Hill Collins P, Bilge S (2020) *Intersectionality*. 2nd ed. Polity, Cambridge UK. - (*Key Concepts*)

Language

The Women's Mental Health Alliance holds some concerns about the term 'diverse communities', noting that this term is used by the Royal Commission.

When 'diverse' is used as a blanket term to describe all groups outside of the 'mainstream', it is 'othering', prompting the question 'diverse from what?'. The implied answer is that the mental health system is, at its core, a system designed for cisgendered, heterosexual, white, able-bodied people living in cities, and that care for diverse communities is an adjunct, rather than an approach that should underpin the whole system. This is particularly concerning when it is likely that the majority of the Victorian population fit into at least one of the diverse communities identified in the Royal Commission chapter.

Language should not homogenise groups of people. It is important that the language that is used recognises structures and power differentials that have contributed to marginalisation. Mental health is shaped by many factors, including gender inequality, ableism, homophobia, transphobia, racism and discrimination. It is also important to understand how systems and structures can reinforce or create health inequities, including poor mental health outcomes for different groups of people. This can better be achieved through the lens and language of intersectionality.

The Women's Health Alliance supports outcomes for 'diverse communities' focused on social justice, equity, access, inclusion and trauma and violence-informed and cultural safety. To do that, it is important to adequately name the groups who currently have less access to these outcomes in the health system – people experiencing marginalisation and those hardly reached by services and systems. The Alliance notes that the language that is used may differ depending on the context and audience. In this paper, we will continue to use 'diverse communities' to align with the Department's current language but encourage the Department to reconsider the language it uses.

Recommendation 1: Reconsider the language used to better reflect the challenges people and communities face in interacting with the mental health system.

Principles for working with diverse communities

There is significant concern among organisations working with and/or representing diverse communities that the Royal Commission did not adequately address these communities' needs and experiences. This concern has been reinforced by the approach to responding to the needs and experiences of diverse communities taken in early work on reforms such as the new Mental Health and Wellbeing Act and the workforce capabilities framework. This approach:

- is not underpinned by a power analysis,²⁴
- does not reflect the intersecting and compounding nature of disadvantage experienced by marginalised groups, and
- does not recognise the impact of structural discrimination and inequality on the mental health of consumers and carers and their engagement with the mental health system.

²⁴ Identifying and understanding where power lies, and how power shapes health policy, systems and health disparities as well as driving structural inequality and disadvantage.

In contrast, any approach to working with diverse communities must be underpinned by the following guiding principles:

- Human rights based
- Trauma and violence-informed
- Lived experience centred
- Strengths based
- Intersectional

Human rights based

Mental health is a human right. All people should be able to equitably access services that uphold their human rights and dignity, regardless of their background or identity. Victorian mental health services have an obligation to uphold The Convention on the Rights of Persons with Disabilities, the Victorian Charter of Human Rights and Responsibilities (the Charter), and the Gender Equality Act 2020. Gender safety is also identified as a new principle of the Mental Health and Wellbeing Act.

The Charter protects 20 human rights and freedoms in Victoria, including:

- the right to equality before the law,
- the right to protection from inhuman or degrading treatment (and the right to human treatment when deprived of liberty),
- the right to privacy, and
- cultural rights, including Aboriginal cultural rights.

All services and interventions should be examined through the lens of whether they uphold these rights among people accessing mental health and wellbeing supports.

Public mental health services also have obligations under the Gender Equality Act 2020 to carry out workforce gender audits, undertake gender impact assessments of their programs and services, and to develop and implement gender equality plans.

The Royal Commission demonstrated that there are systemic human rights breaches in the mental health system. The Department of Health and mental health services require expert advice and capability building in gender-responsive and human rights-based approaches to mental health.

Trauma and violence-informed

A trauma and violence-informed approach recognises the impact of individual and systemic trauma on people's lives. The situations in which trauma arises, the ways in which it is conceptualised, and how people respond to it are influenced by both cultural and individual factors.²⁵ A trauma and violence-informed approach centres respect and understanding, while maximising empowerment and choice for consumers, recognising the pervasiveness and effects of trauma and violence.²⁶ A trauma and violence-informed care approach can facilitate improved treatment of those who have experienced trauma, and is increasingly viewed as potentially beneficial for all.

