THE VICTORIAN SUICIDE PREVENTION AND RESPONSE STRATEGY

WOMEN'S HEALTH GOULBURN NORTH EAST SUBMISSION
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Contact: Women's Health Goulburn North East
Policy and Advocacy Coordinator

whealth@whealth.com.au

Acknowledgements

Women's Health Goulburn North East acknowledges the wisdom, living culture and connection of the Traditional Custodians of the unceded lands on which we work, and acknowledge the profound disruption of colonisation and the Stolen Generations on Aboriginal and Torres Strait Islander peoples. We also respect the self-determination of First Nations people.

We are intersectional in our approach and are proud to stand beside generations of great women whose work has brought us closer to equality for all. We believe in shared and just cultural transformation that embraces diversity, and these acknowledgements are part of the ethical principles that guide our work and conduct.

About Women's Health Goulburn North East

Women's Health Goulburn North East (WHGNE) is a proudly feminist organisation supporting the creation of equal, just, and resilient communities in rural and regional Victoria. We believe in shared and just cultural transformation and locate our work within an ecosystem of broad global alliances working across social movements.

Gender and climate justice sit at the heart of our work, and the urgency of addressing what have become existential crises is what propels us to extend our vision beyond reformative tweaks to inadequate existing systems, towards unapologetically bold and truly transformative change. Our submission draws on the work of women's movements across the globe.

Although we are grappling with the devastating impacts of the COVID-19 pandemic within our communities, we continue to work in solidarity to co-create a vision for the future in which women and children in Australia not only live free from violence, but enjoy equality, justice, respect, and care as members of a society that has actively dismantled systems of oppression, inequality, and discrimination.

About WHGNE

WHGNE is a proudly feminist organisation supporting the creation of regional and rural Victorian communities that centre intersectional equity, care, wellbeing and safety. We view the world through a prevention lens and work according to a social determinants framework to address the root causes of gender inequality and gendered discrimination, exclusion, oppression and violence.

Our vision is that, "Rural and regional women of all ages have optimal health and wellbeing."

We're pleased to have the opportunity to consider this discussion paper in the context of this vision, and to bring our perspective and experience as a regional gender equity organisation to discussions around the creation of a new Victoria suicide prevention and response strategy. Our experience in health promotion and primary prevention means we approach this submission with a focus on prevention, even as we recognise its inextricable links to response and post-vention work.

In submitting this response, we encourage government to refer to submissions to the Victorian Government's Parliamentary Inquiry into Mental Health and Suicide Prevention[1] and the Summary Report from the Victorian Mental Health and Wellbeing Workforce Strategy Forum[2] by the Women's Mental Health Alliance, of which WHGNE is a member. Both submissions illustrate the importance of understanding gender as a key determinant of mental health and wellbeing, and provide powerful insight into the need for a thorough understanding of intersectionality in order to affect change that truly responds to the lived experience and needs of Victorians, notably Victorian women.

It is with this notion of intersectionality that we would like to begin our submission, as it relates directly to the strategy's commitment to a systems approach to suicide prevention.

[1] Women's Mental Health Alliance, 2021, Submission to the Victorian Government's Parliamentary Inquiry into Mental Health and Suicide Prevention. https://womenshealthvic.com.au/resources/WHV_Publications/WMHA-Submission_2021.08.20_Parliamentary-Inquiry-into-Mental-Health-and-Suicide-Prevention_(Fulltext-PDF).pdf

[2] Women's Mental Health Alliance, 2021, Victorian Mental Health and Wellbeing Workforce Strategy Forum Summary Report: Response from the WMHA. https://womenshealthvic.com.au/resources/WHV_Publications/WMHA_Submission_2021.10.25_Victorian-Mental-Health-Workforce-Forum-Summary-Report_Oct-2021_(Fulltext-PDF).pdf

Intersectional equity and the social justice imperative

We're pleased to see that the discussion paper recognises the critical role of an intersectional perspective to this work (p24). However, we would like to see the strategy do greater justice to the focus that intersectionality theory can bring to the power structures and interconnecting social, economic, political and cultural systems that underlie individual and community identities.

