Drummond Street Services

Centre For Family Research & Evaluation

Mental Health at the Margins

Intersectional Toolkit for practitioners and service providers

Contents

Acknowledgement of Country

Drummond Street respectfully acknowledges the Kulin Nation as Traditional Owners of the lands where we deliver our services. We acknowledge Aboriginal and Torres Strait Islanders as the first people of Australia. Sovereignty was never ceded, and Aboriginal and Torres Strait Islanders remain strong in their connection to land, culture and in resisting colonisation.

Acknowledgement of contribution

Drummond Street would like to acknowledge and thank all the community members and practitioners who contributed to the development of this toolkit. Thank you for contributing your time, experience, knowledge and expertise.

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A note about language

Terminology about intersectionality, diversity and lived experience is constantly evolving and varies between communities, services, and sectors. Below is an overview of key terms used in this toolkit, but we encourage you to think deeply within your service and community about the language that is most representative.

Identity describes social categorisations including age, gender, sexual orientation, ethnicity, language, religion, class, socioeconomic status, among others (State of Victoria, 2021).

Identity knowledge refers to a person's specific knowledge about one or more of their **own** identities, which have faced marginalisation and discrimination. This may include being LGBTIQA+, from a culturally and linguistically diverse (CALD) community, from a faith community, and/or having a disability.

Cultural knowledge refers to Aboriginal and Torres Strait Island people and people from diverse cultural backgrounds who have significant knowledge, expertise, and experience about their culture and community. A person's identity and cultural knowledge may overlap. People with cultural knowledge may also hold a unique understanding of the barriers to navigating and accessing services as a member of that community.

Lived experience is used in this toolkit to describe people who have experienced mental health issues or distress. This acknowledges and honours the extent to which people with lived experience have impacted and shaped approaches to mental health, including the development of 'A national framework for recovery-oriented mental health services: Guide for practitioners and providers' (Commonwealth of Australia, 2013).

Family in this toolkit expands upon the sector's definition which includes families and carers (State of Victoria, 2021). It considers a **whole-of-family** approach, centring the client's definition of their family, which may be anyone who they consider significant in their life. This acknowledges that family means different things to different people and that people might play many roles within their family. It considers the complex nature of relationships within families (e.g., people may provide **and** receive care/support) and the impacts of these relationships on different aspects of their lives, including intersecting oppressions and needs. Family includes family of origin (parents, siblings, kinship groups, grandparents), family of creation (partners, children, stepfamilies), family of choice (partners, close friends, housemates, pets), as well as foster carers, communities or villages, and out of home care.

Background and purpose

This toolkit is a product of the Mental Health at the Margins project, funded by the Victorian Department of Health as part of the Diverse Communities Grants program. The project took place amidst ongoing reforms to the mental health service system, in response to findings from the Royal Commission into Victoria's Mental Health System. These findings broadly highlighted the system's failure to support the diverse needs of people needing support. Major themes from the inquiry (State of Victoria, 2021) that inform the context of this project include:

- inequitable access to services, disproportionately affecting those most disadvantaged.
- a lack of safe, responsive, and inclusive care for diverse communities facing additional barriers, such as Aboriginal, LGBTIQA+[1], culturally and linguistically diverse, refugees, asylum seekers, and people living with disabilities.
- the ever presence of widespread stigma and discrimination which can prevent those living with mental illness or psychological distress from help-seeking.

[1] We use the term LGBTIQA+ to include people who are lesbian, gay, bisexual, trans and gender diverse, intersex, queer, questioning, and asexual. We use this term broadly and inclusively. We also acknowledge the diversity of sexualities, sex characteristics and genders, and that some people, groups and organisations may use different versions of this term (e.g., LGBTIQ, LGBT).

- services not meeting local needs including poor integration of services, causing additional difficulties for those experiencing multiple conditions or challenges to access services.
- an imbalanced system with over-reliance on treatment with medication rather than focus on therapeutic and recovery-centred treatment and support.
- lack of recognition of the social factors influencing mental health.
- lack of recognition of the relationship between trauma and mental illness including trauma-informed and holistic approaches to treatment.

Recommendation 34 of the Royal Commission into Victoria's Mental Health System (RCMH) specifically advised that services need to be safe, inclusive, and responsive to the mental health and wellbeing of diverse communities[2]. This recommendation prescribed that work towards achieving this should be done in partnership with diverse communities (including culturally and linguistically diverse communities, LGBTIQA+ communities, and people living with disability) to improve accessibility, promote inclusion and address inequities.

This toolkit aims to contribute to the reform agenda, and Recommendation 34 specifically, to support services and practitioners to be able to better support the needs of people with intersectional identities. The toolkit was informed directly from diverse community members with intersectional identities and either practitioner knowledge and expertise and/or lived experience knowledge and expertise.

The purpose of this toolkit is to:

1. Further understand intersectionality and its application to practice within local and community mental health services.
2. Provide guidance for service providers to support intersectional practice and contribute to system level change.
3. Provide practical ways to create change at team and practitioner levels and at a 'whole of service' level to see how these changes are interrelated.

Our approach to developing this toolkit drew on the expertise and experience of interdisciplinary practitioners and community members from diverse intersecting LGBTIQA+, multicultural/multifaith and disability communities who had lived and living experiences of mental health challenges and experiences navigating the mental health service system.

[2] Victorian Government. (2021). *Recommendation 34: Working in partnership with and improving accessibility for diverse communities*. https://www.health.vic.gov.au/mental-health-reform/recommendation-34

Loud and clear, the feedback expressed that the ability for services to meet the diverse and intersecting needs of diverse people involves an examination of the whole service. People's best service experiences felt safe, affirming, and respectful at every stage of the client journey, from first impressions and engagement, through to transition and connection.