²⁵ Family Safety Victoria (2021). [MARAM Practice Guide: Presentations of family violence in different relationships and communities](#). Family Safety Victoria, Melbourne.

²⁶ Browne AJ, Varcoe CM, Wong ST, et al. (2012) [Closing the health equity gap: evidence-based strategies for primary health care organizations](#). *International Journal for Equity in Health*. 11(Article 59): 1-15.

Lived experience centred

As was well established in the Royal Commission, it is essential that people with lived experience are centred in the design, delivery, leadership, and evaluation of mental health services. The Department of Health and mental health services should aim for the highest level of participation and leadership available for each project, applying co-production principles where possible.²⁷ It is particularly important that this includes representation and leadership by people from diverse communities. This may require the Department and services to think beyond 'business as usual' recruitment methods to address the cultural and accessibility barriers which may prevent people from diverse communities from both applying and being selected to be part of lived experience participation and leadership opportunities. This can include:

- broadening recruitment pathways, for example recruiting through trusted community-led organisations or through non-mental health services;
- developing accessible engagement and recruitment approaches, including in multiple languages;
- building accessibility into engagement and leadership opportunities, for example, being mindful of location, remuneration and language; and
- training project managers in undertaking lived experience-led work, particularly with people from diverse communities.

Strengths based

Communities derive strength from their connectedness, and people can draw strength and self-esteem from their identity within a diverse community. Mental health and wellbeing approaches should be designed to draw on these strengths from individuals within communities, but also identify strengths across communities. This can include:

- working with community-led organisations with strong community connections
- ensuring services are recovery-focused, identifying the existing strengths and connections in peoples' lives
- ensuring a non-pathologising clinical approach that accepts and validates the differences of people's experiences.

Intersectional

Using an intersectional approach to policy, planning and practice can prevent mental health and wellbeing issues across the whole population, and identify appropriate responses if they emerge. This includes using a socio-ecological approach that identifies where power lies, and how that drives structural inequality and disadvantage. Identity emerges from interactions between environment, social dynamics, and cultural and political contexts. To understand people's experiences, we must also understand structures and systems, inclusive of institutional level factors. Attempts to improve mental health and wellbeing within diverse communities must recognise the power and social determinants influencing health outcomes.

Intersectional approaches include:

²⁷ Roper C, Grey F, Cadogan E (2018) [Co-production: putting principles into practice in mental health contexts](#). University of Melbourne, Melbourne.

- addressing the structural, as well as individual, drivers of poor mental health, including gendered violence and gender inequality (including as these are experienced by people from diverse communities and with overlapping identities);
- implementing mutually reinforcing interventions addressing these drivers across multiple settings where people live, work and play; and
- ensuring services are culturally responsive and responsive to different types of trauma.

Recommendation 2: Implement mental health reform underpinned by the principles of being: human-rights based, trauma and violence-informed, lived experience-centred, strengths-based and intersectional.

Engaging with diverse communities

A first step in ensuring that services and programs meet the needs of Victorians from diverse communities is ensuring that people from 'target' communities have been engaged in the design and delivery of services.

Feedback from Women's Mental Health Alliance members suggests that implementation of the Royal Commission recommendations has been rushed and uncoordinated, resulting in missed opportunities to adequately engage with people from diverse communities. Historically, these communities have been 'hardly reached', and so it may require additional time, relationships and capability building on the part of the Department of Health to engage with them.²⁸ Avoiding tokenistic consultation requires the Department to recruit to projects on the bases of 'who is closest to the problem?' and 'who is most disadvantaged when their voices are excluded from this process?'.²⁹

A consequence of not having a variety of comprehensive engagement pathways into diverse communities is that those with well-established relationships are often those most called upon. This can place considerable stress on smaller community-led organisations, particularly when consultation across implementation activities is not well-coordinated. The Department should consider how best to resource communities to engage in reform, including 'hardly reached' communities, and a diverse range of community-led organisations.

Women's Mental Health Alliance members also report that many of the requests for participation in consultation are 'one way', and not based on ongoing mutual relationships between the Division and communities. This can lead to a feeling of extractive and tokenistic engagement, with minimal reflection of their input into decisions and outcomes of consultations.