The discussion paper brushes over the way these systems can influence the contributing or protective factors that people experience when it comes to suicide, suicidal distress and the ripple effect of suicide in communities.

It is critical that this strategy does not fall into the trap of viewing intersectional identities merely as "priority" or "target" populations, or as a stand-in for the recognition of "community diversity". Instead, it must acknowledge that intersectional identity categories related to gender, sexuality, race, ethnicity, indigeneity, ability, age, life stage, geography, migration status, religion, for example, are "mutually shaped and interrelated with broader historical and global forces such as colonialism, neoliberalism, geopolitics, and cultural configurations to produce shifting relations of power and oppression."[3]

This potential to analyse power and challenge oppression is intersectionality's greatest gift to strategies like this, which seek to affect system change. Indeed, with its focus upon power and oppression, intersectionality theory, when translated into practice, requires a commitment to social justice[4], which we believe must be noted among this strategy's priority principles (see "Priority principles").

The effective application of intersectionality theory offers this strategy the potential to identify and address the way power and oppression may contribute to, or protect against, suicidal distress, by illuminating "hidden structural barriers and support(ing) an understanding of how individual experiences differ, even within already marginalised or underrepresented groups."[5]

WHGNE recognises the attempts this discussion paper makes at employing intersectionality in its descriptions of priority groups (p25-27), however nowhere in this discussion are the intersections between the social forces that contribute to the risks experienced by these priority groups named, expressly discussed or highlighted. For intersectionality theory to be effective and meaningful in this context, the discussion paper and any strategy that emerges from it must name the oppressive systems that contribute to risk of, or protect against, suicidal distress.

[3] Rice, C., Harrison, E., & Friedman, M. (2019). Doing justice to intersectionality in research. Cultural Studies <-> Critical Methodologies. https://doi.org/10.1177/1532708619829779

[4] Ibid

[5] UN PRPD and UN Women. (2022). Intersectionality Resource Guide and Toolkit: An Intersectional Approach to Leaving No-one Behind. https://www.unwomen.org/sites/default/files/2022-01/Intersectionality-resource-guide-and-toolkit-en.pdf

To provide an example, we would like to highlight references to the contributing factors to suicidal distress and behaviour among women, although we encourage government to engage the lived experience, knowledge and expertise of other relevant organisations in the state to explore other "priority groups" in similar intersectional detail as it sets about preparing the strategy.

The discussion paper rightly highlights domestic violence - with its related impacts upon women's health, wellbeing, social connections, economic security, housing security and employment - as a contributing factor to suicidal distress among women. However, we recommend that the strategy emphasise the undercurrent of gender inequality that drives gender-based violence, and that ripples throughout the social, justice, health and neoliberal economic systems that shape women's lives and necessitate or influence their experiences with the health, mental health and social sectors. An intersectional lens demonstrates that gender inequality, as a driver of gendered violence, can be compounded by regionality and its associated service challenges, punitive neoliberal welfare systems that further entrench women's economic insecurity and gendered burdens of care.

On the other hand, it is crucial the strategy recognises the protective factors offered by gender equity, particularly for women. Detailed discussion of such protective factors, across "priority groups" is notably absent from this paper. Global research demonstrates a link between gender equity and reduced rates of suicide among women.[6] Gender equity offers women "multiple social roles" that enable them to "develop and consolidate economic and social resources," providing life meaning, social connection and tangible economic capacity and security.[7] Furthermore, increased gender equity has the potential to influence the responses women receive from health and social support services.

