



National Mental Health Workforce Strategy

Submission from the Women's
Mental Health Alliance

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Contents

1. Introduction	3
1.1 The need for workforce development and reform.....	3
1.2 About the Women’s Mental Health Alliance	3
1.3 Our approach to this submission	3
2. Summary of recommendations	4
3. The need for a gender-responsive approach in mental health	7
4. Defining the mental health workforce	8
4.1 Primary prevention workers	9
4.2 Family and sexual violence response workers.....	10
4.3 Community sector workers.....	10
5. Workforce capabilities	11
5.1 A national capabilities framework or frameworks	11
5.2 Capabilities required by mental health workers.....	12
5.3 Capability-building in mental health for general health workers.....	16
5.4 Training and support for capability-building	17
6. Workforce attraction and retention	19
6.1 Funding	19
6.2 Pay and conditions.....	20
6.3 Lived experience workforces	20
6.4 Addressing stigma	21
6.6 International workforce.....	22
7. Workforce innovation	22
7.1 Lived experience workforces	22
7.2 Integrated and multidisciplinary care	22
7.3 Mental health promotion/primary prevention and recovery	23
8. Rural and regional workforce	23
9. Other issues	24
9.1 Power dynamics, gender composition and diversity.....	24
9.2 Workforce attitudes and behaviours.....	25
9.3 System and cultural change	26
9.4 Monitoring and evaluation	26

1. Introduction

The [Women's Mental Health Alliance](#) (the Alliance) welcomes the opportunity to make a submission to inform the development of the National Mental Health Workforce Strategy. This submission has been drafted by Women's Health Victoria (chair of the Alliance) with input from members of the Alliance. We are happy to elaborate further on our submission or provide additional information upon request.

1.1 The need for workforce development and reform

The pressure on the mental health system arising from increased demand associated with COVID-19 restrictions, combined with an ambitious mental health reform agenda at both the national and state level (in Victoria), mean there has never been a more important time to ensure there is an appropriately skilled mental health workforce of sufficient size to promote the mental wellbeing of all Australians and to support those experiencing mental ill-health.

Further, the success of almost every mental health reform underway at both state and national levels fundamentally depends on the availability of an adequate supply of skilled workers, which is currently sorely lacking. The extent to which the mental health system can uphold human rights – a central pillar of Victorian mental health reforms – is dictated by the availability of skilled, sufficient workforce.¹ At the same time, reforms in related sectors, such as family violence and disability, are creating competition for skilled social services workers.

Our expectations of mental health services and the mental health workforce are also changing – there is a push towards a more expansive conceptualisation of mental health and wellbeing that moves beyond the medical model to address social risk factors and deliver integrated, multidisciplinary care, which centres lived experience, is genuinely trauma-informed and responds sensitively to the diverse needs of consumers.

A key challenge in mental health workforce reform is balancing the need to alleviate immediate demand pressures and workforce shortages, while at the same time de-centring old paradigms and shifting towards different ways of thinking and working. These priorities sometimes appear to be in tension with each other. **We urge the Taskforce to embrace both these priorities and consider creative solutions that will both bolster workforce supply and support innovation, through short- and long-term measures.**

1.2 About the Women's Mental Health Alliance

The Alliance was established by Women's Health Victoria in 2019. It is made up of more than 35 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. The Alliance brings together consumer and carer advocates, service providers, clinicians, women's health organisations, human rights bodies and researchers.

1.3 Our approach to this submission

This submission is structured according to key workforce issues raised in the consultation paper. We have indicated which **Consultation Questions** are most relevant to each section of the submission.

We begin the submission 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 submission.

For ease of reference, we have broken down the National Mental Health Workforce Strategy Taskforce's definition of the mental health workforce into three tiers, as outlined in Section 4 of this submission, and this terminology is used throughout the submission.

2. Summary of recommendations

The National Mental Health Workforce Strategy should:

1. Balance the need to alleviate immediate demand pressures and workforce shortages with the need to de-centre old paradigms and shift towards different ways of thinking and working through consideration of creative solutions that will both bolster workforce supply and support innovation, through short- and long-term measures.

