

Victorian Mental Health & Wellbeing Workforce Strategy Forum: Summary Report

**Response from the Women's
Mental Health Alliance**

October 2021

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1. Introduction

The [Women's Mental Health Alliance](#) (the Alliance) welcomes the opportunity to respond to the Summary Report from the Victorian Mental Health and Wellbeing Workforce Strategy Forum. The Alliance also welcomed the opportunity to participate in a workshop as part of the Workforce Capability stream in September.

This Response has been drafted by Women's Health Victoria (chair of the Alliance) with input from members of the Alliance, including a working group dedicated to workforce issues. We are happy to elaborate further on our Response or provide additional information upon request.

1.1 About the Women's Mental Health Alliance

The Alliance was established by Women's Health Victoria in 2019. It is made up of nearly 40 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-informed mental health support.

The Alliance works to ensure the voices of women with lived experience are centred in policy, advocacy and service delivery. It brings together consumer and carer advocates, service providers, clinicians, women's health organisations, human rights bodies and researchers.

1.2 Our approach to this Response

This Response to the Summary Report is structured according to the four themes proposed for the Victorian Mental Health and Wellbeing Workforce Strategy, namely: Workforce Supply; Workforce Wellbeing; Workforce Capability; and Rural and Regional Workforce Development.

We begin the Response by outlining the need for a gender-responsive approach in mental health as this is significantly under-recognised by mental health policy-makers and practitioners and underpins the rest of our Response. This is followed by a summary of our recommendations and an introductory section highlighting the importance of appropriately defining the 'mental health and wellbeing workforce' before we address the four workforce themes.

1.3 The need for a gender-responsive approach in mental health

It is widely recognised that gender is a key social determinant of mental health,¹ and women are approximately twice as likely as men to suffer from a mental illness. For example, Australian data show:²

- Females report consistently higher levels of psychological distress than males
- Females are almost twice as likely as males to experience anxiety and mood disorders (e.g. depression, bipolar disorder)

¹ World Health Organization and Calouste Gulbenkian Foundation (2014) [Social determinants of mental health](#) World Health Organization, Geneva.

² Women's Mental Health Alliance (2021) [Snapshot of Australian women's mental health](#), Women's Health Victoria, Melbourne.

- At least one in five pregnant women/new mothers experiences perinatal anxiety and/or depression
- Females are twice as likely as males to be diagnosed with Post-Traumatic Stress Disorder
- Females are hospitalised for intentional self-harm at almost twice the rate of males
- Females are more likely to attempt suicide than males
- 95% of hospitalisations for an eating disorder are for females

Females also make up the majority of people seeking mental health support/services.³

We also know that different groups of women and girls experience poorer mental health outcomes than the general population. For example, young women report high levels of psychological distress⁴ and have been presenting with self-harm and suicidal behaviours at increasing rates over the last decade.⁵ COVID-19 has only exacerbated this, with reports of significant spikes in presentations for both self-harm and suicidal behaviours and eating disorders among young women.⁶ Aboriginal and Torres Strait Islander women and girls and LGBTIQ+ people experience significantly higher rates of suicide and self-harm than the general population of women and girls, while migrant and refugee women experience higher rates of perinatal anxiety and depression.⁷

Women and girls experience different mental health outcomes from men and boys for both social and biological reasons, as well as due to gendered assumptions and biases that are built into the mental health system. Biological factors related to sex mean that women experience specific mental health conditions linked to their reproductive capacity such as perinatal anxiety and depression. The brain structure and response to stress also differ between females and males. However, gender-based expectations and stereotypes and gendered structural inequalities also play a key role in influencing outcomes because they give rise to different stressors for women and men – particularly experiences of gendered violence/trauma and socio-economic disadvantage - as well as influencing the response they receive from health professionals and support services.

Gender influences all aspects of women's mental health and their interactions with the mental health system – from the underlying risk factors for (or 'determinants' of) poor mental health among women to the types of diagnoses women receive (or don't receive), their ability to access safe and appropriate mental health services, the types of treatment and support they are likely to receive and from whom, and how they are treated when they access services. Again, gendered discrimination and inequality must be considered alongside other forms of oppression. For example, evidence suggests migrant and refugee women experience poorer mental health outcomes than Australian-

³ At a national level, females are both significantly more likely to access Medicare-subsidised mental health services, and more likely to be attended by an ambulance for suicide attempt and self-injury: Australian Institute of Health & Welfare, *Mental Health Services in Australia* [[Website](#)], Table MBS.2. Accessed 31 May 2021; Australian Institute of Health & Welfare, *Suicide & self-harm monitoring* [[Website](#)], Ambulance attendances, self-harm behaviours & mental health. Accessed 31 May 2021.

⁴ Australian Institute of Health and Welfare (2021) [Australia's youth: Mental illness](#).

⁵ Terhaag S, Rioseco P (2021) [Self-injury among adolescents](#), Australian Institute of Family Studies. Melbourne – (*Growing up in Australia Snapshot Series*; Issue 4).

⁶ Scott S, Dalzell S (2021) [Rise of self-harm and use of mental health services since COVID pandemic began, new data reveals](#). ABC, (Jul 20); Le Grand C (2020) [Surge in eating disorders reveals 'tragedy' of lockdown](#). *The Age*, (Dec 12).

⁷ Women's Mental Health Alliance (2021) [Snapshot of Australian women's mental health](#), Women's Health Victoria, Melbourne.

born women, with race and gender inequality, violence against women, settlement stress and trauma all playing a role.⁸

Despite this, gender and women's mental health are not routinely considered as part of mainstream mental health policy or practice,⁹ meaning most mental health services are designed based on a male-centric model that does not recognise the specific needs and experiences of women and girls.

By applying a gender lens to the Victorian Mental Health and Wellbeing Workforce Strategy, we can ensure that we have an appropriately skilled mental health workforce that is able to deliver trauma-informed, gender- and culturally responsive mental health support, as well as to address the gendered social, economic and cultural determinants of mental ill-health through primary prevention. This is essential for improving the mental health and wellbeing of Victorian women and girls.

1.4 Summary of recommendations

The Alliance makes the following recommendations to inform the Victorian Mental Health and Wellbeing Workforce Strategy:

1. Apply a gender lens to all aspects of the Victorian Mental Health and Wellbeing Workforce Strategy to ensure that we have an appropriately skilled mental health workforce that can deliver trauma-informed, gender- and culturally responsive mental health support, as well as address the gendered social, economic and cultural determinants of mental ill-health through primary prevention.
2. Adopt an appropriate definition of the mental health workforce(s) which extends beyond clinical workers and includes: wellbeing workers; general health workers (e.g. GPs, hospital staff); social services workers (including family and sexual violence response workers and workers working with specific population groups); and mental health promotion/primary prevention workers (including consideration of the role communities can play in primary prevention).

Workforce supply and wellbeing

3. Address under-resourcing of the mental health sector as a critical aspect of workforce attraction and retention.
4. Improve pay and conditions for the predominantly female mental health workforce, particularly in the public sector, including by replacing short term funding with ongoing funding to enable employers to offer ongoing employment.
5. Consider opportunities to develop cross-sector placements – for example, between mental health and family violence services or mental health and disability services – to promote cross-disciplinary training and professional development and support workers across different sectors to provide or facilitate more holistic and integrated care.

⁸ Delara M (2016) Social determinants of immigrant women's mental health, *Advances in Public Health*. 2016:9730162.

⁹ 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); Abel K, Newbigging K (2018) [Addressing unmet needs in women's mental health](#). British Medical Association. London.

6. Take steps to address power and hierarchy within the mental health workforce – both at a structural level (e.g. equal remuneration for work of equal value) and at an organisational/interpersonal level (e.g. within multidisciplinary teams/practice). In particular, take active steps to challenge and subvert traditional power hierarchies that deem lived experience and non-clinical workforces to have less value and legitimacy.
7. Invest in the skills and supports needed by workers with lived experience so that they can flourish in the workplace.
8. Tap into a wider range of potential mental health workforces and fast-track new recruits to expand the workforce quickly, including through: better support for student placements and graduate positions; upskilling workforces through short courses; drawing on workers in other sectors who already have some of the required skills and experience; developing more direct pathways into mental health nursing; and reviewing work restrictions for international workers and international students (in collaboration with the Commonwealth).
9. Recognising that this is a feminised workforce, 'upgrade' enabling flexible work to a short to medium term priority in the Strategy.

Workforce capability

10. Revisit the draft capabilities framework to address the significant concerns outlined by the Alliance in Section 5.1 and Appendix A of this Response.
11. Take a more comprehensive and detailed approach to defining the capabilities and training required for each part of the Victorian mental health workforce, similar to the approach taken in the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM).
12. Prioritise capability-building for the mental health workforce in key areas where there are significant gaps in knowledge and skills, including gender-responsive practice, responding to victim-survivors of family and sexual violence, and trauma-informed practice (see also [Appendix B](#)).
13. Ensure the capabilities framework or frameworks includes the following capabilities to enable workers to address the specific mental health needs and experiences of women, girls and gender diverse people:
 - a. Intersectional gender competence
 - b. Capability to respond to gendered violence, including family and sexual violence
 - c. Capability in gender-responsive trauma-and violence-informed practice
 - d. Capability in culturally-responsive practice
 - e. Capability to prevent and respond to gendered violence in mental health facilities and other settings
 - f. Capability in gender-informed mental health promotion/primary prevention.
14. Prioritise capability-building for general health workers ('Tier 2') in mental health and responding to family and sexual violence.
15. Support capability-building in prevention, early intervention, referral and recovery for social services workers ('Tier 3').

16. Ensure the implementation of the capabilities framework or frameworks is supported by: standardised pre-service and in-service training; practice guidance; organisational leadership; resourcing and responsiveness.
17. Support investment in pre-service and in-service training in gender-responsiveness, responding to sexual violence, and gender-responsive trauma-informed practice.
18. Review family violence training initiatives for mental health workforces to identify gaps and promising initiatives to ensure that all mental health workforces receive appropriate training in family violence.
19. Establish a sector capacity building position whose role would be to engage organisational leaders and key stakeholders in mental health to identify and respond to statewide family violence capacity building needs within the mental health workforce.
20. Invest in a specialist trauma centre focused on supporting the recovery of victim-survivors of gendered violence, including family and sexual violence. In addition to specialist treatment and support for victim-survivors and research into gender-informed approaches to trauma, this centre should develop and deliver training and provide secondary consultation for mental health workers.

Rural and regional workforce development

21. Develop a more comprehensive approach to incentives that considers housing, educational opportunities and partner employment.
22. Consider creative and innovative approaches to building the rural workforce, including drawing on local communities.
23. Address barriers to recruitment and retention including prescriptive funding models and restrictive scopes of practice.

Other workforce issues not addressed in the Summary Report

24. Incorporate measures to actively increase the diversity of the mental health workforce, including:
 - a. increasing the proportion of women in clinical roles;
 - b. increasing the number of women and people with lived experience in senior roles;
 - c. setting targets for higher representation of people from migrant and refugee backgrounds within the mental health workforce;
25. Undertake regular workforce data collection to measure progress and assist with workforce planning.
26. Address negative gendered attitudes (stigma and discrimination) towards women with lived experience of mental health and psychological distress within the mental health workforce and workforces in related sectors, such as the legal and justice systems.
27. Ensure workforce development is accompanied by whole-of-organisation approaches to system- and culture change, driven by senior leaders and adequately resourced to provide staff with the space and time required to learn and adapt to new ways of thinking and working.

28. Be accompanied by an outcomes framework and supported by regular monitoring and evaluation – both of the overarching Strategy itself and of any initiatives developed and implemented to deliver on the objectives of the Strategy.