Applying intersectionality to transform the mental health service system must involve a holistic approach at multiple levels. This means creating a 'top-down' environment within mental health services to support intersectional practice. At the same time, the service should be shaped by 'bottom-up' feedback from transdisciplinary teams and clients. These top-down and bottom-up processes sit within the broader context of mental health policy and systems, which can support or limit the use of intersectional practice within a service. The figure below depicts these relationships.

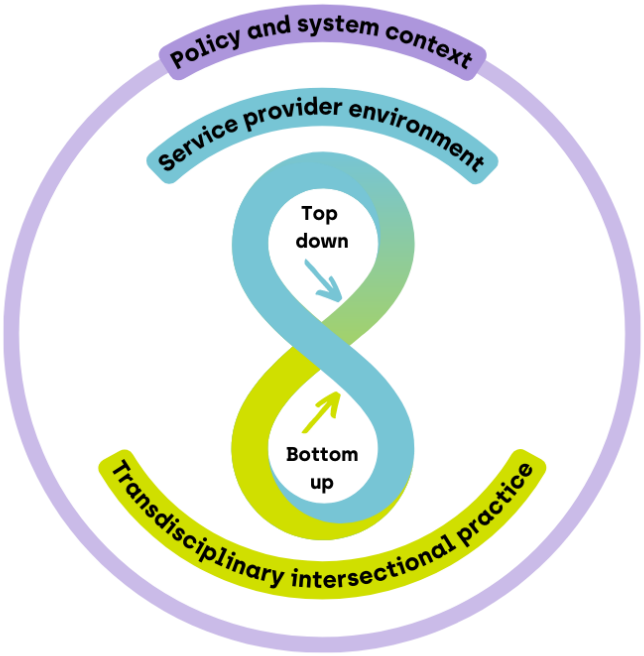


Figure 1 Intersectional practice, service provider environment, and policy and system context

We hope that by using this toolkit, service providers and care teams feel better equipped to apply intersectionality in practice and create safer, more integrated, responsive, inclusive, and affirming mental health services.

Intersectionality – what is it and why apply it?

Intersectionality has a long history in human rights discourse, including in Sojourner Truth's speech *'Ain't I a Woman'* (1851) at an Ohio women's rights convention, but was first explicitly referred to as intersectionality by Kimberlé Crenshaw, who coined the term 'intersectionality' (1989, 1991). Crenshaw defined intersectionality as a prism through which to examine and analyse simultaneous and overlapping forms of systematic discrimination, such as sexism and racism, and their impacts on people, communities and their relationships with systems. Crenshaw's initial conceptualisation described the justice system's erasure of Black women's experiences from feminist discourse in favour of white women, and from anti-racist discourse in favour of Black men. This resulted in Black women facing double exclusion at the 'intersection of racism and sexism' and unique forms of oppression and disadvantage (Akibar & Langroudi, 2021).

In theory

While it is important to maintain intersectionality's original political and critical race theory intent, more recent approaches have pushed researchers, theorists, policy makers, and practitioners to dig deeper into the structural and systemic forces at play in reproducing and perpetuating inequities, disadvantage and the resultant social problems they confront (Autret & Eeden-Moorefield, 2021). Understanding intersectionality involves understanding the dynamics of power and privilege. It also involves acknowledging experiences of oppression and working to address it. Within the mental health context, an example of this is examining characteristics associated with identities that have historically been deemed as 'disorders' or pathologised in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and how this might impact the baseline trust or lack of trust that people have towards the system as a result.

Minority stress theory links experiences of marginalisation to stress via the negative impacts of stigma and discrimination, which then lead to poorer health and wellbeing outcomes (Correro, A. N., & Nielson, K. A. 2020). A recent finding emphasised the 'intersectional nature of minority stress' and 'how this may influence both resilience and psychological injury' (Nicholson et al. 2022). This includes recognition that identity is multi-faceted and made up of several attributes. The same part of an individual's identity that led to them experiencing discrimination may also lead to them

experiencing social connection. This point highlights the importance of context and resilience.

The wheel of power and privilege illustrates the relative positions of power and privilege, where marginalised people are on the outside of the wheel and those holding the most power are at the centre (Duckworth, 2020). It reinforces that a person's experiences with the world are respective to their positions of power and privilege, which can change within different relationships or contexts. In the context of mental health services, this can mean that individuals seeking support who experience intersecting oppressions feel powerless, unseen, unheard, or dismissed, and are likely to either not engage or disengage, meaning they cannot access the support that they need.