Defining the mental health workforce

2. Expand the definition of the mental health workforce to include health promotion workers (as 'Tier 4' of the workforce).
3. Think creatively about the role communities can play in primary prevention, for example through the development of 'community connector'-type workers, including 'cultural connectors'.
4. Explicitly include the family and sexual violence response workforce in the definition/list of mental health workforces ('Tier 3').
5. Include a strong focus on community mental health and psychosocial support/wellbeing workers.
6. Recognise workforces working with specific population groups (such as migrant and refugee communities or LGBTIQ+ communities) in non-mental health specific roles or organisations as part of the broader mental health workforce ('Tier 3').

Workforce capabilities

7. Recognise intersectional gender competence as a priority capability for the mental health workforce.
8. Support the development of a national capabilities framework or frameworks that clearly identifies the required capabilities for different parts of the mental health workforce (similar to the approach taken in Victoria's Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)).
9. Ensure the national 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.
10. Prioritise capability-building for general health workers ('Tier 2') in mental health and responding to family and sexual violence.
 11. Significantly strengthen Actions 4.2.1 and 4.2.2 to ensure that:
 - a. 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);
 - b. prevention, early intervention, referral and support for recovery are considered core skills for 'Tier 3' mental health workers (i.e. social services workers) and supported through both pre-service and in-service training.
 12. 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.
 13. Ensure the implementation of a national capabilities framework or frameworks is supported by: standardised pre-service and in-service training; practice guidance ; organisational leadership; and resourcing.
 14. Support investment in pre-service and in-service training in gender-responsiveness, responding to sexual violence, and gender-responsive trauma-informed practice.
 15. Review family violence training initiatives for mental health workforces across the country to identify gaps and promising initiatives to ensure that all mental health workforces receive appropriate training in family violence.
 16. Establish a sector capacity building role (in each state and territory) 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.

Workforce attraction and retention

17. Address under-resourcing of the mental health sector as a critical aspect of workforce attraction and retention.
18. Improve workplace 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.
19. Invest in the skills and supports needed by workers with lived experience so that they can flourish in the workplace.
20. Address underlying workplace conditions as key to addressing stigma and negative perceptions of mental health work.

21. 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; and developing more direct pathways into mental health nursing.
22. Review work restrictions for international workers and international students to expand the pool of mental health workers.

Workforce innovation

23. Recognise the importance of the full integration of consumer and carer lived experience workforces at all levels as critical to workforce and service innovation.
24. Consider opportunities to develop cross-sector placements to promote cross-disciplinary training and professional development and to support workers across different sectors to be able to provide or facilitate more holistic and integrated care.
25. Address barriers to integrated and multidisciplinary care including: prescriptive funding models and contracts that inhibit innovation; restrictive scopes of practice and industrial barriers; and structures that do not enable sharing of innovative practice, for example, across regional boundaries.
26. Think creatively about opportunities for innovation in mental health promotion and draw on promising practice from the prevention of violence against women sector in place-based, collective impact approaches.

Rural and regional workforce

27. Apply a rural and remote lens to workforce development issues from the outset.
28. Develop a more comprehensive approach to incentives that considers housing, educational opportunities and partner employment.
29. Consider creative and innovative approaches to building the rural workforce, including drawing on local communities.
30. Address the lack of culturally safe services for Aboriginal and Torres Strait Islander people in rural communities.
31. Address barriers to recruitment and retention including prescriptive funding models and restrictive scopes of practice.

Other issues

32. Include measures to address diversity, 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).
33. Include measures to increase the representation of women and lived experience workers in senior roles.

34. Include measures to actively increase the diversity of the mental health workforce.
35. Expand the membership of the Taskforce to include representatives from diverse population groups (in addition to Aboriginal and Torres Strait Islander representatives).
36. Collaborate with the National Mental Health Commission in the development of the forthcoming National Stigma and Discrimination Reduction Strategy to 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.
37. 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 learning.
38. 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.