2. Defining the mental health and wellbeing workforce(s)

A critical starting point for the development of the Victorian mental health and wellbeing workforce strategy is to define the workforce. This step appears to have been missed in the initial development of the strategy and, as a result, it appears the strategy is being developed based on a worryingly narrow definition of mental health workforce, which is largely focused on clinical services.

This is evident even in the title of the report, which is titled 'Mental Health Workforce Report' – entirely missing the 'wellbeing' element, which was so critical to the vision and recommendations of the Royal Commission. This narrow clinical focus is also reflected in early work on the Capabilities Framework – with which the Alliance has been involved – which is also missing a strong focus on wellbeing, prevention and early intervention (as a practice principle and capability domain for *all* mental health workers, a critical capability for social services workers and a core capability for wellbeing/psychosocial support workers). Feedback from the Alliance provided to KPMG on the draft Capabilities Framework is included in [Appendix A](#) to this Response.

2.1 Conceptualising the mental health and wellbeing workforce

The National Mental Health Workforce Strategy Taskforce recently sought submissions in response to its draft National Mental Health Workforce Strategy. The consultation draft¹⁰ defines three categories or 'tiers' of mental health workers (our language):

- Tier 1: "people who work **exclusively in the mental health sector** (for example Aboriginal and Torres Strait Islander mental health workers, mental health nurses and psychiatrists)"
- Tier 2: "those working in **other health settings** who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example allied health, general practitioners and nurses)"
- Tier 3: "people working in **other settings who are likely to have regular contact** with people experiencing suicidality, mental distress and/or ill-health as part of their role (for example aged care workers, educators, drug and alcohol workers, housing and justice services workers)".

Although the National Taskforce's definition of the mental health workforce also has significant gaps (discussed below), the Alliance considers this to be a useful starting point for describing the relevant workforce(s). The Alliance also refers the Department to the Victorian [Capability Framework](#) for responding to family violence, which takes a similar tiered approach to conceptualising the relevant workforce(s) and defines their roles, responsibilities and required capabilities accordingly.

¹⁰ The consultation closed on 30 September 2021 and the consultation draft is no longer publicly available. More information about the strategy and consultations is available here: <https://www.health.gov.au/committees-and-groups/national-mental-health-workforce-strategy-taskforce>

2.2. Gaps in the Victorian Workforce Strategy

While it is apparent that the Victorian Workforce Strategy will capture at least some 'Tier 1' workers, it is unclear whether it covers wellbeing/psychosocial support workers (nominally part of Tier 1 within the National Taskforce's definition but not a focus of the Victorian Workforce Strategy to date). These workers are critical to the delivery of innovative workforce and service delivery models, including integrated and collaborative approaches to care and support, as well as prevention, early intervention and recovery. Without an adequate supply of these workers, workforce reform will fail and the vision of the Royal Commission will not be achieved.

The Summary Report also appears not to capture general health workers ('Tier 2') and social services workers ('Tier 3'). These workers are – and will be increasingly – an essential part of the mental health and wellbeing workforce if we are to shift to stronger focus on prevention, early intervention and recovery, as envisaged by the Royal Commission, and must be included as part of the Victorian Workforce Strategy.

In addition to wellbeing, Tier 2 and Tier 3 workforces, the Victorian Workforce Strategy must also include the **specialist mental health promotion/primary prevention workforce**, which works to address the risk and protective factors for mental health/ill-health at a population level, which would make up 'Tier 4'. (Workforces working with specific population groups would also cross over into Tier 4.)

This broader definition of the mental health workforce should then inform the four streams of work as there are distinct supply, wellbeing, capability and rural and regional issues facing each of these workforces.

If we are to realise the vision of the Royal Commission, the Alliance strongly recommends a broader conceptualisation of the mental health workforce that includes these workforces be adopted.

2.3 Social services workers ('Tier 3')

The Alliance highlights the importance of including family and sexual violence response workers within 'Tier 3'. Violence against women and girls is one of the most common causes of poor mental health. Women who have experienced violence are more likely to suffer from a range of mental health conditions, many of which have long-term impacts.¹¹ This means that family and sexual violence response workers are highly likely to be working with people experiencing mental ill-health, illness or suicidality as part of their role.

There is a significant need for cross-sector capability-building between the mental health and family and sexual violence response sectors. Family and sexual violence response workers require an understanding of the mental health impacts of family and sexual violence in order to be able to provide a supportive response, make appropriate referrals where specialist mental health support is required, and support recovery. The broader mental health workforce also requires substantial capability-building to understand and respond to victim-survivors of family and sexual violence. Further detail on the capabilities required of the mental health workforce to respond to family and sexual violence is set out in Section 5.2 and Appendix B of this Response.

¹¹ ANROWS (2020). [Violence against women and mental health](#). Australia's National Research Organisation for Women's Safety. Sydney – (ANROWS Insights, 04/2020).

Workforces working with specific population groups in non-mental health specific roles or organisations also need to be recognised as part of the broader mental health workforce ('Tier 3' and 'Tier 4' – see further below). This includes organisations working with young people, migrant and refugee communities, and LGBTIQ+ communities etc. For different reasons – such as stigma around mental ill-health in their community or a lack of culturally responsive or safe mental health services – these populations may prefer to access general services targeting their communities. This means that these organisations have both a wealth of knowledge to share about how to support the mental health and wellbeing of people in their communities, but also have direct contact with people experiencing mental ill-health, illness or suicidality. They can also play an essential role as 'cultural connectors' or 'community advocate', liaising between mental health services and consumers from migrant and refugee backgrounds, relaying and explaining information in culturally relevant ways.¹²

2.4 Mental health promotion/primary prevention workers ('Tier 4')

Despite being a core focus of the Royal Commission's vision for reform, primary prevention of mental ill-health (or promotion of mental health and wellbeing) appears to be almost entirely absent from the development of the Victorian Workforce Strategy to date.

VicHealth's *Evidence review: The primary prevention of mental health conditions* (2020) provides a valuable overview of primary prevention approaches in mental health and the need to address population-level risk factors for mental ill-health and protective factors for mental wellbeing, such as child maltreatment, intimate partner violence and bullying, as well as structural inequalities and discrimination, such as racism and socioeconomic disadvantage.¹³

As outlined in the Introduction to this Response, social factors play a very significant role in influencing the mental health outcomes and women and girls, suggesting that efforts to address social risk factors through primary prevention are essential if we are to promote good mental health and wellbeing and prevent mental ill-health among women and girls. The high and increasing rates of mental ill-health among young people – particularly girls and young women – also highlight the critical importance of primary prevention.

While basic capability in primary prevention/mental health promotion should be part of the skill-set of all mental health workers, particularly 'Tier 2' and 'Tier 3' workers, it also requires a specialist workforce that operates largely *outside* the mental health and broader social services systems – for example, in schools, workplaces and community settings. **The Alliance recommends that the definition of the mental health workforce in the Strategy be expanded to include health promotion workers (for example, as 'Tier 4' of the workforce).**

Dedicated attention then needs to be paid to building the supply and capability of mental health promotion workers. There is strong potential to draw on early learnings from the development of the prevention of family violence and violence against women workforce in Victoria following the Royal Commission into Family Violence. For example, the *Preventing Family Violence & Violence Against Women Capability Framework* articulates the distinct capabilities required of prevention 'practitioners' (who specialise in the primary prevention of violence against women) and prevention

¹² Plowman M and Izzo S (2021) [Recommendations for a culturally responsive mental health system](#). Ethnic Communities Council of Victoria and Victorian Transcultural Mental Health. Melbourne, p 18.

¹³ Carbone S (2020) [Evidence review: The primary prevention of mental health conditions](#). VicHealth. Melbourne.

‘contributors’ (who contribute to this work as part of a broader role)¹⁴ and a workforce development strategy for these workforces is currently being developed by the Office for Women in the Department of Families, Fairness and Housing.

The role of carers, families and communities (including community leaders and ‘social connections’) in contributing to primary prevention/mental health promotion should also be articulated and emphasised as part of this Tier 4 workforce. The Royal Commission placed a strong emphasis on place-based approaches to mental health promotion and the importance of social connection.¹⁵

There is an opportunity to think creatively about the role communities can play in primary prevention, including through the development of ‘community connector’-type workers. ‘Cultural connectors’ are particularly important in liaising between mental health practitioners and consumers from migrant and refugee backgrounds.¹⁶

3. Workforce supply

“We need to make mental health services feel like safe and enjoyable places to work. Importantly, this means not looking at workforce issues independent of whole-of-system reform. An engaged and skilled workforce is both a system enabler, and an outcome of a system that is working well.”
- Jo Farmer, [Some thoughts about workforce reform](#), Blogpost, August 2021

3.1 Funding

The Alliance strongly agrees that it is critical to “ensure funding and commissioning approaches and service delivery models support workforce stability” (Workforce Supply, Potential Solution 1).

Workforce supply – both attraction and retention – cannot be addressed without attending to the under-resourcing of the mental health sector. Under-resourcing means that there are workforce shortages and workers are on low-paid, short-term, casualised contracts. This leads to burn-out, which leads to people taking time off, which creates a vicious cycle of additional pressure on remaining staff.

The Alliance also notes that much of the stigmatisation and poor human rights outcomes for consumers that arise through interactions with mental health workers stem from under-resourcing. For example, in order to avoid use of traumatising and coercive interventions (such as compulsory treatment and restrictive interventions) workers need time, resources and training to work through alternatives. At the same time, resourcing is needed to expand the range of services available so that people can access appropriate services *before* they become acutely unwell.

3.2 Pay and conditions

Critical to attracting and retaining an adequate supply of skilled mental health workers is improving the poor pay and conditions. This is also a gendered issue as the mental health workforce is highly feminised. For example, the ORIMA workforce survey found 77% of Victorian mental health workers identify as female.¹⁷ The ORIMA workforce survey also found that 43% of mental health workers had

¹⁴ Family Safety Victoria (2017) [Preventing Family Violence and Violence Against Women Capability Framework](#).

¹⁵ Royal Commission into Victoria’s Mental Health System (2021), [Final Report](#), Vol. 1, Chapter 4.3.5.

¹⁶ Plowman M and Izzo S (2021) [Recommendations for a culturally responsive mental health system](#). Ethnic Communities Council of Victoria and Victorian Transcultural Mental Health, p 18.

¹⁷ Royal Commission into Victoria’s Mental Health System (2021), [Final Report](#), Vol.4, p 463.

personal lived experience of mental health conditions.¹⁸ Workers' mental ill-health is exacerbated by poor pay and conditions.

Poor workplace conditions in the mental health workforce include:

- Low pay – for example, a significant percentage of the community mental health workforce is not covered by an EBA, only the Award, so has access to very basic protections and low wages.
- Insecure work – this is a workforce that is increasingly on fixed term contracts linked to government funding cycles
- High case loads
- Lack of professional development opportunities
- Insufficient access to supervision and support – adequate supervision to address issues of concern is key, but often not available due to high demand and workforce shortages; availability of work-related counselling is also essential,¹⁹ particularly given that a high proportion of mental health workers have lived experience of mental ill-health
- Lack of flexibility – given the majority of mental health workers are women, a significant proportion are likely to be juggling multiple roles in addition to their work – for example as mothers and carers – highlighting the need for gender equitable workplace conditions such as flexible work.

Poor conditions lead to high rates of burn-out and staff turnover, which in turn affects the quality of the service provided. They also exacerbate gender inequality by contributing to financial insecurity and disadvantage for women, for example by making it difficult for workers to secure a mortgage.

Poor pay and conditions in the public mental health sector also drive workers to the private sector. Not only are the pay and conditions better, but workers in the private sector also often have more opportunity to specialise and make better use of their skills and qualifications. This depletes the public sector workforce, which both places additional pressure on public mental health services and increases barriers to access by making certain workforces only available to those who can afford to pay.