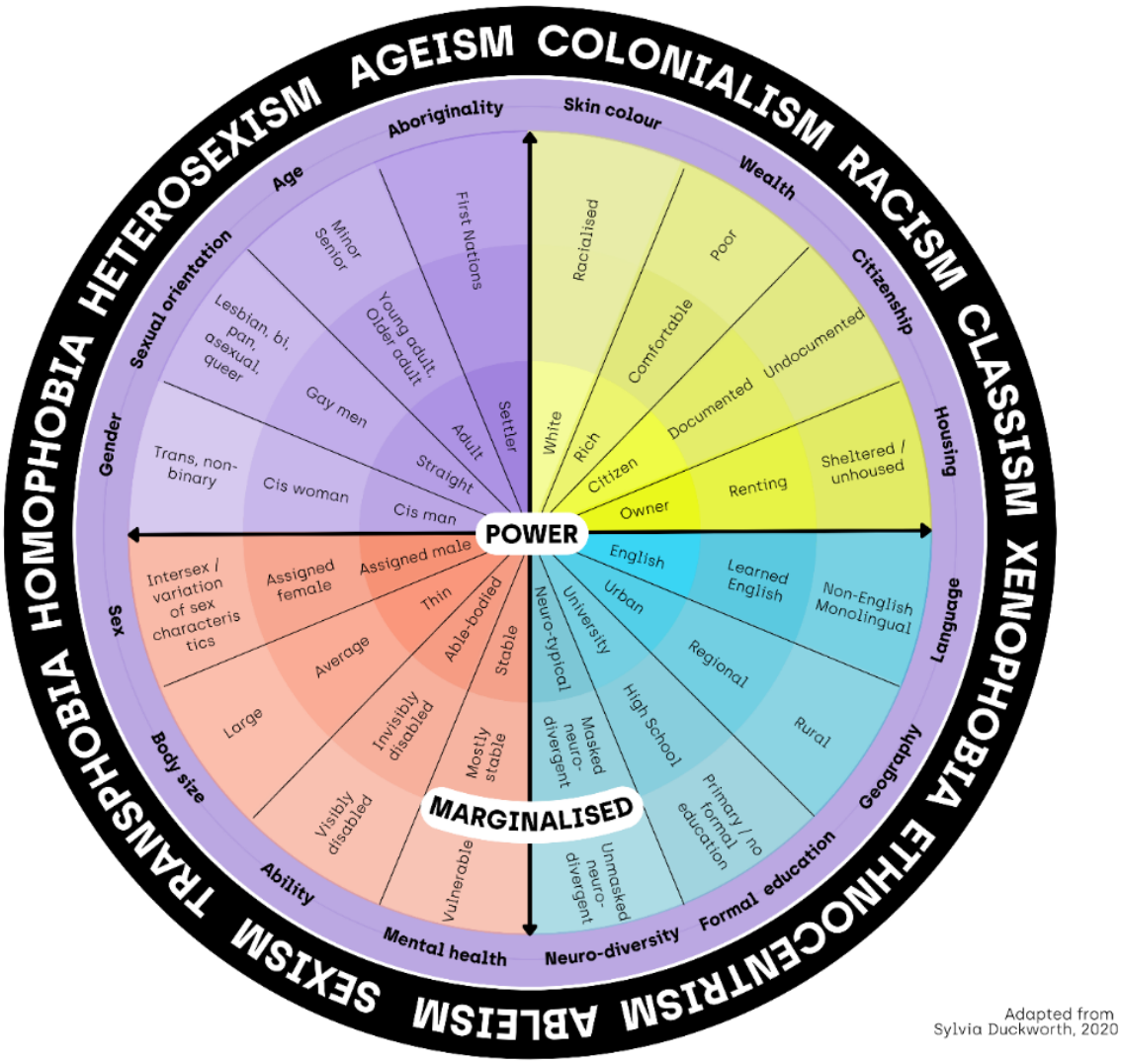


Figure 3 Wheel of Power/Privilege

In research

It is also important to reflect on the fact that people with intersectional identities often face discrimination in multiple areas of their life, relating to multiple parts of their identity. Research makes it clear that discrimination, marginalisation, social exclusion, and other experiences of systemic oppression negatively impact the health and wellbeing of people from diverse communities (Correro, A. N., & Nielson, K. A. 2020).

In a recent survey of LGBTIQA+ people conducted by Drummond Street Services (McCann, et. Al, 2023), the links between discrimination and poorer mental health and wellbeing outcomes were evident. LGBTIQA+ survey respondents were asked about their experiences of different forms of discrimination within different settings over the past five years.

Discrimination was highly prevalent for LGBTIQA+ individuals across public, private, and professional settings as well as in larger institutional settings or in healthcare. This is in line with, and expands on, recent findings regarding experiences of discrimination

among LGBTIQA+ people[3]. Over 60% of survey respondents that answered this question had experienced a form of discrimination in the past five years either at work, in public or within family. Half (52%) of respondents had experienced discrimination within healthcare settings. Importantly, the survey demonstrated the pervasive nature of discrimination.

Intersectional discrimination was common and was associated with poorer mental health and wellbeing, increased loneliness, and greater financial stress. Individuals experienced multiple types of discrimination. Specifically, 75% had experienced more than one type of discrimination and 37% had experienced four or more types of discrimination.

There was a small group of individuals who had only experienced LGBT discrimination, i.e., homophobia or biphobia and/or transphobia. These individuals had higher mental health and wellbeing scores, lower financial stress and decreased loneliness scores compared to individuals who had experienced LGBT discrimination in combination with other forms of discrimination. Further demonstrating the social factors that influence mental health and wellbeing among diverse communities, in particular, the compounding impact of intersectional discrimination on mental health and wellbeing.

In practice

At its core, intersectionality is about understanding:

- the whole of person, family, or community
- their experiences of overlapping discrimination/oppression/marginalisation
- the significant relationships in their life, including with other people, communities, organisations, and systems
- the contexts in which these relationships occur, including historical, current, and systemic
- how the above factors shape how they see, interact with, and experience the world.

Services and practitioners can consider intersectionality as a 'lens' to critically reflect on positions of privilege and oppression (Autret & Eeden-Moorefield, 2021; Butler, 2015; Pallotta-Chiarolli et al., 2021; Tang et al., 2020). This means recognising that mental

[3] Ibid.

health services as institutions hold positions of power and that systems are set up to provide services that isolate different parts of what a person or family may be experiencing. For example, a queer person of colour seeking asylum and experiencing mental health distress and substance abuse would likely have to seek specialised services for each of their intersecting needs in isolation, meaning that areas of need are likely to be missed or not seen as a whole.

Noting the need to consider the overlapping impact of various types of discrimination and minority stress across different aspects of a person's identity, in practice, intersectionality can help services and care teams/practitioners better understand both:

- what is going on for a client that is impacting their mental health and situate it within contexts (including multiple and overlapping forms or discrimination), and
- how best to support clients/consumers holistically and in ways that are trauma-informed, leverage existing strengths, and create new connections that promote safety and wellbeing.