Paradoxically, while global research shows men and boys also benefit from gender equity, research suggests there is "no clear evidence that within-country changes in gender equality is associated with within-country changes in suicide rates" for men.[8] Qualitative research conducted in Macedon, Victoria, is instructive here.[9] Men in regional areas, such as Macedon, have a higher risk of suicide than men in urban areas, with this research demonstrating links between forms of masculinity that idealise stoicism, toughness and a hesitancy to seek support in the face of adversity, and poor mental health.[10] To make inroads into the higher risk, and rates, of suicide among men, gender equality efforts must include the dismantling of cultural expectations of masculinities that deter some men from seeking or offering emotional support, particularly across regional and rural Victoria where formalised support structures may be lacking or difficult to access. Gender equality must *then* include concerted efforts to promote

[6] Milner, A., et al, 2020. Shifts in gender equality and suicide: A panel study of changes over time in 87 countries. Journal of Affective Disorders, 276, 495-500.
https://www.academia.edu/43767715/Shifts_in_gender_equality_and_suicide_A_panel_study_of_changes_over_time_in_87_countries
[7] Ibid
[8] Ibid
[9] Trail K, et al, 2021. Promoting Healthier Masculinities as a Suicide Prevention Intervention in a Regional Australian Community: A Qualitative Study of Stakeholder Perspectives. Front. Sociol. 6:728170., https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8692245/pdf/fsoc-06-728170.pdf
[10] Ibid

the creation and modelling of alternative modes of masculinities, such as those that promote interdependence and care.[11]

Our colleagues at the Multicultural Centre for Women's Health have undertaken detailed research that further demonstrates the interplay between gender inequity and interpersonal and systemic racism, and the harmful influences this particular intersection has on the mental health and wellbeing of migrant and refugee women.[12] Regionality adds an additional overlay of stressors and barriers for migrant and refugee women, with visa discrimination, resettlement stress, language barriers, lack of access to culturally safe provision of services and support, as well as the privacy concerns and stigma associated with seeking support in regional communities, compounding this negative impact for these women.[13]

To be truly intersectional, the strategy must consider the impacts of gender inequity in its overlaps with the aforementioned social forces and the ways these intersections play out across health care, criminal justice, education, housing, employment and the media – among other settings - to drive the individual, relational, community and societal contributing and protective factors listed in the discussion paper.

Vision

1a. The Royal Commission suggested 'towards zero suicides' as a vision for the strategy. Is this appropriate? (Yes/No)

WHGNE considers this an appropriate starting point for a strategic vision, as it highlights the preventable nature of suicide. The ambitious nature of a "towards zero" vision may increase suicide awareness among sectors, services, workplaces and community members beyond those immediately touched by the ripple effect of suicide. We believe it may also serve to mobilise greater resourcing and support of suicide prevention work and programs in community.

However, we would like to emphasise that a "towards zero" vision necessitates radical and holistic socio-structural change. A "towards zero" vision cannot exist without government commitment to a raft of policies across portfolios and budgetary decisions that centre social justice, wellbeing, connection and intersectional equity. Nor can it exist without community efforts to challenge harmful social norms and values.

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[11] Elliott, K., 2016, Caring Masculinities: Theorizing an Emerging Concept, Men and Masculinities 2016, Vol. 19(3) 240-259, https://uwethicsofcare.gws.wisc.edu/wp-content/uploads/2020/03/Elliot-Caring-Masculinities.pdf

[12] Multicultural Centre for Women's Health, 2020, Policy Brief: Immigrant and Refugee Women's Mental Health, https://www.mcwh.com.au/wp-content/uploads/MCWH-Policy-Brief_Mental-Health-.pdf

[13] Hawkes, C., et al, 2021. Individuals of refugee background resettled in regional and rural Australia: A systematic review of mental health research. https://www.researchgate.net/publication/355454568_Individuals_of_refugee_background_resettled_in_regional_and_rural_Australia_A_systematic_review_of_mental_health_research

Furthermore, without dedicated, co-designed resourcing and support of those communities and sectors focused upon suicide prevention, response and post-vention, the “towards zero” vision may come to be damaging,[14] imposing a burden of expectation upon social and health workers who are already stretched and burnt out in an under-resourced, centralised and over-bureaucratised sector. We are particularly concerned about this burden because evidence demonstrates the gendered dynamics of the social sector - almost 90 per cent of workers are women.[15] As with other women-dominated fields involving the care of others, this work is already unequally distributed, poorly remunerated and culturally and economically undervalued.[16] As such, burn-out and vicarious trauma associated with community-wide expectations of the achievement of “zero suicides” is likely to be disproportionately borne by women.