To attract and retain an adequate supply of suitably skilled mental health workers – and therefore deliver high quality services for consumers – it is fundamental to improve workplace pay and conditions for this predominantly female workforce, particularly in the public sector. This includes replacing short term funding with ongoing funding to enable employers to offer ongoing employment. Improving pay and conditions will also assist in addressing the stigma and negative perceptions associated with working in mental health by making it a more attractive field to work in.

¹⁸ Royal Commission into Victoria's Mental Health System (2021), [Final Report](#), Vol.4, p 463.

¹⁹ Department of Health (UK) (2003). [Mainstreaming Gender and Women's Mental Health: Implementation Guidance](#), Department of Health, Mental Health, Health & Social Care Standards & Quality Group.

3.3 Integrated and multidisciplinary care

The Alliance agrees that it is important to “ensure new service delivery models and models of care facilitate genuinely collaborative, multidisciplinary practice, with team structures and roles enabling professionals to work to their full scope of practice” (Workforce Supply, Potential Solution 2).

Women consistently ask for a more holistic approach that addresses mental health within the broader context of their lives.²⁰ A biopsychosocial approach to mental ill-health means moving away from a biomedical model to a broader view of women’s mental distress that recognises and addresses social harms and inequities. This opens up practice opportunities that extend beyond treating ‘dysfunction’ and ‘symptoms’.²¹ A holistic approach must also include practice models that address physical and mental health together, as seen for example at the [Women’s Mental Health Clinic run by Monash Alfred Psychiatry research centre](#) (MAPrc), and that provide psychosocial/wellbeing support alongside clinical supports, as in the Prevention and Recovery Care (PARC) model.

The Alliance agrees with the importance of “embedding practice sharing across disciplines to ensure understanding and value of disciplines in delivering outcomes” (Workforce Supply, Potential Solution 2b). In particular, the Alliance highlights the importance of **integrated and collaborative approaches across sectors as well as disciplines**, including strong collaboration with the family violence and sexual assault response, housing and homelessness, and alcohol and other drug sectors. **The Alliance recommends that consideration be given to opportunities to develop cross-sector placements – for example, between mental health and family violence services or mental health and disability services – to promote cross-disciplinary training and professional development and support workers across different sectors to provide or facilitate more holistic and integrated care.**

To achieve “genuinely collaborative, multidisciplinary practice” which incorporates lived experience workforces, the **Strategy must take steps to address power and hierarchy within the mental health workforce – both at a structural level (e.g. equal remuneration for work of equal value) and at an organisational/interpersonal level (e.g. within multidisciplinary teams/practice where certain workforce groups are considered to have more legitimacy than others).**

Other barriers to integrated and multidisciplinary care will also need to be addressed including:

- Prescriptive funding models and contracts that inhibit innovation, integrated care and practice sharing
- Restrictive scopes of practice and industrial barriers
- Structures that do not enable sharing of innovative practice, for example, across regional boundaries
- Lack of a consistent understanding of what ‘integrated’ and ‘multidisciplinary’ care mean
- Lack of clear targets or outcome indicators for integrated and multidisciplinary care.

²⁰ 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).

²¹ Tseris E (2016) Thinking critically about 'mental health issues' affecting women during/after violence. *Social Alternatives*, 35(4): 37-42.

3.4 Leadership and career pathways

The Alliance agrees with the importance of “establishing visible career pathways and more diverse leadership roles, including for allied health and lived experience workforces” (Workforce Supply, Potential Solution 3).

Lived experience workforces

The Alliance strongly agrees with the need to “capitalise on and invest in the existing lived experience workforce and identify opportunities to expand this workforce across the sector” (Workforce Supply, Potential Solution 1a).

Lived experience roles tend to be short-term, part-time and offer limited opportunities for career progression. Once again, this is a gendered issue as the majority of the lived experience workforce is female. Other barriers include access to only basic training, lack of access to lived experience supervision and the fact that the impact of a peer worker’s lived experience is often not accommodated in the workplace. **It is essential that services invest in the skills and supports needed by workers with lived experience so that they can flourish in the workplace.** This includes supervision by a person with lived experience, separate from line management, to help combat some of the isolation that can lead to the burnout common among peer workers, and providing opportunities for professional development to enable peer workers to develop skills they may not previously have had the opportunity to acquire, for example in management or governance.

Lived experience workforces are also undervalued. Some services see peer work as a ‘cheap’ workforce; they are not treated as an essential and valued role. **The expertise of lived experience workforces needs to be recognised, and power imbalances between lived experience and other workforces addressed.** To support the full integration of lived experience workforces into services and clinical teams, the Victorian Mental Illness Awareness Council recommends setting targets or quotas.²²

Leadership

Leadership within the mental health workforce is a gendered issue. While the mental health workforce is female-dominated, the most powerful roles – that is, senior clinical roles – continue to be dominated by men.²³ **The Strategy must not only increase the representation of women and lived experience workers in senior roles, but also take active steps to challenge and subvert traditional power hierarchies that deem lived experience and non-clinical workforces to have less value and legitimacy.** To achieve this, the perspectives of workforces that have historically been less powerful or under-represented, including lived experience and non-clinical workforces, must be centred and historically powerful professions and positions/roles must step back.

Placements and learning opportunities

The Alliance agrees with the importance of “supporting placements and learning opportunities” (Workforce Supply, Potential Solutions 3a). We emphasise the need to **ensure the mental health sector is funded to provide student placements and graduate positions**, and this must include the resourcing required to support these positions.

²² Victorian Mental Illness Awareness Council (2021) [Summary response to the Royal Commission Report](#).

²³ Royal Commission into Victoria’s Mental Health System, [Interim Report](#), p 536.

The Alliance notes that the Centre for Mental Health Learning is currently working on projects to support organisational readiness for peer workers and placements. The Youth Affairs Council of Victoria is also supporting youth organisation to create workplace opportunities for student by liaising between youth organisations and universities/TAFEs to design and manage student placements and supervision, which could be drawn on as a model.

Training pathways

It takes time to recruit and train 'traditional' health workforces. Given immediate workforce shortages and high demand for mental health services, **it will be critical to tap into a wider range of potential mental health workforces and fast-track new recruits, to expand the workforce quickly.**

The Alliance highlights the following strategies as part of the solution:

- Associated social services workforces can be upskilled in mental health through **short courses and vocational training** – for example, Monash University is delivering a 6-month [Undergraduate Certificate in Mental Health](#), which has been popular with Victoria Police and other social services workforces.
- **Workers in other sectors** who already have some relevant skills/experience and a desire to join the mental health workforce should be supported to do so – an example is [Youth Live4Life ambassadors](#).
- While we welcome the additional funding recently announced to expand the supply of mental health nurses, a more direct pathway is needed for **nurses** to enter mental health – the long training pathway and low pay means fewer and fewer nurses are being attracted to mental health.
- There is also an opportunity for the Victorian Government work with the Commonwealth to **review work restrictions for international workers and international students** in order to expand the pool of mental health workers. For example, the Alliance understands that international nursing students are unable to undertake graduate placements in the public health system, limiting the pool from which mental health services are able to draw. Lack of recognition of overseas qualifications and regulatory/registration requirements for different mental health professions can also present barriers for international workers.

4. Workforce wellbeing

The Alliance agrees with the Opportunities for improvement and Potential solutions for Workforce wellbeing outlined in the Summary Report, and notes the critical importance of workforce wellbeing for the delivery of high quality mental health services that uphold consumer rights. We also note that workforce wellbeing is a gendered issue, since the majority of mental health workers are women.

We have highlighted the urgent need to address pay and conditions for the mental health workforce in Section 3.2 of this Response. This is critical to supporting workforce wellbeing, as well as attracting and retaining an adequate supply of skilled workers.

We have also highlighted **the importance of adequate support and supervision for all mental health workforces, and especially lived experience workforces**, in Sections 3.2 and 3.4 of this Response, including the link to resourcing and workforce supply issues (i.e. high service demand

limiting time for supervision and low supply of workers able to provide supervision). Availability of work-related counselling is also essential,²⁴ particularly given that a high proportion of mental health workers have lived experience of mental ill-health.

We are concerned that enabling 'flexible ways of working' is identified as a 'long term' solution in the Summary Report. While we recognise this is tied to funding issues, gender equitable workplace conditions such as flexible work are essential to worker wellbeing, especially since the majority of mental health workers are women, a significant proportion of whom are likely to be juggling multiple roles in addition to their work – for example as mothers and carers. **Enabling flexible work should be upgraded to a short to medium term priority in the Strategy.**

5. Workforce capability

5.1 Concerns with the draft Capabilities Framework

The Alliance has significant concerns about the approach to developing a capabilities framework for the Victorian Workforce Strategy, and about the current draft framework. In summary, we are concerned that:

- there has been inadequate consultation (certainly no co-design) in the development of the framework;
- it is too broad and general to be meaningfully implemented;
- it is still strongly focused on clinical workforces – we refer to the absence of an adequate definition of the mental health workforce highlighted in Section 2 of this Response;
- it remains embedded in a mental illness/biomedical and individualised model of mental health, rather than a wellbeing framework tied to the social model of health;
- it conflates workforce and system issues, making systemic flaws the responsibility of individual workers;
- it does not acknowledge or address power inequalities that contribute to poor mental health, influence interactions between consumers and workers within the mental health system, and present a barrier to implementing improved ways of working, such as integrated and multidisciplinary care;
- its conceptualisation of 'diversity' lacks a power analysis and an understanding of the influence of structural inequality, discrimination and oppression on mental health and consumer engagement with the mental health system;
- by grouping together all population groups that are not white, male, cis, heterosexual, able-bodied or otherwise 'mainstream' under the banner of 'diversity', it fails to recognise the unique needs of different cohorts, including the unique needs of women and girls;
- it demonstrates a fundamental lack of understanding of the core elements of trauma-informed practice.

²⁴ Department of Health (UK) (2003). [Mainstreaming Gender and Women's Mental Health: Implementation Guidance](#), Department of Health, Mental Health, Health & Social Care Standards & Quality Group.

In addition, the framework will need to align with the new Mental Health & Wellbeing Act. For example, the consultation draft for the new Act proposed the inclusion of a principle requiring mental health services to provide 'gender-responsive' services. The accountability mechanisms proposed for the Act would require mental health services to report on their compliance with the Act's principles. This means that mental health workers will require capability in gender-responsive practice, but this is not covered by the draft framework.

Similarly, the new Mental Health & Wellbeing Act will need to align with the requirements of the Family Violence Information Sharing Scheme and the Child Information Sharing Scheme (under which mental health services are already prescribed information-sharing entities) to ensure consumers have the power to exclude people (such as perpetrators of family violence) from receiving information from, and providing information to, a mental health service. [Recent media reports](#) indicate that mental health workers require capability-building to understand and comply with these requirements.

We have articulated our concerns with the draft Capabilities Framework in more detail in feedback provided to KPMG, a copy of which is appended to this Response at [Appendix A](#).

5.2 A more comprehensive approach to capability-building

While we note the proposal that "Appropriate review and revision mechanisms should be built in to ensure that it aligns with new and emerging models of care, and the diversity of the workforce" ((Workforce Capability Potential Solution 3), the Alliance remains concerned that the current draft Capabilities Framework is inadequate to guide the development of the mental health workforce in a way that will meet the needs of consumers in a reformed mental health system.