Intersectionality encourages practice that looks beyond the mental health presentation or diagnosis to engage in a transdisciplinary therapeutic process that is respectfully curious, centres a person's agency and choice, and elevates lived experience, cultural and identity knowledge. It also encourages self-reflection and awareness of one's own positions of power and privilege, including in the transdisciplinary team and as a part of the social care system. Understanding this involves acknowledging that we all have multifaceted elements of our identity (as exemplified in Figure 4 below) that shape how we see and experience the world. For example, gender and the implications of gendered norms do not only impact those who are positioned on the outside of the wheel, cis-men also have a gender and are affected by the power/privilege this creates.

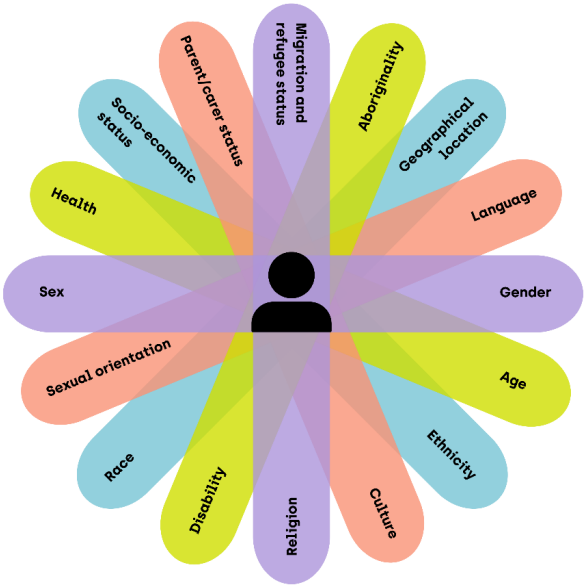
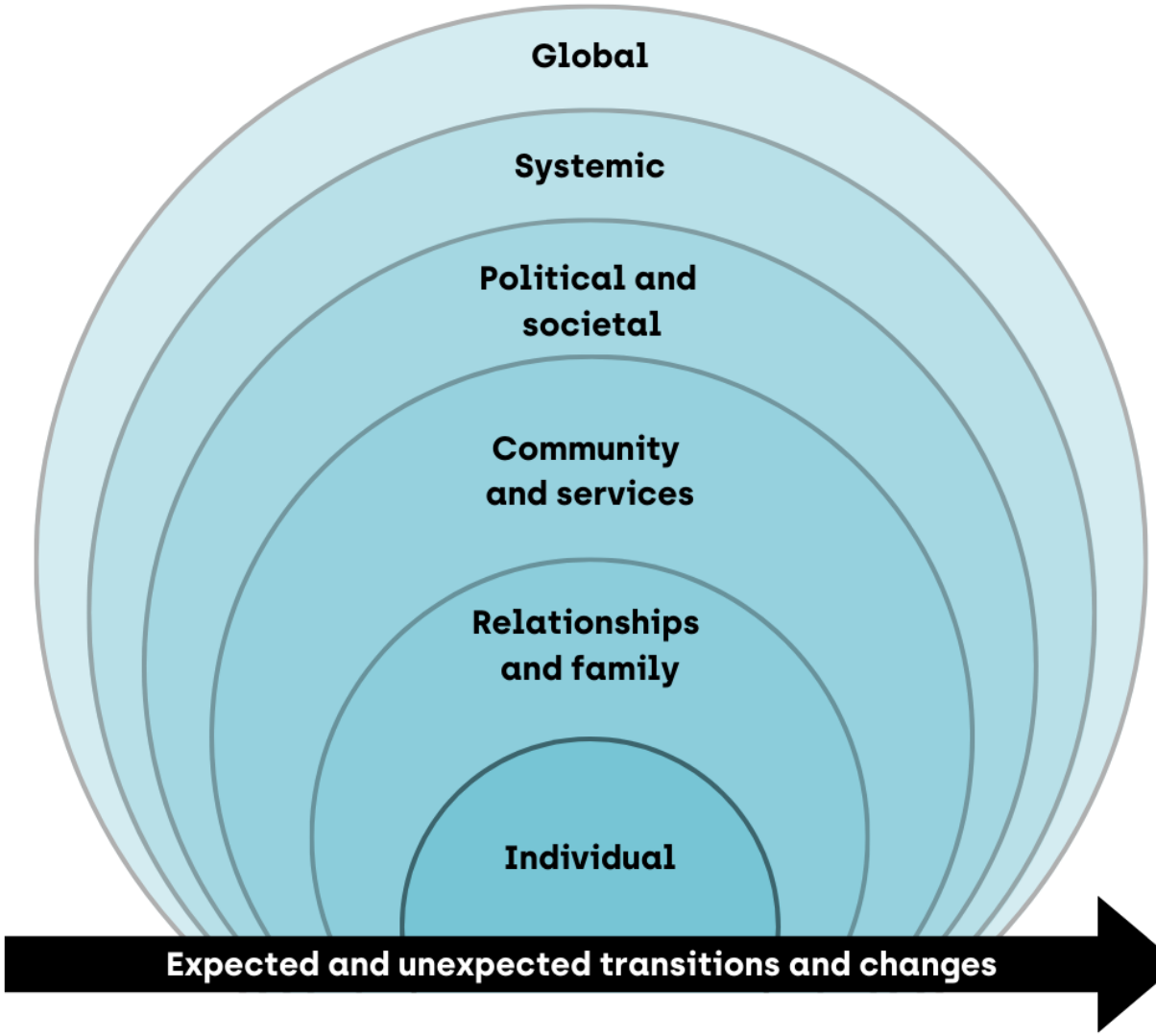


Figure 4 Individual factors.