Best practice for engaging with diverse communities includes:

- allocating appropriate time and resources into consultation processes, and not rushing to meet deadlines
- engaging diverse communities early, and ensuring representation is not an afterthought

²⁸ Sokol R, Fisher E, Hill J (2015) Identifying those whom health promotion hardly reaches: a systematic review. *Evaluation and the Health Professions* 38(4): 518-537.

²⁹ Chen J (2017) [Intersectionality matters: A guide to engaging immigrant and refugee communities in Australia](#). Multicultural Centre for Women's Health, Melbourne.

- being cognisant of power dynamics between and within communities, including ensuring a gender lens is applied to all work undertaken on service design, policy, delivery, and evaluation
- ensuring all projects have partners from diverse communities, focused on the individual needs of a project and the communities it aims to work with
- developing partnerships and ongoing relationships with communities, including a diversity of organisations within communities
- providing information and support that is accessible and culturally relevant
- providing pro-active opportunities for people from diverse communities to provide feedback about what is or isn't working about a process, and building flexibility into projects to allow time to respond and adapt.

The Women's Mental Health Alliance supports efforts by community-led organisations, for example the Multicultural Centre for Women's Health, to provide policy input and co-design advice to inform the reform process to ensure that migrant women's needs are equitably included in the reformed mental health system.

Recommendation 3: Support community-led organisations to develop best practice guidance for engaging with diverse communities, in particular women in these communities, and incorporate this guidance into their projects.

Recommendation 4: Build mechanisms to hold projects to account for their engagement with diverse communities, including meaningful partnerships, reporting to communities and feedback mechanisms.

Leadership by diverse communities

To move beyond tokenism, engagement with diverse communities must also include leadership by people with lived experience from diverse communities.

Firstly, this requires the Mental Health and Wellbeing Division and services to develop organisational structures and cultures that are accessible and culturally safe for people from diverse communities. The Division and mental health services must both actively recruit staff from diverse communities, but also work to create a workplace culture that is safe for people once recruited. This includes:

- taking an active- anti-discrimination stance, with zero tolerance for racism, homophobia, transphobia, sexism, ageism, ableism, and other forms of discrimination
- investing in training and accreditation that supports a positive culture, such as Rainbow Tick Accreditation
- ensuring greater diversity is reflected in leadership teams and within decision-making processes at the highest level
- address power imbalance by having two or more people with lived experience on any committees, project teams etc
- providing lived experience and cultural supervision pathways for leaders (separate to line management)

Where leadership opportunities emerge, the Mental Health and Wellbeing Division should be transparent about the steps it has taken to ensure diversity in these leadership positions. This would require public information about who has been appointed and how diversity has been reflected, for example, in recruitment to the Interim Regional Bodies.

In addition to the work the Division and services must do internally to diversify recruitment and support retention, it may be necessary to support the development of leaders from within diverse communities, noting that lack of access to such positions undermines people's ability to develop experience and demonstrate capability. Examples of this include VMIAC's recent Consumers Leading in Governance program and YACVIC's work to support young people to apply to the Interim Regional Bodies. There are also opportunities to support people to 'grow in role', through coaching and mentorship.

Recommendation 5: Invest in, and support initiatives that aim to build capacity of people from diverse communities to take up leadership opportunities within mental health reform activities.

Creating a community and service system that supports diverse communities

While the Mental Health and Wellbeing Division has direct control over the development of a service system that supports diverse communities, it is important to recognise that the mental health and wellbeing of diverse communities is enabled by actions in communities and across other service systems.

Systemic issues, such as racism, ableism, homophobia, transphobia, gender inequality and ageism, are significant drivers of poor mental health and wellbeing among diverse communities.³⁰ Central to efforts to improve the mental health and wellbeing of diverse communities is actively eliminating marginalisation, stigma, and discrimination.

Recommendation 6: Invest in and support cross-government efforts to eliminate marginalisation, stigma and discrimination.

It is also important to recognise that mental health and wellbeing issues are not simply treated in the mental health system. Women's Mental Health Alliance members noted this may be particularly the case from people from diverse communities who may be reluctant to access mainstream mental health services. Community groups, schools, physical health services and other services are effective places for supporting the positive mental health and wellbeing of people from diverse communities, as well as to provide mental health literacy and support to navigate the mental health system.