The Alliance recommends that a more comprehensive and detailed approach is taken to defining the capabilities and training required for each part of the Victorian mental health workforce, recognising the different roles that each workforce plays. A capability framework or frameworks for each part of the mental health workforce should identify:

1. the type of worker (see Section 2 on Defining the mental health and wellbeing workforce)
2. the severity or stage of mental ill-health they need to be able to respond to
3. the current level of capability within that workforce
4. priority workforces where there are critical knowledge and skill gaps

For example, some health and social services workers, such as GPs, allied health workers, housing and youth workers will need strong capabilities in prevention, early intervention and supporting recovery, while first responders (such as police and paramedics) will require strong capabilities in preventing escalation.

The Victorian Family Violence [Multi-Agency Risk Assessment and Management \(MARAM\) Framework](#) provides a useful example of a comprehensive and effective approach to defining the workforce and clearly identifying the different responsibilities and required capabilities for different roles within that workforce. While it is focused on risk identification and management, it covers a wide range of workforces and identifies what is expected of them. **The Alliance recommends that a capabilities framework or frameworks be developed for both clinical and non-clinical mental health workforces that clearly identifies the required capabilities for different parts of the mental health workforce similar to the approach taken in the MARAM.**

Another positive aspect of the MARAM Framework is that it recognises that capability-building is not simply a question of training, nor is it solely the responsibility of the individual worker. The MARAM Framework provides guidance on organisational alignment with MARAM, including leadership and policy alignment. We outline what is needed to implement a capabilities framework or frameworks for the mental health workforce effectively in Section 5.4 of this Response.

5.3 Capabilities required by the mental health workforce

In the first instance, **capability-building should focus on key areas where there are significant gaps in knowledge and skills. Three such areas are gender-responsive practice, responding to victim-survivors of family and sexual violence, and trauma-informed practice.** This capability gap applies to all four tiers of the mental health workforce, but is particularly acute for Tier 1 workers.

As outlined in the Introduction to this Response, women and girls experience significantly higher rates of mental ill-health for both social and biological reasons. If we want to deliver safe, high quality mental health services that meet the needs of women and girls, and we want our mental health promotion efforts to effectively address the drivers of poor mental health among women and girls, then **intersectional gender competence must be recognised as a priority capability for the mental health workforce.**

Violence against women and girls is one of the most common causes of poor mental health. Women who have experienced violence are more likely to suffer from a range of mental health conditions, many of which have long-term impacts.²⁵ However, recent Australian research shows mental health staff ('Tier 1' mental health workers) feel unprepared to work with patients/consumers with histories of family violence and sexual abuse. For example, they frequently do not ask about sexual violence, whether historical or experienced within mental health services, and often do not take disclosures seriously, minimise the experience or blame consumers.²⁶ The terrible experience of one victim-survivor of family violence within the mental health system was recently [reported by the ABC](#); the article noted that 36 complaints had been received by the Mental Health Complaints Commissioner in 2020-21 from victim-survivors of family violence about poor experiences within public mental health services.

Given the high prevalence of gendered violence and its significant mental health impacts, **it is essential that the Victorian Workforce Strategy include a focus on building capability to identify and respond to victim-survivors of gendered violence, as well as integrating an understanding of the impacts of gendered violence into mental health practice.**

Initiatives implemented following the Royal Commission into Family Violence – such as the [MARAM Framework](#), the [Strengthening Hospital Responses to Family Violence](#) project and the [Specialist Family Violence Advisor Capacity Building Program](#) in mental health and alcohol and other drug services – have played an important role in building the capability of Victorian mental health practitioners to *identify family violence, manage risk and make appropriate referrals*. However, these initiatives stop short of integrating an understanding of the impacts of gendered violence into mental health *practice*; the mental health workforce still lacks the basic capability to *work with and*

²⁵ ANROWS (2020). [Violence against women and mental health](#). Australia's National Research Organisation for Women's Safety. Sydney – (ANROWS Insights, 04/2020).

²⁶ O'Dwyer C et al. (2019) [Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#). *BMC Health Services Research* 19:839.

support victim-survivors of gendered violence (beyond identification, risk management and referral) and to work with people who use violence.

Key capabilities required by mental health workers include:

- **Intersectional gender competence**
- **Capability to respond to victim-survivors of gendered violence, including family and sexual violence**
- **Capability in gender-responsive trauma-and violence-informed practice**
- **Capability in culturally responsive practice**
- **Capability to prevent and respond to gendered violence in mental health facilities and other health settings**
- **Capability in gender-informed mental health promotion/primary prevention**

More detail on these required capabilities is outlined in [Appendix B](#).

Alliance members have also identified a particular need to build capability in mental health and in responding to family and sexual violence across the general health workforce ('Tier 2' mental health workers). A 2021 survey of health professionals conducted by Jean Hailes for Women's Health found that:

- 64% of GPs, 58% of registered nurses, 55% of midwives and 53% of maternal and child health nurses selected mental health as the health topic most relevant to their practice; and
- 24% of GPs, 48% of registered nurses, 44% of midwives and 34% of maternal and child health nurses indicated mental health as an area they would like to develop skills in.²⁷

General health workers, including GPs, nurses and midwives, as well as dietitians, exercise physiologists and other allied health workers, require the capability to:

- recognise risks for mental health
- recognise poor mental health
- screen for and manage mental health conditions
- undertake safety and risk assessment.

The Victorian Government should work with the Commonwealth to ensure pre-service training in mental health is included as an essential part of training for 'Tier 2' mental health workers (i.e. general health workers, such as GPs, nurses and midwives, and emergency department workers). In addition, there are some promising mental health initiatives emerging in primary care, such as [ALIVE: A National Research Translation Centre to Implement Mental Health Care at Scale in Primary Care and Community Settings](#) which has the potential to play a leadership role in building mental health capability across the general health workforce. It will be important for the Victorian

²⁷ Data provided to the Alliance by Jean Hailes for Women's Health. Respondents to the survey of health professionals regarding their women's health learning needs included 331 GPs, 143 registered nurses, 64 midwives and 39 maternal and child health nurses.

Workforce Strategy to be coordinated with the National Workforce Strategy to address capability gaps in primary care.

Alliance members have also highlighted the need for health workers in hospital settings to have increased capability in mental health, and in women's mental health in particular. For example, general health workers may be the first point of contact in the hospital system for women presenting with eating disorders (because presentations often relate to physical health issues such as nutrition deficiencies), but they lack an understanding of eating disorders and often respond in stigmatising ways, heightening distress and prolonging patient journeys.

Like the rest of the mental health workforce, general health workers also require capability-building in responding to family and sexual violence. While there are some promising initiatives being led by the RANZCP and the RACGP (see [Appendix B](#)), allied health workers, such as dietitians and exercise physiologists – who play an important role in mental health – are further behind in their understanding of, and capability to respond to, family and sexual violence and its mental health impacts. **There is an opportunity to build on promising initiatives in general practice to further develop the capability of this critical workforce in mental health and family violence, while at the same time drawing on these initiatives to build capability in other general health workforces, such as allied health.**

Finally, **prevention, early intervention, referral and support for recovery must be considered core skills for 'Tier 3' mental health workers (i.e. social services workers) and supported through both pre-service and in-service training.**

5.4 Funding and implementation supports

The Alliance strongly agrees that “funding and implementation supports will be required to ensure the framework is meaningfully translated into practice” (Workforce Capability, Potential Solution 2). We support all the actions outlined in the Report under this Potential Solution.

As the Summary Report has identified, capability frameworks are only valuable if they are properly implemented. This requires:

- **Standardised pre-service and in-service training** for mental health workers in the capabilities required for their role, including for first contact, managerial and executive roles – specific training gaps and needs are outlined in [Appendix C](#) to this Response
- **Practice guidance** to support implementation of new ways of working, consistent practice and supervision
- **Organisational leadership** to ensure that professional development is prioritised and resourced, and organisational policies and practice create an enabling environment for improved ways of working to be implemented – this is addressed further in Section 7.3 of this Response
- **Resourcing**, including for adequate professional supervision and to enable staff undertaking professional development to be backfilled
- **Responsiveness** to emerging needs and issues within the sector, for example, with the increasing reliance on telehealth, mental health workforces will require guidance on screening for mental ill-health and family violence remotely in a safe manner.

The Alliance supports the need for “innovative approaches to training” (Workforce Capability, Potential Solution 1a). Aside from innovation, there are also major gaps in the availability of training in key capabilities. Currently, very little if any pre-service or in-service training is available for the mental health workforce (all tiers) in gender competence, responding to victim-survivors of gendered violence or gender-responsive trauma-informed practice,

We have highlighted training gaps and opportunities in [Appendix C](#) to this Response. In summary, **we recommend:**

- significant investment in both pre-service (for example, as part of tertiary curricula) and in-service **training in gender-responsiveness;**
- **a review be undertaken of family violence training initiatives for mental health workforces** to identify gaps and promising initiatives that warrant further investment and roll-out to ensure that all mental health workforces (all tiers) receive appropriate training in family violence;
- **the establishment of a mental health sector capacity building position** whose role would be to engage organisational leaders and key stakeholders within both clinical and community mental health to identify and respond to statewide family violence capacity building needs within the mental health workforce, as well as provide guidance and develop resources to support the mental health workforce to align to the MARAM;
- specialist training be developed for mental health workforces in **understanding and responding to sexual violence;**
- the Victorian Government invest in a **specialist trauma centre focused on supporting the recovery of victim-survivors of gendered violence, including family and sexual violence.** In addition to specialist treatment and support for victim-survivors and research into gender-informed approaches to trauma, this centre should develop and deliver training and provide secondary consultation for mental health workers.

6. Rural and regional workforce development

Rural and remote areas struggle to attract and retain the workforce needed to deliver sufficient services to meet demand, even in the private sector. It is encouraging to see rural and regional workforce development prioritised as a key focus area of the Strategy.

The Alliance supports the Potential Solutions outlined in the Summary Report and makes the following additional observations/recommendations:

6.1 Value proposition

The focus of attracting mental health workers to rural areas to date has been on financial incentives. However, **a more comprehensive approach to incentives is needed that considers housing, educational opportunities and partner employment.**

6.2 Different options for support and learning

Creative and innovative approaches to building the rural workforce need to be considered. For example, lack of access to services in rural and regional areas means the broader community already plays a critical role as a ‘safety net’ for people experiencing mental ill-health and distress.

Community members could be provided with training opportunities to build their expertise, even if they don't take on professional roles.

6.3 Other barriers to building the rural workforce

Prescriptive funding models and industrial issues restricting scope of practice will also need to be addressed to facilitate new approaches to addressing rural workforce shortages, such as 'hub and spoke' models where metropolitan-based services partner with rural services to boost supply and capability, for example through rotating placements.

7. Workforce issues not addressed in the Summary Report

7.1 Workforce diversity

The Strategy must also include measures to actively increase the diversity of the mental health workforce. This includes increasing the proportion of **women in clinical roles**, particularly psychiatry. The Mental Health Complaints Commissioner has reported that one of the key grounds for complaint from victim-survivors of family violence when accessing mental health services is the inability to see a female clinician.²⁸

As noted in Section 3.4 of this Response, increasing the number of **women and people with lived experience in senior roles** should also be a workforce development priority in the Strategy. For example, the Royal Commission's interim report noted that there was a disproportionately low proportion of women in senior roles in psychiatry.²⁹

The Ethnic Communities Council of Victoria and Victorian Transcultural Mental Health recommend setting targets for higher workforce mutuality within the mental health sector, that is, working towards achieving a **higher representation of people from migrant and refugee backgrounds** in the mental health services workforce so that the sector is more reflective of the actual diversity of the community. They recommend developing culturally-responsive recruitment and retention programs, policies and protocols that support mental health services workforces that are more reflective of the cultural diversity of the catchments or communities that these workforces serve.³⁰

Regular workforce data collection is also essential to measure progress and assist with workforce planning. This should include collection of data on workers' gender and culture/ethnicity, including at a regional level.