We are also concerned the "toward zero” vision might privilege “outcome” over “process”, implying the need for paternalistic, coercive healthcare measures[17] that may deter those experiencing suicidal distress from seeking support or openly discussing their experiences.

With these concerns in mind, this ambitious vision must be embedded in a statement that emphasises the need for radical structural and cultural change to reshape systems in ways that enable people to live hopeful, healthy, empowered and connected lives.

WHGNE recommends the strategy’s vision include a statement akin to the following:

> ***“Caring, connected, equitable and healthy communities working together towards zero suicides.”***

Priority populations

We appreciate the inclusion of “priority groups” in this paper, but we urge the strategy authors to further refine this population information to ensure it reflects the complexity and nuanced power relationships that underlie these intersectional identities. The strategy must also detail the specific intersectional protective factors that relate to each of the priority groups, information that is completely lacking in this iteration of the discussion paper, which only describes risk factors for priority populations (p25).

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[14] Karlsson, P,. *et al.* Skepticism towards the Swedish vision zero for suicide: interviews with 12 psychiatrists. *BMC Med Ethics* **19**, 26 (2018). https://doi.org/10.1186/s12910-018-0265-6

[15] Tradewind Australia, 2020, Gender Equality in the Social Work Sector: The State of Play, https://www.twrecruitment.com.au/blog/2020/02/gender-equality-in-the-social-work-industry-the-state-of-play?source=google.com

[16] Workplace Gender Equality Agency, Unpaid Care Work and the Labour Market. https://www.wgea.gov.au/sites/default/files/documents/australian-unpaid-care-work-and-the-labour-market.pdf

[17] Karlsson, P., et al. Skepticism towards the Swedish vision zero for suicide: interviews with 12 psychiatrists. *BMC Med Ethics* **19**, 26 (2018). https://doi.org/10.1186/s12910-018-0265-6

To echo our opening remarks, intersectionality theory has much to offer this analysis, illuminating the barriers to "priority populations" enjoying the protective factors (p12) of connection, social support, positive relationships, safe and inclusive work and educational environments, meaningful and life-supporting employment, self-determination, cultural connection and spirituality, compassion, appropriate and secure housing, and culturally safe service provision.

To provide just one example of this, the discussion paper lists "family and relationship issues, domestic violence, cultural expectations and eating disorders" as contributing factors to suicidal distress experienced by women. Recognising the unique intersections of gender inequality, stereotyping and patriarchy with other forms of power and oppression across various settings in community, can give rise to the promotion and strengthening of a host of protective factors for women – from the economic security and life satisfaction that comes from equally paid and valued jobs, to strong, respectful and caring relationships, to gendered health and mental health services that offer trauma-informed, person-centred care.

We would also like to recommend the inclusion of "carers" in the priority group data, in recognition of the unique gendered dynamics of care work (whether formal or informal) and the need for specialised and tailored support for carers.

Griffith University research conducted in 2014 reported a "small but significant" proportion of women in unpaid care roles experienced suicidal thoughts (seven per cent) compared to non-carers (5.7 per cent).[18] Contributing factors to suicidal thoughts among women carers include limited social support, poor mental health and depression, and for some, dissatisfaction with the caring role. Critically for the purposes of this strategy, carer dissatisfaction is a "potentially modifiable risk factor,"[19] which presents government and community with opportunities to prioritise initiatives that support, resource and value carers and strengthen and improve services for those who are being cared for.