In particular, there are opportunities to strengthen the links between the family violence and sexual assault service systems and the mental health system. Violence against women is one of the most common causes of poor mental health.³¹ Women who have experienced domestic, family and sexual violence (DFSV) are more likely to suffer from a range of mental health conditions, including anxiety, depression, post-traumatic stress disorder (PTSD), self-harm and suicide.³² However, there is a gap in our existing mental health system for services that address the intensive needs of women impacted by complex trauma as a result of

³⁰ Sullivan C, Vaughan C and Wright J (2020) [Migrant and refugee women's mental health in Australia: a literature review](#). School of Population and Global Health, University of Melbourne, Melbourne;
Suicide Prevention Australia (2016) [Suicide and suicidal behaviour in women: issues and prevention: a discussion paper](#). Suicide Prevention Australia. Sydney, p. 24;
Hill AO, et al. (2020) [Writing Themselves in 4: The health and wellbeing of LGBTQIA+ young people in Australia :Victoria summary report](#). ARCSHS, La Trobe University, Melbourne.

³¹ ANROWS (2020). [Violence against women and mental health](#). Australia's National Research Organisation for Women's Safety, Sydney. - (*ANROWS Insights*, 04/2020).

³² Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, et al. (2011) Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *JAMA*. 306(5): 513-21. [doi: 10.1001/jama.2011.1098](#).

violence. While there is limited demographic data to analyse the intersectional impacts of family violence, evidence suggests that people from diverse communities are likely to experiencing compounding impacts from family violence, including from stigma, community power imbalances, isolation and discrimination when accessing services.³³

Trauma and violence-informed mental health care for victim-survivors of DFSV must incorporate an understanding of the dynamics of these forms of violence and analysis of gendered power relations, drawing links between women's individual experiences and systemic issues of gender inequality and violence, as well as other forms of systemic oppression such as racism, homophobia and poverty.³⁴ In other words, a gendered intersectional lens is required. Integrated and holistic care and support is also essential, recognising the complex needs of victim-survivors of DFSV (which may also include physical health issues, experiences of child abuse, war- and migration-related trauma, and alcohol and drug issues) and the other stressors prevalent among victim-survivors (including child protection and custody issues, financial insecurity, insecure housing, legal issues, social isolation). Whether and how these issues are addressed will influence how individual survivors are affected by the abuse, their ability to participate in treatment, and their response to treatment.

Unfortunately, despite the well-established links between gendered violence and mental ill-health – and evidence that the impacts of trauma are gendered – neither the Royal Commission into Family Violence nor the Royal Commission into Victoria's Mental Health System adequately addressed the need for specialist trauma recovery support for victim-survivors of DFSV in the mental health system. Perhaps this is because the mental health impacts of gendered violence and trauma sit at the intersection between the family violence, sexual assault and mental health sectors.

The Alliance welcomes the recommendations from the Royal Commission to strengthen trauma-informed practice in mental health through the establishment of a state-wide trauma service and the roll-out of specialist trauma practitioners (recommendations 23 and 24). However, these recommendations are not informed by a gender analysis, or an understanding of the intersecting nature of diverse identities. An understanding of trauma and violence-informed practice recognizes that most people affected by systemic inequities and structural violence have experienced, and often continue to experience, varying forms of violence with traumatic impact. Such care consists of respectful, empowerment practices informed by understanding the pervasiveness and effects of trauma and violence, rather than 'trauma treatment' such as psychotherapy'.³⁵ The Alliance recommends that all mental health services are trauma- and violence-informed and nuanced to respond to differences in the types and nature of trauma experienced, which will inform service setting, service types and approaches.

Recommendation 7: Support local and area mental health services to have whole-of-organisation knowledge of and the capacity to deliver trauma- and violence-informed care. This knowledge includes different types of trauma (e.g., domestic, family and sexual violence, settlement, natural disasters, torture, war, incarceration, neglect), systemic inequities, and structural drivers of violence and trauma.

³³ Victorian Government (2021) [Intersectionality and family violence](#). Victorian Government, Melbourne

³⁴ Tseris, E (2019) *Trauma, women's mental health, and social justice: pitfalls and possibilities*. Routledge, London

³⁵ Browne AJ, Varcoe CM, Wong ST, et al. (2012) [Closing the health equity gap: evidence-based strategies for primary health care organizations](#). *International Journal for Equity in Health*. 11(Article 59): 1-15.