7.2 Workforce attitudes and behaviours

There is clear evidence that **women who are experiencing mental ill-health or psychological distress, are diagnosed with a mental health condition, or have experienced gendered violence** are

²⁸ <https://www.abc.net.au/news/2021-10-03/melbourne-hospital-misdiagnosed-family-violence-victim/100277596>

²⁹ Royal Commission into Victoria's Mental Health System, [Interim Report](#), p 536.

³⁰ Plowman M, Izzo S (2021) [Recommendations for a culturally responsive mental health system](#). Ethnic Communities Council of Victoria and Victorian Transcultural Mental Health, p 18.

subjected to stigma and discrimination in their interactions with mental health practitioners and services. This must be addressed as a workforce issue.

For example, there is evidence that women who self-harm or attempt suicide can be perceived or described by health practitioners as 'attention-seeking' and manipulative.³¹ Research has shown that, after hospitalisation for self-harm, women report feeling dissatisfied with emergency and psychiatric services due to negative attitudes directed towards them.³² In inpatient units in Victoria, recent research shows some staff perceive female consumers as more difficult to care for, and express negative attitudes towards the women in their care.³³ There is also evidence to suggest that negative perceptions of female consumers result in some mental health workers dismissing or denying disclosures of sexual assault.³⁴

Shame, fear of stigma and fear of not being believed can also be a barrier to help-seeking among women who have experienced violence: 'victim-blaming' has been reported as an issue for women who are seeking help for complex post-traumatic stress and anxiety.³⁵

Taking a broad definition of the mental health workforce as outlined in Section 2 of this Response, **it will also be critical to address negative and stigmatising attitudes outside the clinical mental health workforce.** There should be a particular focus on the legal and justice sector. The stigma associated with female mental illness in the legal system allows mental health diagnoses to be used against women in family law/custody matters and in sexual assault matters. As Australia's National Research Organisation for Women's Safety (ANROWS) has highlighted, raising mental health in Family Court matters is gendered, with it given as the 'reason limiting child contact' with mothers in 30 percent of such cases, but only in 2 percent of cases limiting contact with fathers, which does not reflect the prevalence of mental ill-health.³⁶

Family members, friends and carers of those with mental illness, who are predominantly women, also experience the impacts of stigma and discrimination through contact with mental health services. There are also persistent and harmful stereotypes such as 'the schizophrenogenic mother', which place guilt and blame on the mother/ female caregiver. These harmful and unfounded stereotypes problematise the individual and their experience of mental distress, whilst simultaneously framing the female caregiver as a problem or causal factor.³⁷ While it is true that some family members can cause harm, it is not the experience of all consumers and these attitudes must be dispelled within mental health workforces.

³¹ Suicide Prevention Australia (2016). [Suicide and suicidal behaviour in women: issues and prevention. a discussion paper](#). Suicide Prevention Australia. Sydney.

³² Suicide Prevention Australia (2016). [Suicide and suicidal behaviour in women: issues and prevention. a discussion paper](#). Suicide Prevention Australia. Sydney.

³³ O'Dwyer C et al (2019) [Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#) *BMC Health Services Research* 19:839.

³⁴ O'Dwyer C et al (2019) [Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#) *BMC Health Services Research* 19:839.

³⁵ Women's Mental Health Alliance (2020) [Additional evidence on gender and mental health for the Royal Commission into Victoria's mental health system](#). Women's Health Victoria. Melbourne.

³⁶ ANROWS (2020). [Violence against women and mental health](#). Australia's National Research Organisation for Women's Safety. Sydney. pp 7-8. - (ANROWS Insights, 04/2020)

³⁷ Van der Sanden R et al (2015) [Stigma by association among family members of people with a mental illness: a qualitative analysis](#). *Community and Applied Social Psychology*. 25(5): 400-417; Scheyett A (1990) [The oppression of caring: women caregivers of relatives with mental illness](#). *Affilia*. 5(1), 32-48; Johnston J (2013) [The ghost of the schizophrenogenic-mother](#). *AMA Journal of Ethics - Virtual Mentor*. 15(9), 801-805.

7.3 System and cultural change

Workforce training and capability-building is insufficient to embed new ways of working, address entrenched attitudes and behaviours and dismantle harmful and discriminatory practices and structures. **Workforce development must be accompanied by whole-of-organisation approaches to system- and culture change, driven by senior leaders and adequately resourced to provide staff with the space and time required to learn and adapt to new ways of thinking and working.**

For example, research shows that some mental health staff see providing gender-responsive care as the responsibility of others, and point out that there is not enough time to build the relationships with inpatients required for gender-responsive care.³⁸ This highlights the importance of whole-of-organisation capacity-building and a commitment from leadership, which is prioritised and consistent across the sector. It is essential that senior staff are engaged and buy into the change process, prioritise the issue, and role-model attitudes and behaviours. This will also help to manage resistance.

Mechanisms for accountability and transparency (for example, requirements for all sexual safety incidents to be reported to the CEO) are also important to drive engagement and prioritisation at the leadership and middle management levels, but must be accompanied by values-driven change management.

7.4 Monitoring and evaluation

The Victorian Mental Health Workforce Strategy must be accompanied by an outcomes framework and supported by regular monitoring and evaluation – both of the overarching Strategy itself and of any initiatives developed and implemented to deliver on the objectives of the Strategy. This will enable progress to be measured and support accountability against the aims and objectives of the Strategy, including those outlined in this Response such as integration of the lived experience workforce, increased capability in intersectional gender-responsive care, workforce diversity and expansion of integrated and multidisciplinary care.

³⁸ O'Dwyer C et al (2019) [Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#) *BMC Health Services Research* 19:839.

Appendix A: Women's Mental Health Alliance

Feedback on the draft Victorian Capabilities Framework

Overarching comments

The Alliance's workforce working group expresses significant concerns with the current draft capabilities framework. While we have provided comments on specific wording below, our view is that the framework requires significant reworking.

- A key gap in the development of the Victorian Workforce Strategy overall is the absence of any definition of the mental health and wellbeing workforce. The capabilities framework seems to still be focused on clinical mental health services and practitioners, but the Royal Commission envisages a stronger focus on non-clinical and wellbeing support.
- The framework remains embedded in a mental illness/biomedical and individualised model. It needs a much stronger focus on wellbeing and the social model of health.
 - Health promotion, prevention and early intervention should be 'upgraded' to Practice Principles and embedded throughout the framework.
 - While there is an attempt to incorporate references to the social determinants of health, the framework fails to grasp the influence of structural inequality, discrimination and oppression on mental health and on consumer engagement with mental health services. The framing of Practice Principle 2 'Individuals in their context' is an example of how this has been misunderstood; it continues to individualise and pathologise social harms.
- The framework conflates workforce and system issues. It is making systemic flaws (such as poorly integrated services) the responsibility of individual workers. The framework needs to better articulate the interface between the system and the workforce and their respective responsibilities.
- There is a disconnect between the framework and the policy/legislative reality. For example, while it is proposed that practice will be 'trauma-informed', the reality is that even under the new Mental Health & Wellbeing Act, coercive practices that are inconsistent with trauma-informed practice will still be permitted (e.g. compulsory treatment, seclusion and restraint).
- The role of power inequalities and dynamics (at both a structural and an interpersonal level) in contributing to poor mental health, influencing interactions between consumers and workers within the mental health system, and as a barrier to integrated and multidisciplinary care (i.e. hierarchy between clinical, non-clinical and peer workers) needs to be recognised and addressed in the framework.
- Working group members described the framework as 'bland' and 'beige'. The Royal Commission has set out a transformational reform agenda, but it is unclear how the capabilities framework identifies ways of working that are 'new' and match the aspirations of the Royal Commission.

- The framework is often circular in how it defines the practice principles and capability domains. For example, the workforce statement for Practice Principle 4 ('All practice is trauma-informed and responsive') is 'We are trauma-informed and trauma-responsive in all that we do', which does not shed any light on what this means for workforce practice.
- While the introductory section notes that key terms will need to be defined, the draft framework then goes on to use important terms like trauma-informed practice and 'diversity-responsive' in very loose and 'woolly' ways.
- The working group raised strong concerns that the Practice Principle and Capability Domain relating to trauma-informed practice demonstrate a fundamental lack of understanding of the core elements of trauma-informed practice.
- Consumers and carers have different needs and interests and should not be conflated through a single 'consumer and carer outcome statement'.
- Consumers and carers should write their outcome statements, not merely 'endorse' them.
- In some cases, the 'statements' for consumer and carer outcomes, workforce and system do not map to the principle or capability they are seeking to illuminate. Examples are provided for individual Practice Principles and Capability Domains below.
- The Alliance has significant concerns about the conceptualisation of 'diversity' in the framework.
 - It is important to recognise that inequities of need, access and outcome arise not from a person's 'diverse identity', but from structural inequalities and experiences of discrimination.
 - As distinct from an 'intersectional' lens, a 'diversity' lens also fails to recognise that people experience multiple and compounding forms of inequality, discrimination and oppression at the same time (for example, racism, sexism and homophobia) and that this experience is indivisible.
 - Women make up around 50% of the population and around 60% of mental health service users, so a diversity lens is inadequate (while recognising there is diversity among women).
 - A 'diversity' lens positions everyone who is not white/ male/ cisgender/ heterosexual/ able-bodied or otherwise 'mainstream' as 'other'.

Any approach to recognising and responding to the diverse needs of service users must be underpinned by an understanding of the impacts of inequality and discrimination on mental health. In addition to ensuring the workforce is responsive to people's needs and experiences, it is also necessary – at a system level – to address the structural and systemic inequalities, assumptions and biases that influence individuals' mental health and access to and experiences of the mental health system. That is, rather than individualised approaches that aim to 'fix' or 'empower' the individual to access a system that marginalises their needs and experiences or sees their needs through the lens of 'other', the mental health system – and its workforce – must reflect on structural barriers and entrenched biases; that is, there needs to be a shift in focus from the 'marginalised' to the 'marginaliser'.

In addition, by grouping together all population groups that are not white, male, cis, heterosexual, able-bodied etc under the banner of 'diversity', the framework fails to

recognise the unique needs of different cohorts. For example, what young people say is wrong with the mental health system is that it doesn't recognise their specific needs *as young people*.

- The framework will need to align with the new Mental Health & Wellbeing Act. For example, the consultation draft for the new Act proposed the inclusion of a principle requiring mental health services to provide 'gender-responsive' services. The accountability mechanisms proposed for the Act would require mental health services to report on their compliance with the Act's principles. This means that mental health workers will require capability in gender-responsive practice, but this is not covered by the draft framework.
- The framework positions consumers as being at odds with the workforce. This is not limited to, but exacerbated by, the use of 'I' and 'them' language.
- The working group supports the emphasis on compassion noted in the introductory section and feels this needs to be embedded more strongly throughout the framework.
- The distinction between practice principles and capability domains is unclear. It is unclear how the capability domains build on the practice principles. Where they overlap, they are not always consistent.
- The working group queried where worker wellbeing – including avoiding and responding to trauma experienced by staff – fits. There are some references to this within the Practice Principles and Capability Domains which are not appropriate for a focused delivering on the best outcomes for consumers (see, for example, comments on Capability Domain 2 below).

Practice principles

1: All practice is responsive to the needs of individuals

- While this principle appears to be focusing on 'person-centred care', as a stand-alone principle, it is not clear how it differs from the others (as it incorporates many aspects of other principles e.g. strengths-based).
- The broader social context/social determinants of mental health and wellbeing are missing from this principle. While this is notionally picked up in Practice Principle 2, person-centred care cannot be divorced from the social context.
- Person-centred care is really a system-wide issue (i.e. it relates to collaborative practice etc), rather than something individual workers can implement/operationalise. For example, the workforce statement ('We consider how the individual interacts with the system and provide an integrated response with the individual and their needs and wellbeing goals firmly at the centre of everything we do') is not something that workers have control over.
- The consumer/carer statement needs to be strengthened. Consumers should have their rights upheld, not just have their 'preferences considered'. Consumer preferences should also guide treatment, not just be a consideration.