The socio-ecological model (below) illustrates the overlapping risk and protective factors at various levels (e.g., individual, family, systemic) that can impact an individual's experiences and relationships. Through an intersectional lens, the socio-ecological model helps us to identify that:

- multiple risk factors at multiple levels lead to a compounding experience of discrimination and oppression, and
- risk factors should be identified in relation to all aspects of the individual's identity.

By maintaining a focus on both these aspects, we can apply Marmot's (2010) concept of 'proportionate universalism' where universal policy action is targeted, proportionate to the level of need. For example, overlapping forms of discrimination (e.g., racism, homophobia) may lead to less access to resources (e.g., housing, employment) and result in poorer wellbeing and greater need for mental health care. Addressing mental health care therefore requires intervention at multiple levels, including through both **targeted** approaches (e.g., addressing discrimination within systems, including mental health care) and **universal** approaches (e.g., improving universal access to housing, employment and mental health care).



Socio-ecological factors

Global:
- International events (e.g., conflict, pandemics)
- Globalisation and migration

Systemic:
- Social and health systems
- Systemic social inequities (e.g., access to resources, food, education, housing, employment)

Political and societal:
- Social and health policies
- Social and health legislation
- Societal values and beliefs

Community and services:
- Home environment
- Parent mental health
- Parenting
- Family relationships

Relationships and family:
- Home environment
- Family/significant relationships

Individual:
- Gender
- Cultural background
- Disability
- Socioeconomic status

Note. This list is not exhaustive

Figure 5 Adapted from Understanding Health (4th ed. p.98), by H. Keleher and C. MacDougall, 2016, Australia: Oxford.

How to use this toolkit

This toolkit is structured around seven elements of intersectionality that outline core principles and practices. After the seven elements are summarised, the toolkit applies these elements across the stages of a client's journey through the mental health service system.

Considerations are proposed at two levels: transdisciplinary practice and at the service level. Throughout, it acknowledges the impact of the broader policy and system context.

The toolkit:

- Provides considerations that guide the application of intersectionality in practice for care teams/practitioners and service providers at each stage of a client's journey.
- Promotes a collaborative and reflexive approach that is trauma-informed and elevates lived experience, cultural and identity knowledge and voices.
- Considers the socioecological model as a framework for both care teams/practitioners and service providers to understand factors that impact trust, safety, mental health and help-seeking experiences as well as interconnections and relationships between these, to provide safer, more inclusive and responsive care and support.

Care teams, practitioners and service leaders can work through these considerations to help assess current practice and identify how to apply intersectionality to create safer, more responsive and inclusive services.

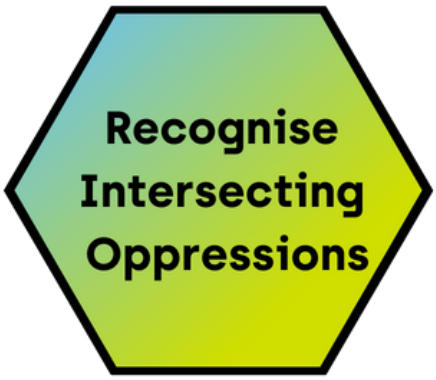
The seven elements of intersectional practice

To begin thinking about how intersectionality is put into practice, below is a summary of the seven elements of intersectional practice. It highlights the need to think about intersectionality across all levels of the service – including for the whole-of-service, collaborative care teams, and individual practitioners. Broadly, some questions to hold in mind when considering these seven elements across the client journey include:

- How can we understand and respond to multiple and intersecting oppressions, struggles, and needs and their relation or contribution to poor mental health?
- Whose voices are missing and how can we invite those voices to the table? How can we further elevate the voices of those with lived experience and cultural and identity knowledge?
- How can we collaborate within and across teams, services, and with clients to assess and improve service delivery and outcomes?

Figure 6 Seven Elements of Intersectional Practice

1. Recognise Intersecting Oppressions



Core principles

People's interactions with the mental health sector are impacted significantly when they have experienced disadvantage and oppression based on their intersecting identities. It is incumbent on services to see the effect of this disadvantage on the person's mental health and wellbeing, and to understand and address overlapping forms of marginalisation.

Key practices

- Ask people about their identities, including gender identity, culture, sexuality, class, etc.
- Acknowledge the impact of stigma and discrimination on people's lives
- Acknowledge that mental health and wellbeing issues are not only the result of individual pathology but are shaped by the person's context and experiences
- Critically reflect on the wider context and power structures impacting clients' experiences
- Educate a transdisciplinary team about diverse identities, cultures, and experiences of clients or service users, including historical harms enacted by MH systems
- Address the power structures that lead to disadvantage and discrimination as part of mental health service intervention.

2. Safe and Inclusive Workplace Culture

Core principles

Intersectional practice thrives within a climate of inclusion and safety, where diverse voices and forms of knowledge are valued, and have influence at every level

of the service. Organisations recognise and address the impact of systems of power and privilege, and consciously make space within their structures and processes to address these in meaningful ways.

Key practices

- We all play a part in contributing to the overall culture of safety and inclusion
- Respectful curiosity about diverse cultural, identity and lived-experiences
- Value lived-experience, cultural and identity knowledge
- Welcoming and accessible physical and virtual spaces
- Visible signs of diverse cultures and identities on display
- Actively integrating processes that acknowledge and value diversity, including use of pronouns, acknowledgement of country, etc.