Priority areas

WHGNE endorses the following priority areas mentioned in the discussion paper:

• lived experience partnerships

• self-determined Aboriginal suicide prevention

• intersectional and targeted approaches for groups disproportionately affected by suicide

• data and evidence to drive outcomes

[18] O'Dwyer, S.T, et al, 2014. Feeling that life is not worth living (death thoughts) among middle-aged, Australian women providing unpaid care, https://doi.org/10.1016/j.maturitas.2014.01.013

[19] Ibid

• workforce and community capabilities and responses

• whole-of-government leadership, accountability and collaboration

• a responsive, integrated and compassionate system.

We believe there is merit in also including the following priority areas:

- **Advocacy for policy change, and policy change** at all levels of government, to disrupt and reimagine the structural factors that contribute to poor mental health, suicidal distress, thinking and behaviour (for instance, gender inequality, economic insecurity and poverty, racism, homelessness, involuntary unemployment, rural/regional isolation) and strengthen the protective factors that reduce the likelihood or risk of suicidal distress. These protective factors may include:
  - the realisation of gender equity in community and education settings, workplaces and government to eliminate discrimination, engender respect for gender diversity, dismantle harmful models of masculinity and create and model "caring masculinities", enable people to live their authentic lives, prevent gender-based violence and create opportunity and a sense of belonging for all. WHGNE notes that the implementation of the Gender Equality Act 2020 has spear-headed this work among defined public entities across Victoria, and we recommend the strategy prioritises the strengthening and scaling of this work.
  - equitable, wellbeing-centred economic systems that include non-coercive social support payments that are adequate to cover basic needs;
  - public education investment, educational support and choice for young people, particularly in regional and rural areas
  - investment in digital equity measures to increase connection and access to support resources, particularly in regional areas;
  - Investment in regional public transport to increase connection and access to support services and resources;
  - The diversion of juveniles from detention and incarceration and investment in and resourcing of trauma-informed prevention, rehabilitation and community-connection programs in order to break the cycle of intergenerational trauma and build belonging and social support networks among young people;
  - broadening the eligibility criteria of people from migrant and refugee backgrounds to publicly funded healthcare;
  - a state government jobs guarantee, designed to address involuntary unemployment and provide gateways to meaningful, well-paid employment with good conditions.

- **Decentralised and empowered community-led partnerships** and peer-led prevention activities that promote community agency, inclusion, connection and accessibility through every stage of programming – from funding decisions to evaluation methods.

Principles for the development and implementation of the strategy

We endorse the five principles laid out in the discussion paper:

• valuing lived experience

• supporting equity and taking an intersectional approach

• supporting Aboriginal self-determination

• being adaptable and evidence-informed

• taking a person-centred approach

And would like to see the inclusion of these additional principles to guide the development and implementation of the strategy:

- **Commitment to social justice –** this principle flows from our above remarks around the implicit social justice imperatives of intersectionality, with its focus upon power and oppression. We agree – and hope we can inspire government agreement - with the statement that "it does intellectual disservice to coopt the parts of a theory that are compatible with existing structures and power relations...while ignoring aspects of the theory that orient to intervening in those structures and relations to liberatory ends."[20]

- **Commitment to optimal wellbeing for all -** this principle centres a universal, but intersectionally relative, right to wellbeing and the need for this to be prioritised in everything from government policy and budgeting, to community activity and health promotion.

- **Engendering collective responsibility –** this principle conveys the importance of a shared, whole-of-community and –government approach to suicide prevention, and supports the prioritisation of publicly funded and accessible infrastructure to support health and wellbeing.

[20] Rice, C., et al, 2019. Doing justice to intersectionality in research. Cultural Studies <-> Critical Methodologies. https://doi.org/10.1177/1532708619829779

- **Compassion –** this principle is supported by lived experience accounts[21] offered by people who interacted with the systems that should support and care for people experiencing suicidal distress or the ripple effects of suicide. These personal accounts demonstrate the need to centre empathy and compassion in our collective work to prevent suicide in our communities and the need to humanise our increasingly bureaucratic service systems.