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,² and women are approximately twice as likely as men to suffer from a mental illness. For example, Australian data show:³

- 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)
- 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.⁴

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 distress⁵ and have been presenting with self-harm and suicidal behaviours at increasing rates over the last decade.⁶ 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.⁷ 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.⁸

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-born women, with race and gender inequality, violence against women, settlement stress and trauma all playing a role.⁹

Despite this, gender and women's mental health are not routinely considered as part of mainstream mental health policy or practice,¹⁰ 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.

Having appropriately skilled mental health workforces that are 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, is essential for improving the mental health and wellbeing of Australian women and girls.

4. Defining the mental health workforce

This section addresses Consultation Questions 1-3.

A critical starting point for the development of a national mental health workforce strategy – and one of the Terms of Reference for the National Mental Health Workforce Strategy Taskforce – is to define the mental health workforce.

The Consultation Draft effectively identifies three categories or tiers of the mental health workforce:

- 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)”

However, the Alliance has identified several critical gaps in this definition, in particular:

- The definition does not include the primary prevention/mental health promotion workforce;
- Intersections with gendered violence are not recognised – for example, family/sexual violence response workers are not recognised as part of the intersecting Social Services Workforces in Figure 1.1;
- The definition needs to better articulate and support the role of community mental health/psychosocial support/wellbeing workers, including those based in not-for-profit organisations;
- Workforces working with specific population groups also need to be recognised as part of the broader mental health workforce – for example, youth workers, organisations/workers working with migrant and refugee populations, LGBTIQ populations etc.

4.1 Primary prevention workers

Primary prevention of mental ill-health (or promotion of mental health and wellbeing) is almost entirely absent from the Consultation Draft. While prevention is mentioned as a key part of supporting Australians to be mentally well (p. 4), the primary prevention workforce is missing from both the Aim of the strategy articulated on page 5 of the Consultation Draft – which focuses on meeting people’s ‘support and treatment requirements’ – and from the definition of the ‘mental health workforce’ on page 3 (and Figure 1.1).

As outlined in the Introduction to this submission, 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. We refer the Taskforce to VicHealth’s *Evidence review: The primary prevention of mental health conditions* (2020) which 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.¹¹

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 'contributors' (who contribute to this work as part of a broader role)¹² and a workforce development strategy is currently in development.

The role of carers, families and communities (including community leaders and 'social connections') in contributing to primary prevention/mental health promotion also needs to be better articulated and strengthened (see Figure 1.1). The Royal Commission into Victoria's Mental Health System placed a strong emphasis on place-based approaches to mental health promotion and the importance of social connection.¹³ **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.¹⁴

4.2 Family and sexual violence response workers

While we recognise that the list of Social Services Workforces in Figure 1.1 is not intended to be comprehensive/exclusive, **the Alliance recommends that the family and sexual violence response workforce be explicitly included in the definition/list of mental health workforces ('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.¹⁵ 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 5.3 of this submission.

4.3 Community sector workers

Workforce planning must consider the whole mental health sector, including workers based in community organisations/non-government/not-for-profit organisations. **There must be a strong focus in the National Mental Health Workforce Strategy on community mental health and psychosocial support/wellbeing workers.** These workers are critical to the delivery of innovative workforce and service delivery models, including integrated and collaborative approaches to care and support. Without an adequate supply of these workers, workforce reform will fail.

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'). 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.¹⁶

5. Workforce capabilities

This section addresses Consultation Questions 1, 3, 7, 9 and 10.

The Alliance notes that the Consultation Questions do not specifically address *Objective 4: The mental health workforce is appropriately skilled*. However, we believe capability-building for the mental health workforce in trauma-informed, gender- and culturally responsive care and support – as well as gender-informed mental health promotion – is critical to achieve the Aim of the Strategy “to develop an appropriately skilled mental health workforce of sufficient size that is suitably deployed to help Australians be mentally well by meeting their support and treatment requirements at the time and in the way that best meets their needs”. In this section we address this objective as well as issues related to integrated and multidisciplinary care, flagged in Question 9.