3. Workforce Mutuality

Core principles

The needs of people with intersecting identities, who have experienced overlapping forms of discrimination and disadvantage, are best met when the mental health workforce reflects the diversity of people that they support. Actively recruiting to build a workforce that includes people with lived experience, and those with diverse cultural and identity knowledge will assist in breaking down barriers to people accessing mental health and wellbeing support. People are more likely to access services where they see themselves represented. As part of a recovery-oriented service, implementing supportive hiring practices breaks down barriers to employment for those with intersectional backgrounds and can create long-term employment pathways.

Key practices

- Work collaboratively with colleagues from diverse backgrounds and experiences
- Seek out diverse forms of knowledge to inform best practice with clients
- Value and elevate the cultural, identity and lived-experience knowledge of colleagues and peers
- Develop affirmative action hiring policies and procedures

- Make space at the table to elevate diverse voices, and create an authorising environment for these voices to shape practice and service development across all levels
- Where the knowledge is not present in the immediate team, actively seek secondary consultations with specialised services.

4. Reflexive Practice

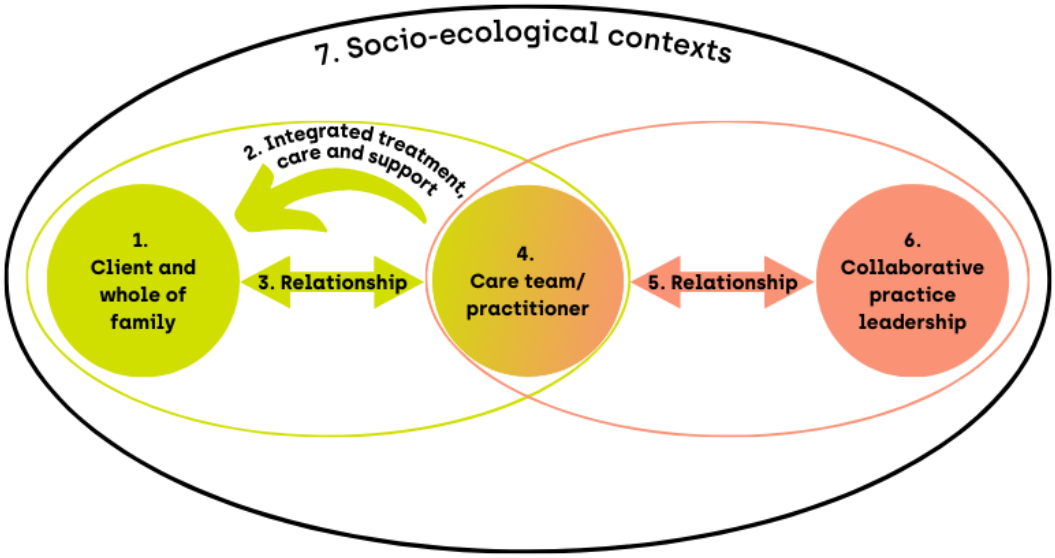
Core principles

Reflexive practice is commonly understood as the ability to engage in a process of continual reflection and learning. Within intersectional practice, this involves exploration of the impact of overlapping systems of power and privilege and their dynamic influence on mental health service provision at all levels. Reflexivity also involves the practitioner acknowledging and challenging their own assumptions and implicit biases, and how these shape their work with clients.

The diagram below is adapted from Hawkins and Shohet's Seven-Eyed model of supervision. It illustrates the many areas that reflexive work can occur across different levels of the service, including with clients and within a transdisciplinary team. The diagram illustrates the ways in which power and privilege may impact across many levels, including:

1. The ways in which systems of power may impact on the **individual client**, their family, their identities, and the presenting issues.
2. The **integrated treatment, care and support**, and how it may address the client's relative experiences of marginalisation or disadvantage.
3. The **practitioner's** internal biases and experiences of systemic power and privilege.
4. The quality of the **practitioner-client engagement**, including the impact of power differences, privilege and internal biases.
5. The supervisor or **service leadership's** experiences of power and privilege.

6. The impact of the supervisor or service leadership's assumptions or biases that may affect their **relationship with the care team**, and their assumptions about the client and family.
7. The intersecting impacts of the socio-ecological contexts on the client, family,



care team/practitioner, and practice leadership. How and why might people's experience of their context vary?

Figure 7 Adapted from Hawkins and Shohet's Seven-Eyed model of supervision

Key practices

- Communicate openness to hearing how clients experience the practitioner in practice
- Acknowledge what is not yet known about the client and their context
- Notice and challenge implicit biases in and between sessions
- Reflect on power and privilege as a practitioner, team and service
- Actively apply an intersectional lens during routine supervision
- Practise self-education to address gaps in knowledge and awareness.

5. Elevate Diverse Knowledges

Core principles

An intersectional approach to collaboration focuses on elevating lived experience, cultural and identity knowledges. This occurs with clients and across transdisciplinary teams to provide integrated planning and treatment, care, and support. Diverse forms of knowledge are braided together with other sources of evidence, including practitioner experience and research findings. This key area centres client agency and choice in their own experiences of mental health services and recognises the expertise of practitioners with lived experience, cultural, and identity knowledge.

Key practices

- Work to proactively include diverse cultural, identity, and lived experience knowledges in transdisciplinary teams
- Draw on own cultural, identity, and lived experience knowledges, where safe and appropriate
- Elevate diverse and marginalised voices across all levels of service
- Work to address gaps in service delivery and practice
- Communicate and share power across care teams
- Facilitate collaborative practice leadership that engages and elevates diverse knowledges, including secondary consultations where appropriate.

6. Purposeful Advocacy

Core Principles

An intersectional approach to advocacy involves an understanding of inequities and gaps in services, especially for marginalised people. Interventions and supports are targeted to address systems of discrimination for

intersectional groups. It includes proactive engagement with communities, including through outreach and accessible intake processes for marginalised people.