2: All practice is understanding of individuals in their context

- This principle locates the 'problem' with the individual, rather than focusing on how the system needs to change to better accommodate people with a diversity of needs and experiences. The system statement must include reflection on and addressing the barriers to access and engagement imposed by the system.

- Structural/systemic barriers (e.g. sexism, racism) that impact mental health and engagement with services need to be recognised.
- 'Experiences' need to be recognised as well as 'background, relationships, community'/'characteristics, interpersonal relationships and community'. Two people from the same background/community etc may have very different experiences, for example of gendered violence.
- Service delivery must be 'responsive' to an individual's broader context and circumstances (including structural inequalities and discrimination), not just 'respectful' of this.
- There is a disconnect between the description of 'what does this look like in practice?' and the workforce statement.

3: All practice is strengths-based and wellbeing oriented

- No comments

4: All practice is trauma-informed and responsive

- 'Trauma-responsive' is not terminology known to the working group (who work in this field).
- Definition and statements are circular. For example, in the workforce statement, trauma-informed practice is defined as trauma-informed practice. There is a wealth of research into the key principles of trauma-informed practice – as well as useful critiques – that should be incorporated.³⁹
- Trauma-informed practice must be enabled at a systems level – particularly through legislative and policy settings and adequate resourcing. Unless this is enabled at a system level, individual workers cannot implement it.
- The focus on 'understanding, acknowledging and responding to people's experience of trauma' is too narrow. Trauma-informed practice is about being alive to the possibility that anyone can have experienced trauma.
- This principle needs to explicitly include prevention/avoidance of trauma within the mental health system and addressing it when it does occur – we know that consumers experience trauma within the mental health system; this needs to be acknowledged and addressed. This must be picked up across the definitions and statements, particularly in the system outcome statement.
- The principle needs to incorporate acknowledgement of power relations – both in the consumer's interaction with the mental health system and in the experience of any pre-existing trauma. Trauma-informed practice should draw links between individual experiences and systemic issues of inequality, oppression and violence.

³⁹ See, for example, Tseris, E. (2019). [Social work and women's mental health: Does trauma theory provide a useful framework?](#) British Journal of Social Work 49(3), 686-703; Tseris, E. (2013). [Trauma Theory Without Feminism? Evaluating Contemporary Understandings of Traumatized Women](#). Affilia: Journal of Women and Social Work (28)2, 153-164; Kelsey Hegarty et al (2017), [Women's Input into a Trauma-informed systems model of care in Health settings: The WITH study – Final report](#) (ANROWS); Women's Health Victoria (2019). [Spotlight on trauma-informed practice and women](#). Women's Health Victoria.

- This principle needs to talk about not only how a person's experience of trauma shapes their mental health and wellbeing, but also how it shapes their response to/engagement with treatment and care.
- The principle needs to grapple with different and intersectional experiences of trauma e.g. trauma arising from gendered violence; intergenerational trauma arising from experiences of colonisation; trauma related to war, pre-migration, migration and settlement.
- The consumer/carer statement is generic and does not reflect trauma-informed practice.
- Women who have experienced trauma often have complex needs meaning that collaboration and integrated care/services will be critical system enablers for trauma-informed practice and should be reflected in the system outcome statement.

5: All practice is culturally safe and diversity responsive

- A mental health system that better responds to the needs and experiences of all Victorians is essential for increasing equity in mental health outcomes.
- The Alliance notes that current approaches to care, treatment and support are based on practice, research and evidence that has systematically excluded women, gender diverse people and other marginalised populations. It is important to recognise that inequities of need, access and outcome arise not from a person's 'diverse identity', but from structural inequalities and experiences of discrimination. A 'diversity' lens also fails to recognise that people experience multiple and compounding forms of inequality, discrimination and oppression at the same time (for example, racism, sexism and homophobia) and that this experience is indivisible (i.e. intersectionality). Further, a 'diversity' lens positions everyone who is not white/ male/ cisgender/ heterosexual/ able-bodied or otherwise 'mainstream' as 'other'. **Any approach to recognising and responding to the diverse needs of service users must be underpinned by an understanding of the impacts of inequality and discrimination on mental health. In addition to ensuring the workforce is responsive to people's needs and experiences, it is also necessary – at a system level – to address the structural and systemic inequalities, assumptions and biases that influence individuals' mental health and access to and experiences of the mental health system.** That is, rather than individualised approaches that aim to 'fix' or 'empower' the individual to access a system that marginalises their needs and experiences or sees their needs through the lens of 'other', the mental health system – and its workforce – must reflect on structural barriers and entrenched biases; that is, there needs to be a shift in focus from the 'marginalised' to the 'marginaliser'.
- In addition, by grouping together all population groups that are not white, male, cis, heterosexual, able-bodied etc under the banner of 'diversity', the framework fails to recognise the unique needs of different cohorts. For example, what young people say is wrong with the mental health system is that it doesn't recognise their specific needs *as young people*.
- There is a long history of women experiencing gendered violence within mental health facilities, as recognised in Chapter 10 of the Royal Commission's report and Recommendation 13. In this context, the Alliance believes explicit inclusion of a commitment to gender safety (as well as cultural safety) is warranted in this Practice Principle. It will be important to ensure that the right to safety is articulated in a way which focuses on

respecting and promoting rights and freedoms rather than through the language of 'protection' and 'vulnerability', which further disempowers people.

- As for Practice Principle 2, 'experiences' must be included together with 'background and needs'. Two people from the same background may have very different experiences.
- While we recognise the intent behind use of the word 'impartial' (given many consumers are stigmatised and experience discrimination within the mental health system), not only is it impossible to provide treatment, care and support that is not influenced by individual or systematic attitudes and biases, but a consumer who has experienced stigma and discrimination does not need 'impartial' care, but care that is affirming, actively 'anti-discriminatory' and upholds consumer rights. As noted above, reflection on and redressing of systemic barriers, discrimination and biases is also necessary.

6: All practice is ethical and grounded in human rights

- This principle should be foundational and underpin all other principles. The working group recommends it be 'promoted' to be the first principle.
- 'Ethical' practice is one of the terms that will need to be clearly defined and supported by practice guidance. It should include recognising and challenging power differentials within service delivery contexts, as well as recognising experiences of power and oppression may underpin or contribute to many consumers' mental ill-health.
- It should not be the responsibility of individual consumers to challenge stigma and discrimination. As noted above, challenging and redressing stigma and discrimination is a system issue.
- The working group objects to the consumer/carer statement 'I trust my practitioner to empower me to actively engage in decision-making about my care'. Consumers and carers should not be reliant on the 'generosity' and 'good will' of practitioners to have their rights upheld and have power imbalances addressed.
- The language of 'best interests' in the system statement should be replaced with 'best outcomes'. There is a long history of clinicians and services deciding what they believe to be in the 'best interests' of consumers, which is disempowering, may be at odds with consumer preferences and leads to poor outcomes.
- Again, this principle requires a focus on challenging and addressing discrimination and inequality at the system level.

7: All practice is respectful, compassionate and collaborative

- The working group suggests that this principle be split into two principles as respectful and compassionate practice is different from collaborative practice.
- The working group would like to see compassionate practice more strongly embedded throughout the framework.

Capability domains

1: Understanding mental health legislation and human rights

- This principle should also include freedom from violence.
- This principle will need to be reconciled with the policy context, recognising that some aspects of the proposed new Mental Health and Wellbeing Act are not consistent with human rights

2: Embedding responsible, safe and ethical practice

- Who defines what ethical practice is where a profession is not regulated by codes of conduct or standards of ethical practice?
- The framing of the system outcome statement suggests this is about protecting workers from 'dangerous consumers'. The system outcome needs to be about adequately resourcing services to enable workers to work in a way that avoids traumatising and coercive practices that give rise to 'threatening' behaviours.

3: Engaging with empathy

- The working group would prefer this principle to be reframed as 'engaging with compassion', which is considered to be more active e.g. not just 'I see your pain', but 'I see your pain and we can work together to address it'.
- As for other principles, the definition of engaging with empathy is circular.

4: Working with Aboriginal consumers, families and communities

- The working group does not include any Aboriginal and/or Torres Strait Islander members and makes no comments on this principle.
- While recognising the unique needs and experiences of Aboriginal and/or Torres Strait Islander peoples, we would like to see this level of detail replicated for other population groups, who also have specific needs and experiences – for example, a capability domain related to gender-responsive practice.

5: Working with diverse consumers, families and communities

- Please refer to comments on Practice Principle 5.
- It is unclear whether women and girls are intended to be included within the definition of 'diverse' cohorts. Women make up around 50% of the population and around 60% of mental health service users, so the label 'diverse' does not fit (recognising of course that there is diversity among women). If gender is not picked up here, where is it addressed?
- Workforce statement needs to be amended to read 'We recognise that diversity exists in many forms' (not 'can exist').

6: Promoting prevention, early intervention and help-seeking

- We are pleased to see prevention and early intervention incorporated as capabilities for all mental health workers. However, our view is that health promotion, prevention and early intervention should be 'upgraded' to Practice Principles and embedded throughout the framework. It also needs to be recognised that prevention and health promotion are about more than 'empowering' and supporting 'help-seeking'; they are about addressing the social

and other determinants of mental ill-health, including structural discrimination and inequality.

- Prevention and mental health promotion must also be gender- and culturally-responsive and trauma-informed to ensure they do no harm. For example, gender competence in mental health promotion Gender competence in mental health promotion requires specific acknowledgement of gender-based risk factors/social determinants, including experiences of gender discrimination, gendered violence, income inequality, gender norms and stereotypes, and gendered roles including unpaid care work. It must involve the capacity to recognise and address gender-based discriminatory attitudes and behaviours.⁴⁰

7: Supporting system navigation, partnerships and collaborative care

- This is not really a 'capability' that workers are able to action, but rather a system-level issue. It must be 'enabled' by the system' before it can be 'enacted' by workers, otherwise it places an unfair onus on workers to identify and/or create pathways to integrated care for consumers.
- This principle also needs to address power and hierarchy within the mental health workforce – both at a structural level (e.g. equal remuneration for work of equal value) and at an organisational/interpersonal level (e.g. within multidisciplinary teams/practice where clinical workforces are considered to have more legitimacy than non-clinical and peer workforces).
- The workforce statement does not speak to supporting system navigation.

8: Enabling reflective and supportive ways of working

- Again, reflective practice needs to be enabled at a system level. The system outcome does not match this capability domain; it must demonstrate how reflective practice and supportive ways of working will be *enabled* at a system level.
- 'What will this look like in practice?' and the workforce statement need to include critical reflection not just on 'actions', but on attitudes and beliefs. Reflective practice should aim to support values-based and transformative learning.⁴¹

9: Embedding evidence-informed continuous improvement

- Again, this principle must be enabled at the system level. For example, workers need the time and capability to use the data to which they have access to be able to enact continuous improvement etc.

10: Delivering holistic and collaborative assessment and care planning

- The definition and statements for this principle do not illustrate how holistic and collaborative assessment and care planning will be enabled and enacted. The current wording duplicates other principles and capability domains related to diversity-responsiveness, person-centred care etc.

11: Delivering therapeutic intervention, care and support

- The language of 'intervention' should be avoided; 'treatment, care and support' is preferred.

⁴⁰ Fisher J (2020) [Gender competence and mental health promotion](#). *World Psychiatry* 19:1.

⁴¹ Love D. (2021) [Gender responsive teaching practice within tertiary education: Women's Health Victoria Knowledge Paper 4](#). Women's Health Victoria, Melbourne.