The Alliance strongly supports Action 3.1.2 “to define the competencies required by the mental health workforce to deliver the components of care” and **we would be keen to contribute our expertise to this work**. We also support the Consultation Draft’s recognition of the need for the mental health workforce to have contemporary skills to support “recovery-oriented, trauma-informed, person-centred and culturally safe support and treatment” (p. 19). However, we note that the Draft does not provide any further detail about what this means or requires, nor does it recognise the need for the mental health workforce to provide gender-responsive care and support.

The Background Paper rightly recognises the need for inclusive and culturally safe services for Aboriginal and Torres Strait Islander peoples, LGBTIQ+ and CALD communities (p. 24), but does not recognise the need for gender-safe and responsive services. However, as outlined in the Introduction to this submission, 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**. We set out below some of the key competencies – or capabilities – that are required by the mental health workforce to ensure it meets the needs of women and girls, including those who are victim-survivors of gendered violence.

5.1 A national capabilities framework or frameworks

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

1. the type of worker
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 ('Tier 2' and 'Tier 3') 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.

In Victoria, the 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 national 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 national capabilities framework or frameworks for the mental health workforce effectively in section 5.3 of this submission.

5.2 Capabilities required by mental health workers

The national capabilities framework or frameworks recommended by the Alliance must include the following elements:

1. **Intersectional gender competence**,¹⁷ 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;¹⁸
 - Capacity to recognise and address gender-based discriminatory attitudes and behaviours (see also Section 9.2 of this submission);
 - Implementing actions to counter gender bias and gendered attitudes, stereotypes and inequalities in research, training and clinical practice (see also Section 9.2); 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.¹⁹

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

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.²⁰

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;²¹
- 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;²²
- Align with principles underpinning trauma-informed practice (explored below).

Initiatives implemented following the Victorian 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*. These initiatives warrant further investment and rollout to mental health and health workforces beyond Victoria.

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 the National Mental Health Workforce Strategy Taskforce has been tasked with considering “the application of trauma-informed care and practice at the organisational and individual practitioner level within mental health services” (Terms of Reference, p. 2). However, this is not addressed in the draft strategy.

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 experiences of gendered violence, including family and sexual violence.²³ 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.²⁴

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.²⁵

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.²⁶

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.²⁷

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.²⁸

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,²⁹ and leads to specific mental health impacts:

- **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.³⁰
- **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:³¹

- 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;³²
- 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,³³
- Extend beyond individual practice to the whole organisation 'from the environment to the reception staff';³⁴ and
- 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).³⁵

4. Capability in culturally responsive practice

It is also important to ensure that health workers 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 into Victoria's Mental Health System 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). These recommendations should be adopted nationally. 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.³⁶ Recognising this, the Royal Commission into Victoria's Mental Health System has recently recommended that all new and existing mental health facilities be upgraded to enable gender separation (Recommendation 13). 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.

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

As highlighted in Section 4.1 of this submission, primary prevention/mental health promotion is a major gap in the Consultation Draft.

In addition to building the gender competence of mental health practitioners, it is essential that any national workforce strategy and capability framework(s) incorporate a strong focus on building capability within the health promotion workforce 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.

5.3 Capability-building in mental health for general health workers

Action 4.2.1 in the Consultation Draft is to: “Invest in training initiatives to support the development of basic mental health skills in the social services workforce” and Action 4.2.2 is to: “where feasible, include development of basic mental health skills in pre-service training for people in roles where they are likely to treat, interact with or support people experiencing suicidality, mental distress and/or ill-health”. **The Alliance recommends Actions 4.2.1 and 4.2.2 be significantly strengthened to ensure that:**

- 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);
- prevention, early intervention, referral and support for recovery are considered core skills for ‘Tier 3’ mental health workers (i.e. social services workers) and supported through both pre-service and in-service training.

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.³⁷

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

As noted in Section 5.2.2 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.

5.4 Training and support for capability-building

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 outlined in Section 5.2 and 5.3, according to their role, including for first contact, managerial and executive roles – specific training gaps and needs are outlined below
- **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
- **Resourcing**, including for adequate professional supervision and to enable staff undertaking professional development to be backfilled.