Key practices

- Openly listen to clients to identify their perspective on barriers and priorities
- Advocate for clients to ensure supports and systems are adequately meeting their needs
- Proactively engage with community groups from intersectional backgrounds
- Make sure intake pathways are accessible to marginalised people who need support.

7. Accountability to Community

Core Principles

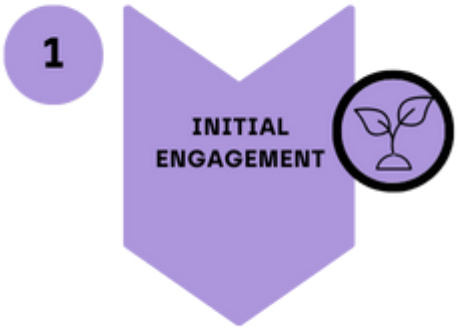
Maintaining accountability to the community requires that feedback pathways are accessible for all clients and communities. Feedback is meaningfully considered and acted upon, with outcomes communicated to affected groups. At a service level, systems are developed to collect intersectional data proactively and sensitively, and to transparently report on levels of engagement with diverse communities.

Key practices

- Create space to informally and formally collect feedback from clients about their experience
- Collect data and seek feedback in a way that is culturally safe and meaningfully explained to clients
- Remain open to receiving and responding to negative feedback that people might have relating to their service experience
- When reviewing intersectional information about clients, consider the overlapping impact of all aspects of identity, culture and lived experience
- Adapt practice in response to client and community feedback
- Escalate feedback about the service/system and advocate for appropriate change.

CLIENT JOURNEY	IN PRACTICE	SERVICE LEVEL CONSIDERATIONS
1 INITIAL ENGAGEMENT 	• Positions of power and privilege • Creating a safe environment/space • Asking about identities and needs • Awareness of and challenging assumptions and unconscious bias • Communicating affirmation • Acknowledge and explore stigma/discrimination • Engage in reflexive education	• Acknowledging power, historical context, intersecting oppressions • Community engagement • Collecting and interpreting data in intersectional ways • Workforce mutuality, • Affirmative action employment • Frameworks that underpin culture and practice - social justice
2 INITIAL ASSESSMENT 	• Elevating cultural knowledge, identity/self knowledge, and lived experience knowledge • Awareness of unconscious bias and assumptions • Socioecological factors as prompts • Collaboration towards integrated responses that consider intersecting needs	• Assessment tools and secondary consults/referrals • Structure of care teams and processes • Continuity of care and trust building • Person-centred, trauma-informed approaches
3 BIOPSYCHO-SOCIAL ASSESSMENT 	• Advocating for clients and elevating their voices • Elevating diverse knowledges • Feedback processes for clients to express needs • Understanding and addressing intersecting needs • In-depth exploration of dynamic significant socioecological factors	• Creating space/process for clients to raise needs and concerns • Support and facilitate collaborative practice leadership • Manage care team dynamics - collaborative practice • Ongoing workforce training, capacity building, implementation
4 INTEGRATED CARE PLANNING 	• Building off biopsychosocial assessment collaborating with clients • Acknowledging power dynamics • Checking in on context • Centring client agency and choice • Elevating diverse knowledges • Building off strengths, supports, interests to build in community and social supports in care plan	• Processes to determine structure of care teams to target intersecting needs • Communication and holistic integration of service - elevating all knowledge • Facilitate regular review of care plan to meet evolving intersectional needs
5 INTEGRATED TREATMENT, CARE & SUPPORT 	• Collaboration across teams, disciplines, and with clients • Address and respond to experiences of discrimination/intersecting oppressions • Checking in - what's working, what isn't, adjusting to intersecting needs • Advocacy with other services and systems	• Partnerships in place, referral pathways • Ongoing dynamic processes for collaborative case reviews elevating diverse voices • Structures of care teams or case reviews • Support client access to services • Support integrated care, reflexivity
6 TRANSITION AND CONNECTION 	• Continuity of care for people with intersecting oppressions • Check in about context, whole-of-family, socioecological factors • Existing supports to tap into and connect to new supports • Support client to sustain beyond service • Create safety for clients to provide feedback and improve practice • Empower clients to connect with community where they have a voice	• Targeted community engagement supporting continuity of care • Advocacy and proactive partnerships and connection • Co-production and continuous improvement, using multiple sources of data to assess and improve services alongside clients/community • Policy sector activism, promoting system level change

Intersectionality across the client journey



Initial engagement

Examining initial engagement through an intersectional lens involves considering both:

- Client initial engagement with a service
- Community engagement

The engagement stage provides opportunities for building relationships and trust to set the tone for the rest of the relationship/journey. Both in practice and at the service level, first impressions and previous experiences with the service system matter. This includes making services and practice safe; acknowledging and addressing stigma and historical harms; and recognising the position of power that the service holds.

In practice

Creating a good first impression at the point of initial engagement involves ensuring that the client feels welcome through whichever channel they choose to engage through, whether that's online, over the phone, or in person. An intersectional approach to initial engagement is about making sure the client knows that their whole of self is seen, welcome, and affirmed – centring their agency and what is important to them and creating a safe environment. Awareness of one's own positions of power and privilege, as well as unconscious biases and assumptions, is important for care teams and individual practitioners to have before initial engagement.

What we heard from community:

"They've always asked me like, "What is your background?", and subtly unpacked as well [as] some of the expectations that have come from each culture which, I think, is a testament to good practitioners really putting in the time to get to know your background and understanding you."

Community member [co-design group

Activity - Positions of power and privilege

Consider the different power dynamics that could impact the therapeutic relationship, and importantly, the ways that your power and privilege as a practitioner may impact the way the client engages during the session.