- This principle should include that treatment, care and support are evidence-based.
- While we assume the capability domains are intended to be 'read together' and enacted in an intersecting and comprehensive way, the working group would like to see prevention and early intervention incorporated into this capability. As it is currently framed, it is focused on intervening at the point where the person is already ill.
- In the workforce statement, it is unclear what is meant by 'We understand that recovery is not only related to the mental ill health itself but also to *the challenges associated with it*'. If the reference to 'challenges' is referring to stigma and discrimination related to mental illness, this should be named.
- The system statement does not match the capability domain.

12: Understanding and responding to trauma

- Please refer to comments on Practice Principle 4. As noted in our Overarching comments, it is unclear how the Capability Domains differ from/are intended to build on the Practice Principles.
- Care, support and treatment should be trauma-informed, not 'aligned with trauma-informed approaches'.
- The framing of consumer/carer statement 'helping me to acknowledge, understanding [sic] and respond to the impact of my experiences of trauma' does not speak to the need for the workforce (not just the consumer) to acknowledge, understand and respond to the consumer's experience of trauma.
- The workforce statement does not reflect the prevalence of trauma in the aetiology of a wide range of mental health conditions, particularly those where women are over-represented. We suggest rewording to 'We recognise that trauma *often* affects mental health and wellbeing...' or 'We recognise that trauma *is a major driver of* poor mental health and wellbeing...'
- The workforce statement focuses on 'not retraumatising' people; while this is critical, the workforce also needs to be able to respond to/address experiences of trauma as part of their practice.
- The system statement here is an improvement on the system statement for the related Practice Principle as it articulates some of the elements of trauma-informed practice. However, trauma-informed practice involves more than what is articulated here.

13: Understanding and responding to mental health crisis and suicide

- The working group like the way this capability domain is framed within a social determinants of health framework rather than a risk management framework.
- The distinction between mental health crisis and suicide needs to be articulated. 'Mental health *and wellbeing* crisis' does not make sense.
- There is evidence that women in particular are subjected to negative gendered attitudes when they present with self-harm and suicidal behaviours.⁴² We recommend that the

⁴² Suicide Prevention Australia (2016). [Suicide and suicidal behaviour in women: issues and prevention. a discussion paper](#). Suicide Prevention Australia. Sydney.

consumer/carer statement include 'I am not judged' and the workforce statement should also include a reference to non-judgemental support.

- The system statement does not specifically relate to this capability domain.

14: Working effectively with families, carers and supporters

- The workforce statement should include respect for consumers' boundaries in relation to inclusion of/information-sharing with family and carers, and not making assumptions about the level of involvement of families/carers. For example, poor practice such as that described in this [recent ABC article](#) must absolutely be avoided.

15: Working effectively with digital technologies

- This capability domain must acknowledge and address barriers to access to digital technology for consumers (e.g. income, disability, language, rurality etc) across all statements, otherwise it will be merely tokenistic.
- Again, this capability domain is shifting the responsibility for a system issue onto individual workers.

Appendix B: Capabilities required by the mental health workforce

Capabilities required by the mental health workforce

In the first instance, capability-building should focus on key areas where there are significant gaps in knowledge and skills. Two such areas are gender-responsive practice and responding to victim-survivors of family and sexual violence. This capability gap applies to all four tiers of the mental health workforce, but is particularly acute for Tier 1 workers.

As outlined in the Introduction to this Response, women and girls experience significantly higher rates of mental ill-health for both social and biological reasons. If we want to deliver safe, high quality mental health services that meet the needs of women and girls, and we want our mental health promotion efforts to effectively address the drivers of poor mental health among women and girls, then **intersectional gender competence must be recognised as a priority capability for the mental health workforce.**

The capabilities framework or frameworks must include the following elements:

1. **Intersectional gender competence**,⁴³ that is, an understanding of the ways in which gender and other social factors influence women's mental health, together with the capability to respond to women's needs and experiences, including:
 - Understanding the role of gender as a social determinant of mental health and the importance of a biopsychosocial model – this includes prioritising an understanding of mental distress in the context of women's lives and the ability to work with women in a way that values and supports their social roles, for example as mothers and carers;⁴⁴
 - Capacity to recognise and address gender-based discriminatory attitudes and behaviours (see also Section 7.2 of this Response);
 - Implementing actions to counter gender bias and gendered attitudes, stereotypes and inequalities in research, training and clinical practice (see also Section 7.2); and
 - Gendered cross-cultural awareness (this is addressed further as part of *Capability 4: Capability in intersectional and culturally-responsive practice*).

2. Capability to respond to gendered violence, including family and sexual violence

Violence against women and girls is one of the most common causes of poor mental health. Women who have experienced violence are more likely to suffer from a range of mental health conditions, many of which have long-term impacts.⁴⁵

However, recent Australian research shows mental health staff feel unprepared to work with patients/consumers with histories of family violence and sexual abuse. For example, they frequently

⁴³ Fisher J (2020) [Gender competence and mental health promotion](#). *World Psychiatry* 19:1.

⁴⁴ Abel KM and Newbigging K (2018) [Addressing unmet needs in women's mental health](#). British Medical Association. London; Greaves L and Poole N (2009) [Mother and child reunion: achieving balance in policies affecting substance-using mothers and their children](#). *Women's Health and Urban Life*, 8(1): 54-66.

⁴⁵ ANROWS (2020). [Violence against women and mental health](#). Australia's National Research Organisation for Women's Safety. Sydney – (ANROWS Insights, 04/2020).

do not ask about sexual violence, whether historical or experienced within mental health services, and often do not take disclosures seriously, minimise the experience or blame consumers.⁴⁶ The terrible experience of one victim-survivor of family violence within the mental health system was recently [reported by the ABC](#); the article noted that 36 complaints had been received by the Mental Health Complaints Commissioner in 2020-21 from victim-survivors of family violence about poor experiences within public mental health services.

Any national mental health workforce strategy must include a focus on building capability to identify and respond to women (and men and gender diverse people) who have experienced gendered violence, as well as integrating an understanding of the impacts of gendered violence into mental health practice. This should:

- Include routine screening for trauma, violence and abuse and meaningful incorporation of disclosures into treatment plans. Evidence suggests that victim-survivors of family violence are reluctant to disclose abuse in the absence of direct questioning;⁴⁷
- Draw on the CATCH model, which identifies Commitment, Advocacy, Trust, Collaboration, and Health system support as vital in building readiness and confidence to provide sensitive care for survivors of family violence;⁴⁸
- Include capability-building in information-sharing aligned with the requirements of the Family Violence Information Sharing Scheme and Child Information Sharing Scheme;
- Align with principles underpinning trauma-informed practice (explored below).

Initiatives implemented following the Royal Commission into Family Violence – such as the [MARAM Framework](#), the [Strengthening Hospital Responses to Family Violence](#) project and the [Specialist Family Violence Advisor Capacity Building Program](#) in mental health and alcohol and other drug services – have played an important role in building the capability of Victorian mental health practitioners to *identify family violence, manage risk and make appropriate referrals*. However, these initiatives stop short of integrating an understanding of the impacts of gendered violence into mental health *practice*; the mental health workforce still lacks the basic capability to *work with and support* victim-survivors of gendered violence (beyond identification, risk management and referral) and to work with people who use violence.

3. Capability in gender-responsive trauma-and violence-informed practice

The Alliance notes that trauma-informed practice is proposed to be included as both a Practice Principle and a Capability Domain in the capabilities framework. We welcome this inclusion, but have highlighted the limitations of the current approach in our feedback on the draft capabilities framework (see [Appendix A](#)).

An organisational and practice model that is grounded in understanding and responding to trauma is critical in any service that supports women, due to the links between poor mental health and

⁴⁶ O'Dwyer C et al. (2019) [Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units](#). *BMC Health Services Research* 19:839.

⁴⁷ Trevillion K et al (2014) [Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis](#). *International Review of Psychiatry*. 26 (4):430-44; Rose D et al (2011) [Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study](#). *British Journal of Psychiatry*; 198(3):189-194.

⁴⁸ Hegarty K et al (2020) [Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis](#). *PLoS ONE* 15(6): e0234067.

experiences of gendered violence, including family and sexual violence.⁴⁹ It is also important that a gender lens is applied to trauma-informed approaches, recognising that women and girls have different experiences of trauma from men and boys, and trauma impacts them differently.

Overall, women have a two to three times higher risk of developing Post-Traumatic Stress Disorder compared to men, and this is believed to be attributable to both psychosocial and biological factors. Men and women experience different types of trauma, both in private life and at work (e.g. police officers), with women being exposed to more high-impact trauma (e.g. sexual trauma) than men, and at a younger age.⁵⁰

The context in which women experience violence is also different from that of men. The root cause of intimate partner violence (IPV) – a major source of trauma for women – is gender inequality and involves the perpetrator exerting power and control over the victim-survivor. Women who have experienced IPV often face other stressors including access to housing and employment, and often lack the economic resources that men have access to. Women who have experienced IPV may also have chronic physical health conditions.⁵¹

While trauma has negative impacts on both women and men, their biological/psychological responses are different. Trauma early in life (which women are more likely to experience) has more impact, especially when it involves type II trauma (i.e. prolonged and repeated, rather than a single incident), interfering with neurobiological development and personality.⁵²

Traumatic stress affects different areas of the brains of boys and girls at different ages. Trauma increases hypothalamic pituitary adrenal activation in females with resultant multiple effects in physical health, behaviour and cognition. For example, autoimmune diseases, infertility and obesity are all more common in traumatised girls and women.⁵³

In addition, women handle stressful situations differently and tend to adopt different psychological defences in the face of adversity. They may use a tend-and-befriend, dependent and/or submissive response rather than the fight-or-flight response that is often assumed. Emotion-focused, defensive and palliative coping are more prevalent in women, while problem-focused coping is higher in men.⁵⁴

Different groups of women will also experience trauma differently. For example, migrant and refugee women's experience of violence and trauma is impacted by both racism and gender inequality,⁵⁵ and leads to specific mental health impacts:

⁴⁹ Quadara A (2015) [Implementing trauma-informed systems of care in health settings: The WITH study: State of knowledge paper](#). Australia's National Research Organisation for Women's Safety. Sydney – (ANROWS Landscapes, 10/2015).

⁵⁰ Olff M (2017) [Sex and gender differences in post-traumatic stress disorder: an update](#). *European Journal of Psychotraumatology*, 8(sup4), 1351204.

⁵¹ Dillon G et al (2013) [Mental and physical health and intimate partner violence against women: a review of the literature](#). *International Journal of Family Medicine*. 2013:313909.

⁵² Olff M (2017) [Sex and gender differences in post-traumatic stress disorder: an update](#). *European Journal of Psychotraumatology*, 8(sup4), 1351204.

⁵³ Thomas N et al (2019) Borderline personality disorder, trauma and the hypothalamo-pituitary-adrenal axis. *Neuropsychiatric Disease and Treatment*.15: 2601–2612.

⁵⁴ Olff M (2017) [Sex and gender differences in post-traumatic stress disorder: an update](#). *European Journal of Psychotraumatology*, 8(sup4), 1351204.

⁵⁵ Delara M (2016) Social determinants of immigrant women's mental health, *Advances in Public Health*. 2016:9730162.

- **Violence against women:** Migrant and refugee women generally report stress, fear and anxiety during the relationship, regardless of the frequency or severity of the perpetrator's violence. Many migrant women also report feelings of isolation, depression, guilt and self-blame, low self-esteem, loss of confidence and in some cases suicidal thoughts.⁵⁶
- **Settlement stress and trauma:** Settlement stress and migration-related trauma contributes to a higher likelihood of mental health conditions among migrants and refugees. Social isolation during the settlement period, lack of family and social support, discrimination, and longer length of migrants' residence in the host country can increase the likelihood of common mental health conditions.