Cross-cultural perspectives on mental health and wellbeing

As discussed, people from diverse communities face multiple barriers accessing mental health services. While some of these exist at the service level (including inaccessible and culturally unsafe services), it is also important to note that mental health and wellbeing (including experiences of ill-health) are understood differently across diverse communities. The current mental health system is embedded in a Western, biomedical model, which can create a barrier to awareness and willingness to engage with services by people who hold non-Western cultural attitudes to mental health and wellbeing.³⁶ This has developed because of the lack of engagement with diverse communities at the service development stage. Greater recognition is needed of the role and opportunity of non-Western and/or holistic models of care, and of the impact that the social, cultural and political conditions of society and its structures have on community and individual wellbeing. Communities need better opportunities for self-determination to design, develop and deliver their own support and care options.

The concept of accessing mental health services assumes knowledge, awareness, connections into other services, navigation of complex systems, and literacy around psychologies and psychosocial therapies. People from some diverse communities may experience a lack of trust in mainstream services to adequately address their mental health and wellbeing needs in a culturally safe way, particularly for communities who have experienced trauma, discrimination, and racism from systems (including the mental health system) due to government policies and lack of culturally safe models of care, i.e. First Nations communities and refugees.

Transcultural Mental Health Victoria and the Ethnic Communities Council of Victoria have also emphasised the importance of 'cultural connectors' in liaising between mental health practitioners and consumers from migrant and refugee backgrounds – staff dedicated to liaising and advocating between practitioners and consumers, providing information and explaining it in a culturally relevant way.³⁷

Cross-cultural perspectives can be better embedded in the mental health service system by:

- supporting service delivery models that support diverse understandings of mental health and wellbeing support, including family counselling and non-clinical therapies
- employing bi-cultural workers and cultural connectors (community advocates who liaise between practitioners and mental health consumers from migrant and refugee backgrounds) within services
- exploring intersectional models for safe and accessible care
- funding language services with specialist knowledge in mental health and wellbeing
- directly funding community-based services to provide mental health and wellbeing supports
- funding specialist services for diverse communities
- funding partnerships, outreach and co-located working between clinical services and community-based services
- funding services to invest the time and resources to develop and implement access and inclusion plans, including Disability Action Plans, Rainbow Ticks and Reconciliation Action Plans

³⁶ Victorian Transcultural Mental Health (2022) [Principles guiding our work](#). Victorian Transcultural Mental Health, Melbourne.

³⁷ Plowman M, Izzo S (2021) [Recommendations for a culturally responsive mental health system](#). Ethnic Communities Council of Victoria and Victorian Transcultural Mental Health, Melbourne. p 18.

- investing in and support community-led prevention initiatives that work to increase understanding about mental health and wellbeing, navigate the mental health system, and address drivers of poor mental wellbeing such as social isolation.

Recommendations 8: Invest in service and community level initiatives which promote cross-cultural perspectives on mental health and wellbeing.

Enabling a diverse workforce

While the Royal Commission identified the importance of a diverse workforce for supporting the cultural safety of consumers and carers from diverse communities (and the workforce itself), the report provides little detail on what is required to enable a diverse workforce. Victoria's Mental Health and Wellbeing Workforce Strategy (2021-24) focuses on building a stronger pipeline of people from diverse communities into the mental health workforce. However, it is important to recognise that retention of these workers in the mental health system relies on creating culturally safe and inclusive workplaces.

Actions to support a safe and inclusive workplace include³⁸:

- funding multiple positions for identified roles (e.g., multicultural workers, LGBTQIA+ workers, Aboriginal and Torres Strait Islander workers) to ensure that one staff member is not holding the whole cultural load for a service, and provide sufficient support and mentoring;
- assessing and addressing organisational readiness to recruit workers from diverse communities;
- providing reasonable adjustments to work premises, schedules and equipment;
- acknowledging and celebrating diversity, including through values, practices, holidays and celebrations;
- creating and publicising inclusive policies;
- establishing mentoring and support networks; and
- providing culturally appropriate supervision.

Recommendations 9: Invest in initiatives to support the development of culturally safe workplaces and the retention of a diverse workforce.