- **Commitment to trauma-informed care –** this principle calls for an elevation of a focus on trauma and acknowledges that "the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing".[22] It prioritises the transformation of services, programs, and organisations so that they "realise the widespread impact of trauma and understand potential paths for recovery; recognise the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and respond by fully integrating knowledge about trauma into policies, procedures, and practices, and seek to actively resist re-traumatisation."[23]

- **Valuing the benefits of community-led approaches –** this principle relates to our experience of the work and effectiveness of community-led initiatives such as the Wangaratta-based Grit and Resilience Project. Core to the effectiveness of this project has been an understanding of the *readiness* of community for suicide prevention work, alongside the *need* for this work; the existing connections and cultural understandings that exist within community to give this work a solid foundation; and the hard work of designing a project towards sustainability (and obsolescence). Anecdotal evidence suggests to us that co-design and community-led approaches must begin with the funding and budgetary decisions that shape community-led approaches to prevention, to ensure that communities are able to truly design for the needs and priorities of community.

Suicide prevention and response initiatives and actions

As an organisation that is uniquely concerned with gender equity and the wellbeing benefits it offers to regional and rural women, gender-diverse people and their communities, WHGNE recommends the following initiatives be included in the strategy:

- The application of an intersectional lens to Victorian health and mental health research, strategies, initiatives, programs and workforce development to support the delivery of equitable, culturally safe, trauma-informed support, health and wellbeing across all Victorian

[21] Australian Government, 2020, Compassion First: Designing our national approach from the lived experience of suicidal behaviour, https://lifeinmindaustralia.imgix.net/assets/src/uploads/Compassion_First.pdf
[22] Substance Abuse and Mental Health Services Administration, 2014. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf
[23] Ibid

communities.

- The transformation of mental health service models away from patriarchal clinical practice towards healing-focused and trauma-informed models.

- Urgent measures to address the under-resourcing and cultural and economic under-valuing of health and mental health workforces (including social service workers, health promotion and primary prevention services), via improved conditions, gender equal pay for equal work, promotion and support of flexible working arrangements.

- The empowerment, support and resourcing, via secure, long-term funding, of community-led gender equity initiatives across all community settings to challenge gendered power imbalances, stereotypes and discrimination, and create, promote and model caring masculinities.

- The empowerment, support and resourcing of dedicated, community-led mental health, wellbeing and suicide prevention initiatives and partnerships. Particular care should be paid towards ensuring funding models and reporting requirements do not pose barriers to communities tailoring their initiatives to localised needs, priorities, readiness and capacity.

- Support and resourcing of gender equality and family violence prevention training across health and mental health services.

- Support people with lived experience to enter, contribute to, retain roles and feel valued within the social service, mental health and suicide prevention sectors.

- Expansion of the range of, and improved access to, integrated/multidisciplinary wellbeing services and initiatives in regional and rural Victoria. Services must be supported to work at the intersections of family violence, housing stress and homelessness, economic insecurity and involuntary unemployment, and other sectors.

- The expansion and mainstreaming of social prescribing initiatives, as recommended by the Royal Commission into Victoria's Mental Health System, across regional and rural Victoria, beyond the current trial sites.

- Anti-stigma initiatives that are particularly focused upon the health, mental health, legal and justice sectors, in recognition of ANROWs research demonstrating the negative gendered

impacts of raising mental health in Family Court matters involving child custody and contact.[24]

- Bilingual and bicultural education around mental illness and stigma for all communities and services as part of an intersectional approach to reducing stigma and dismantling the barriers to help-seeking in some migrant and refugee communities.

[24] ANROWS (2020). Violence against women and mental health. Australia's National Research Organisation for Women's Safety. Sydney – (ANROWS Insights, 04/2020). https://www.anrows.org.au/publication/violence-against-women-and-mental-health/

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