Capability-building will also need to be responsive 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.

Training

Currently, very little if any pre-service or in-service training is available for the mental health workforce 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 5.2.2 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 across the country 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 (perhaps in each state and territory) 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 risk assessment and management frameworks (such as the MARAM in Victoria). 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 Section 5.2.3, 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). **The Alliance recommends that training in gender-responsive trauma-informed practice be developed**, for example as a partnership between a mental health training provider and experts in gender and trauma.

6. Workforce attraction and retention

This section addresses Consultation Questions 5 and 6.

This submission addresses the issues of workforce attraction and retention together as they are effectively ‘two sides of the same coin’. We address six key issues identified by the Alliance:

- Funding
- Pay and conditions
- Lived experience workforces
- Addressing stigma
- Training and career pathways
- International workforce

“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

6.1 Funding

The Alliance believes that workforce 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.

Consideration also needs to be given to the allocation of resources across the public and private mental health sectors. For example, eligibility for Medicare rebates drives demand towards certain services/practitioners. Funding and policy decisions can also have unintended consequences: for example, the recent increase in the number of Medicare-funded sessions under a Mental Health Treatment Plan from 10 to 20 has had the perverse effect of reducing access to mental health support by limiting access for new clients. A bottleneck in the private system then creates huge demand for the public mental health system.

6.2 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.³⁸ The ORIMA workforce survey also found that 43% of mental health workers had personal lived experience of mental health conditions.³⁹ 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,⁴⁰ 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.

6.3 Lived experience workforces

The Background Paper points to a critical shortage of peer mental health workers (p. 15). This is closely linked to workplace pay and conditions as there is a high degree of interest among people

with lived experience to become peer workers, but a shortage of attractive employment options. Once again, this is a gendered issue as the majority of the lived experience workforce is female.

Lived experience roles tend to be short-term, part-time and offer limited opportunities for career progression. 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 (as outlined further in Section 9.1). 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.⁴¹

6.4 Addressing stigma

The Alliance supports the Consultation Draft's focus on addressing stigma and negative perceptions associated with working in mental health. We note that much of the stigma associated with working in mental health relates to the stigmatisation of people experiencing mental illness and psychological distress, which highlights the importance of linking these efforts to the forthcoming National Stigma Reduction Strategy.

The Alliance also notes that much of the stigmatisation and poor human rights outcomes for consumers in mental health services arises from workforce issues. For example, the section of the Consultation Draft on improving occupational safety (Priority Area 5.3, p. 28) is largely focused on infrastructure and ensuring treatment is provided in a 'suitable environment' (Action 5.3.1). However, this downplays the critical importance of ensuring the workforce has the time, resources and training to work through alternatives to traumatising and coercive interventions (such as compulsory treatment and restrictive interventions), as well as the importance of expanding the range of services available so that people can access appropriate services *before* they become acutely unwell.

Reducing the stigma and negative 'perceptions' associated with working in mental health is also linked to workplace conditions. It is not simply a perception that mental health is not an attractive work option; mental health services are *actually* less attractive places to work than other health settings. This means that **addressing stigma and negative perceptions of mental health work requires underlying workplace conditions to be addressed.**

6.5 Training and career 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:

- The mental health sector must be funded to provide **student placements and graduate positions**, and this must include the resourcing required to support these positions. 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 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.
- 'Tier 3' (social services) workforces can be upskilled 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 'Tier 3' 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](#).
- 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.

6.6 International workforce

The Alliance recommends that work restrictions for international workers and international students be reviewed 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.

7. Workforce innovation

This section addresses Consultation Questions 7 and 9.

The Alliance supports the focus in the Consultation Draft on encouraging innovation in service delivery models and workforce optimisation approaches. This is essential both to deliver high quality services that meet consumer needs and to address workforce shortages.