Funding

It is important to recognise that work with diverse communities requires time and resourcing. Current funding models typically do not resource adequately, or at all, the costs associated with creating culturally safe environments in mental health services. Services should be adequately funded to undertake the activities required to deliver culturally safe and anti-discriminatory practice. The Royal Commission recognised costs associated with language and communication services, but many other costs are associated with undertaking ongoing engagement and service delivery with diverse communities.

For example, the development of partnerships with community services often comes without funding but is fundamental to building relationships and service pathways for diverse communities. The costs of such partnership development are disproportionately held by smaller services, typically community-led organisations.

³⁸ Institute for Social Research (2020) [National Mental Health Workforce Strategy: a literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries](#). University of Queensland, Brisbane.

Recommendation 10: Actively fund the costs of delivering accessible and inclusive services to diverse communities.

Recommendation 11: Fund the development of partnerships between mainstream services and community-led organisations.

The Alliance supports the Royal Commission's explicit recommendation for recurrent funding to Switchboard Victoria while recognising that there are numerous other programs and community-led organisations, delivering high quality programs, which face similar challenges relating to short-term funding. Short-term funding cycles (and programs funded for 'pilots' that are not extended) undermine the ability of services to develop relationships with communities, and further undermine trust between the service system and diverse communities. Funding models need to factor in the cost of implementing these requirements so services are supported to deliver on them.

Recommendation 12: Increase funding certainty for community-led organisations.

Currently, there are limited accountability mechanisms for ensuring services are working with and delivering appropriate services for diverse communities. Many programs are opt-in, such as Rainbow Tick Accreditation. Commissioning and funding arrangements provide a mechanism to require services to demonstrate their approaches to working with diverse communities and doing what they can to make services accessible, inclusive and culturally safe. Reporting should require services to actively demonstrate how they are addressing the needs of diverse communities, and to report on complaints/breaches of their responsibilities to diverse communities.

Recommendation 13: Build accountability mechanisms into funding and reporting arrangements.

Measuring outcomes

As noted by the Royal Commission, there is a lack of administrative and population-level data that allows the Victorian Government and services to understand the prevalence of mental health and wellbeing need among the community, and the appropriateness of service responses.

The Women's Mental Health Alliance supports a review into existing data sources and encourages the Department to incorporate a gendered and intersectional analysis of mental health data relating to diverse communities.

Recommendation 14: Support a review into mental health and wellbeing data with the objective of improving the transparency of mental health access and outcomes for diverse communities.

The Women's Mental Health Alliance also supports the Royal Commission's emphasis on evaluation of reform initiatives, with a focus on consumer perspectives. Evaluation should be included from the beginning of implementation. Success measures should be developed that incorporate a gendered and intersectional lens to ensure accountability of reforms to the needs of diverse communities.

Recommendation 15: Provide evaluation guidance to all reform projects on incorporating the lived experience, including that of diverse communities, into evaluations.

Appendix

Recommendation 34 calls for the Victorian Government to:

1. ensure the active engagement of Victoria's diverse communities throughout the process of planning, implementing and managing the reformed mental health and wellbeing system.
2. legislatively provide that the Secretary of the Department of Health is responsible for the delivery of a mental health and wellbeing system that responds to the needs of Victoria's diverse communities and promotes access and equity of outcomes, with this function able to be delegated to the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45 (1)).
3. ensure that the Mental Health and Wellbeing Division:
 - a) collects, analyses and reports on data on the mental health and wellbeing of Victoria's diverse communities for planning and funding purposes and to improve transparency in mental health and wellbeing outcomes for diverse communities;
 - b) ensures that Victorians, regardless of first or preferred language, hearing, literacy or neurocognitive ability, have access to appropriate mental health and wellbeing information and means of communication throughout the mental health and wellbeing system;
 - c) enables Victoria's diverse communities and community-led organisations to:
 - design and deliver mental health and wellbeing information and awareness campaigns; and
 - assist their communities to navigate the mental health and wellbeing system.
4. by the end of 2021, provide recurrent funding to Switchboard Victoria to deliver its Rainbow Door program, at scale, to support people who identify as lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning to navigate and access the mental health and wellbeing system.
5. enable the development of digital technologies to support the delivery of language services that assist access to and engagement with mental health and wellbeing services.