Evidence indicates that an effective gender-responsive and intersectional trauma-informed approach must:⁵⁷

- Be empowering, strengths-based and promote autonomy;
- Ensure the physical and emotional safety of consumers/survivors;
- Incorporate 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;⁵⁸
- Be responsive to the lived, social and cultural contexts (e.g. recognising gender, race, culture, ethnicity) of consumers, which shape both their needs and their recovery and healing pathways;
- De-centre therapeutic expertise and emphasise collaboration;
- Recognise the potential for coercive practices within mental health settings to be retraumatising and avoid their perpetuation through training and resources for staff to implement gender-informed alternatives to coercion;⁵⁹
- Extend beyond individual practice to the whole organisation 'from the environment to the reception staff';⁶⁰ and

⁵⁶ Vaughan C et al (2016) Promoting community-led responses to violence against immigrant and refugee women in metropolitan and regional Australia: The ASPIRE Project: Research report. Australia's National Research Organisation for Women's Safety. Sydney.

⁵⁷ Quadara A (2015) [Implementing trauma-informed systems of care in health settings: The WITH study: State of knowledge paper](#). Australia's National Research Organisation for Women's Safety. Sydney – (ANROWS Landscapes, 10/2015); Tseris, E. (2019). [Social work and women's mental health: Does trauma theory provide a useful framework?](#) *British Journal of Social Work*, 49(3): 686-703.

⁵⁸ Quadara A (2015) [Implementing trauma-informed systems of care in health settings: The WITH study: State of knowledge paper](#). Australia's National Research Organisation for Women's Safety. Sydney – (ANROWS Landscapes, 10/2015).

⁵⁹ Kezelman C and Stavropoulos P (2012) [Practice guidelines for treatment of complex trauma and trauma informed care and service delivery – Blue Knot Foundation](#); Mental Health Coordinating Council (MHCC) (2013) [Trauma informed care and practice: towards a cultural shift in policy reform across mental health and human services in Australia: a national strategic direction](#); Williams J et al (2001) [Mental health services for "difficult" women: reflections on some recent developments](#). *Feminist Review*, 68(1): 89–104.

⁶⁰ Hegarty K et al (2017) [Women's Input into a Trauma-informed systems model of care in Health settings: The WITH study – Final report](#) Australia's National Research Organisation for Women's Safety. Sydney. p 3-5.

- Integrate care across services, recognising women's complex needs (mental health problems, family and sexual violence, child abuse, war- and migration-related trauma, alcohol and drug issues).⁶¹

For these reasons, a more nuanced approach to trauma-informed practice than is currently outlined in the draft capabilities framework is required, which is both a gender- and culturally responsive.

4. Capability in culturally responsive practice

It is also important to ensure that the mental health workforce can provide culturally-responsive mental health support – particularly in the perinatal period. Women of migrant and refugee backgrounds are at higher risk of perinatal anxiety and depression and a culturally-responsive, trauma-informed approach to screening is important, recognising cultural differences in understandings and approaches to mental health, and the potential for women with a history of violence and trauma to be triggered during pregnancy and birth.

The Royal Commission recommended perinatal screening tools be reviewed to ensure they are culturally responsive, as well as increasing capacity in community perinatal mental health support across the state (Recommendation 18). This will need to be accompanied by capability-building. Screening for perinatal mental health issues, while imperfect, should be encouraged across maternity care for all pregnancies.

5. Capability to prevent and respond to gendered violence in mental health facilities and other health settings

Women continue to experience unacceptably high rates of gendered and sexual violence within mental health facilities – both from other patients/consumers and from staff.⁶² Recognising this, the Royal Commission has recommended that all new and existing mental health facilities be upgraded to enable gender separation (Recommendation 13). However, as outlined in the Women's Mental Health Alliance's [gender analysis](#), Recommendation 13 does not recognise that, to be effective, changes to the physical environment must be accompanied by increased workforce capability in preventing and responding to gendered violence.

It is also important to recognise the need for capability-building in preventing and addressing gendered violence in other health settings where women may present with mental illness, such as emergency departments ('Tier 2' workers).

6. Capability in gender-informed mental health promotion/primary prevention

As highlighted in Section 2 of this Response, specialist primary prevention/mental health promotion workers must be included within the definition of the mental health workforce ('Tier 4').

It is essential that the Victorian Workforce Strategy and capabilities framework(s) incorporate a strong focus on building the capability of all mental health workers in gender-informed mental health promotion, as well as a specific focus on building the capability of the health promotion

⁶¹ Hegarty K et al (2017) [Women's Input into a Trauma-informed systems model of care in Health settings: The WITH study – Final report](#) Australia's National Research Organisation for Women's Safety. Sydney. p 3-5.

⁶² See, for example, Mental Health Complaints Commissioner (2018) [The right to be safe: Ensuring sexual safety in mental health inpatient units – sexual safety project report](#).

workforce ('Tier 4') to deliver gender-informed mental health promotion/primary prevention programs.

Gender competence in mental health promotion requires specific acknowledgement of gender-based risks (or social determinants), including experiences of gender discrimination, gendered violence, income inequality, gender norms and stereotypes, and gendered roles including unpaid care work.

Capability-building in mental health for general health workers

As highlighted in Section 2 of this Response, the Alliance recommends that general health workers be included within the definition of the mental health workforce ('Tier 2' within the National Mental Health Workforce Strategy Taskforce's schema).

1. Capability in mental health

Alliance members have identified a particular need to build mental health capability across the general health workforce ('Tier 2' mental health workers). A 2021 survey of health professionals conducted by Jean Hailes for Women's Health found that:

- 64% of GPs, 58% of registered nurses, 55% of midwives and 53% of maternal and child health nurses selected mental health as the health topic most relevant to their practice; and
- 24% of GPs, 48% of registered nurses, 44% of midwives and 34% of maternal and child health nurses indicated mental health as an area they would like to develop skills in.⁶³

General health workers, including GPs, nurses and midwives, as well as dietitians, exercise physiologists and other allied health workers, require the capability to:

- recognise risks for mental health
- recognise poor mental health
- screen for and manage mental health conditions
- undertake safety and risk assessment.

There are some promising mental health initiatives emerging in primary care, such as [ALIVE: A National Research Translation Centre to Implement Mental Health Care at Scale in Primary Care and Community Settings](#) which has the potential to play a leadership role in building mental health capability across the general health workforce.

Alliance members have also highlighted the need for health workers in hospital settings to have increased capability in mental health, and in women's mental health in particular. For example, general health workers may be the first point of contact in the hospital system for women presenting with eating disorders (because presentations often relate to physical health issues such as nutrition deficiencies), but they lack an understanding of eating disorders and often respond in stigmatising ways, heightening distress and prolonging patient journeys.

2. Capability in family and sexual violence

⁶³ Data provided to the Alliance by Jean Hailes for Women's Health. Respondents to the survey of health professionals regarding their women's health learning needs included 331 GPs, 143 registered nurses, 64 midwives and 39 maternal and child health nurses.

As noted above, all mental health workers also require capability-building in responding to family and sexual violence, and this applies equally to 'Tier 2' workers (general health workers). Some progress has been made in relation to capability-building in family violence in Victoria, particularly in relation to GPs and hospital workers. This has been supported by the MARAM Framework; for example, screening for family violence in pregnancy is mandated under MARAM in Victoria, and this has been useful. However, there is still a need for capability-building for health workers to understand what to do with the results of any risk assessment.

In primary care, the [RACGP](#) has developed an extensive resource on family violence and runs a professional development program on family violence. The Safer Families Centre of Research Excellence has recently commenced rolling out the [Readiness Program](#), a new national training program for primary care providers to effectively recognise, respond, refer and record domestic and family violence using a trauma and violence informed approach.

However, allied health workers, such as dietitians and exercise physiologists – who play an important role in mental health – are further behind in their understanding of, and capability to respond to, family and sexual violence and its mental health impacts.

There is an opportunity to build on promising initiatives in general practice to further develop the capability of this critical workforce in mental health and family violence, while at the same time drawing on these initiatives to build capability in other general health workforces, such as allied health.

Appendix C: Gaps and opportunities in training for mental health workforces

There are also major gaps in the availability of training in the key capabilities identified in this Response. Currently, very little if any pre-service or in-service training is available for the mental health workforce (all Tiers) in gender competence, gender-responsive trauma-informed practice, or responding to victim-survivors of gendered violence.

Gender-responsiveness

In terms of training in **gender-responsiveness**, Victoria's Centre for Mental Health Learning offers a very short e-learning module on gender and mental health. While this provides a useful overview, it is introductory only and requires updating. The Women's Mental Health Network Victoria previously offered training for mental health practitioners in gender-sensitive practice, but this has not been maintained due to lack of resourcing. **There is a need for significant investment in both pre-service (for example, as part of tertiary curricula) and in-service training in gender-responsiveness.**

Family violence

As outlined in Section 5.2 above, progress has been made in Victoria following the Royal Commission into Family Violence in building the capability of mental health workforces to identify **family violence**, manage risk and make appropriate referrals (via implementation of the MARAM Framework). A range of training options are available through relevant Colleges and other training providers. However, there are still gaps in implementation, with some mental health workforces (such as allied health) lagging.

Moreover, little if any training appears to be available to support mental health workforces to build an understanding of the mental health impacts of family violence into their *practice* (beyond identification, risk management and referral). One promising example is a new elective offered by Monash University in 'Contemporary Research and Practice in Family Violence' as part of the Master of Mental Health Science in the Department of Psychiatry. This course provides students with an understanding of theory, policy and practice in family violence, including its health and mental health impacts.

The Alliance recommends a review be undertaken of family violence training initiatives for mental health workforces to identify gaps and promising initiatives that warrant further investment and roll-out to ensure that all mental health workforces receive appropriate training in family violence.

This could be supported by the establishment of a sector capacity building role whose role would be to engage organisational leaders and key stakeholders within both clinical and community mental health to identify and respond to statewide family violence capacity building needs within the mental health workforce, as well as provide guidance and develop resources to support the mental health workforce to align to the MARAM. This role would be particularly important during the implementation of reforms in both sectors to ensure that family violence knowledge and skills are embedded throughout.

Sexual violence

Very little training is available for mental health workforces that addresses sexual violence. While training on family violence is becoming increasingly available, training on sexual violence appears to be limited to ad hoc, one-off webinars and workshops. Developing the skills to ask about sexual assault/abuse (past or present) and to respond to disclosures requires nuanced specialist training.

The Alliance recommends that specialist training be developed for mental health workforces in understanding and responding to sexual violence. This could be developed through a partnership between a mental health training provider, such as the Centre for Mental Health Learning and a sexual assault services provider.

Trauma-informed practice

The level of trauma-informed practice in the mental health sector is still immature. As outlined in [Appendix B](#), trauma-informed practice must be nuanced to respond to differences in the types and nature of trauma experienced. It is encouraging that the Centre for Mental Health Learning in Victoria offers training in trauma-informed practice, often with a specific lens (for example, Foundation House has developed training with a refugee trauma lens).

However, given that intimate partner violence is one of the leading causes of mental ill-health – and involves unique dynamics and impacts – the Alliance is of the view that victim-survivors' experience of trauma requires a dedicated focus. **The Alliance recommends that the Victorian Government invest in a specialist trauma centre that is focused on supporting the recovery of victim-survivors of gendered violence, including family and sexual violence. In addition to specialist treatment and support for victim-survivors and research into gender-informed approaches to trauma, this centre should develop and deliver training and provide secondary consultation for mental health workers.** This could be delivered as part of the implementation of Recommendations 23 and 24 of the Royal Commission.