7.1 Lived experience workforces

The Alliance emphasises the importance of the full integration of consumer and carer lived experience workforces at all levels as critical to workforce and service innovation. The need to centre the voices of people with lived experience is central to the recommendations of the Royal Commission into Victoria's Mental Health System. Consumers and carers must be included in workforce development conversations not only as representatives of their own experience of the service system, but also as lived experience workers. In Section 6.3, we have outlined some of the considerations for building the lived experience workforce and, in Section 9.1, we have highlighted the importance of addressing power imbalances to support genuine integration of these workforces.

7.2 Integrated and multidisciplinary care

The Alliance supports proposed Action 4.1.1 to develop training modules that build skills for the provision of integrated and multidisciplinary care. Women consistently ask for a more holistic

approach that addresses mental health within the broader context of their lives.⁴² 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'.⁴³ 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.

Similarly, **the Alliance highlights the importance of integrated and collaborative approaches across sectors**, including strong collaboration and warm referrals with the family violence and sexual assault response, housing and homelessness, and alcohol and other drug sectors ('Tier 3' workforces). **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 be able to provide or facilitate more holistic and integrated care.**

Barriers to integrated and multidisciplinary care will need to be addressed including:

- Prescriptive funding models and contracts that inhibit innovation
- 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.

7.3 Mental health promotion/primary prevention and recovery

A further opportunity for innovation is in mental health promotion/primary prevention and recovery. Mental health promotion is an underdeveloped field with huge potential for innovation. For example, as outlined in Section 4.1, there is ample scope to think creatively and develop new types of roles and workers, such as 'community connector'-type roles that link people into supports within their local community, facilitating the human connection that underpins wellbeing and recovery.

There are also opportunities to draw on promising practice from the prevention of violence against women sector in place-based, collective impact approaches to develop locally-relevant, gender-informed approaches to the primary prevention of mental ill-health.⁴⁴

8. Rural and regional workforce

This section of the submission addresses Consultation Question 8.

Rural and remote areas struggle to attract and retain the workforce needed to deliver sufficient services to meet demand, even in the private sector. **A rural and remote lens must be applied to the National Mental Health Workforce Strategy from the beginning and not as an afterthought;**

the complexities of building the rural workforce need to be at the forefront of service design and workforce development.

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.**

Creative and innovative approaches to building the rural workforce also 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.

The lack of culturally safe services in rural communities also needs to be addressed, from both a supply and a capability perspective, so that Aboriginal and Torres Strait Islander people who want to be treated on Country within their communities do not have to travel to metropolitan areas.

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.

Greater visibility of the mental health workforce and an understanding of their different roles and responsibilities will also make it easier for rural communities to navigate mental health service options.

9. Other issues

This section addresses Consultation Questions 1, 3 and 10.

9.1 Power dynamics, gender composition and diversity

The National Mental Health Workforce Strategy must take steps to address diversity, 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). The devaluing of lived experience and non-clinical workforces is also linked to discrepancies in pay and conditions.

Yet again this 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.⁴⁵ **Not only must we therefore increase the representation of women and lived experience workers in senior roles, but we must 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.

The Strategy must also include measures to actively increase the diversity of the mental health workforce, including bicultural and bilingual community mental health and support workers. The Ethnic Communities Council of Victoria and Victorian Transcultural Mental Health recommend

setting targets for higher workforce mutuality within the mental health sector i.e. 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.⁴⁶

Diversity is also a major gap in the composition of the Taskforce; other than Aboriginal and Torres Strait Islander people, no other population groups are represented.

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.

9.2 Workforce attitudes and behaviours

The National Mental Health Workforce Strategy Taskforce must collaborate with the National Mental Health Commission in the development of the forthcoming National Stigma and Discrimination Reduction Strategy to 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.

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 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.⁴⁷ 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.⁴⁸ 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.⁴⁹ 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.⁵⁰

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.⁵¹

Given the broad definition of the mental health workforce adopted by the Taskforce, 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.⁵²

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.⁵³ 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.

9.3 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 learning.**

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.⁵⁴ 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.

9.4 Monitoring and evaluation

The National 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 submission such as integration of the lived experience workforce, increased capability in intersectional gender-responsive care, workforce diversity and expansion of integrated and multidisciplinary care.**

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