Understanding your power and social position improves your understanding about how the intersection of your identities/experiences may be benefiting and/or limiting to your practice. This involves recognising and addressing explicit and implicit ways that your social position, and its associated power, privilege and marginalisation, can play out in the therapeutic relationship.

Use the wheel of power and privilege to identify your positions:

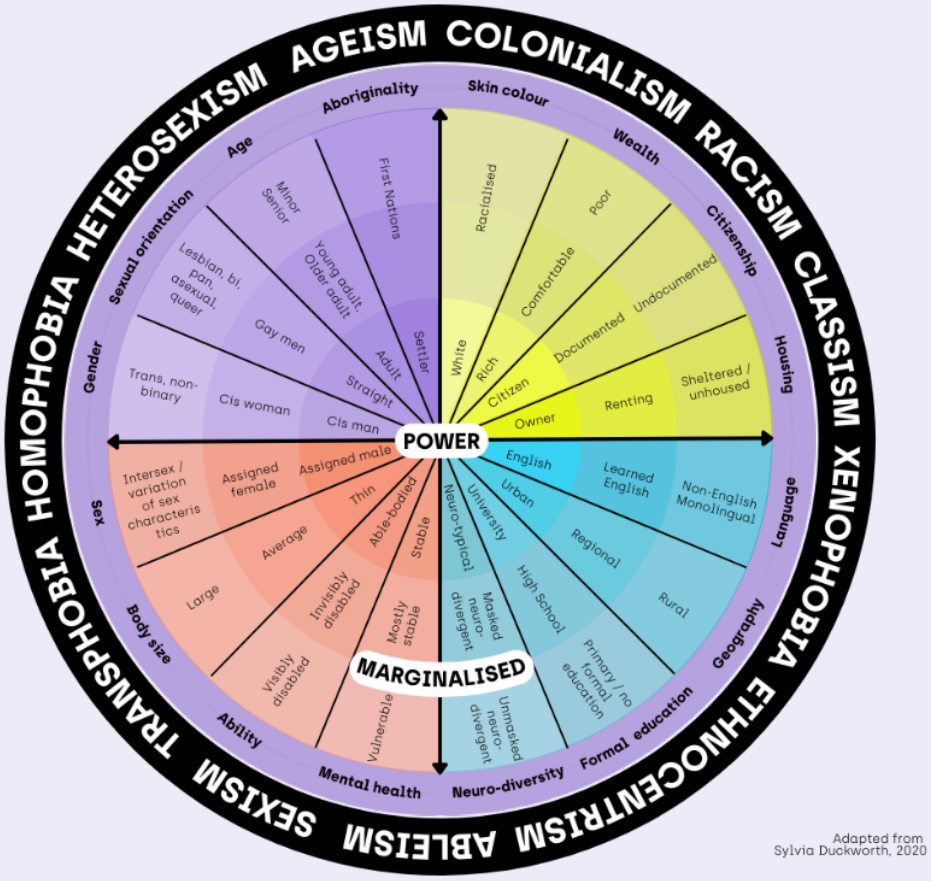


Figure 8 Wheel of Power and Privilege

Reflect on your social positions:

- How do they impact your overall approach to practice?
- What are the benefits to practice?
- What are the limits to practice?

Reflection – Examining unconscious bias

Unconscious (or implicit) bias is a term that describes the associations we hold, outside our conscious awareness and control. Unconscious bias affects everyone – it is triggered by our brain automatically making quick judgments and assessments. Unfortunately, this leads to making assumptions about individuals that often fall in line with stereotypes.

Reflect on 3-4 of your social positions in the previous activity and consider how this might inform the unconscious biases you hold:

- What are some assumptions/biases that you might hold? How have these been shaped by your own experiences and positions of power/privilege?
- What are the impacts of these assumptions/biases on your practice?
- How can you work to respond differently to unlearn these unconscious biases?
- How can you use respectful curiosity to explore and ask rather than assume in relation to this assumption/bias?
- What resources can you explore to learn about different cultures/identities/oppressions/needs and begin to dismantle your unconscious biases?

Activity- Moving beyond a checklist[4]

Accessibility is more than ramps, flags, large print handouts or plates of gluten free food. Think about your specific target communities and consider how you could do the following:

- 1. Consult: Ask your target communities what they need in order to attend, meaningfully participate and stay at your meetings or events. Consider catering, physical space, lighting and sound, quiet rooms, language groups attending, how a meeting is presented (talking, powerpoints, handouts). Don't make assumptions – ask and consult.
- 2. Promote: Ensure that the promotion of your meeting or event includes an accessibility statement, stating what is being made available and what can be requested. What languages should be considered? Consider appointing a dedicated point of contact for people to email or call about accessibility.
- 3. Reflect: Evaluate and reflect. Ask for honest feedback. Talk to practitioners and presenters. Consider how the organisation will take on and address any feedback, including any negative feedback or complaints given.

What we heard from community:

"...practitioners and organisations need to be able to go and do their own research and their own learning as well. And ... have the background knowledge [regarding] things like gender identity and ... disability, race, just everything basically, because whilst they should listen to clients or service users, it also helps if they already have their own knowledge. So it's not just clients teaching them everything ... I think that's a big thing as well, is organisations making the effort to learn about social issues and identities and how that relates to mental health."

Community member (co-design group)

[4] This activity was adapted from the Advocacy at the Intersections project- https://www.queerspace.org.au/advocacy-intersections/

Reflection – creating a safe environment

Creating a safe environment requires a whole-of-service approach and we all have a role to play. Consider how you create a safe environment for a client to feel seen, welcome to bring their whole self and comfortable to share their experiences:

- How do you introduce yourself?
- How do you make the client feel comfortable and safe in the space (physical or virtual)?
- How do you ask a client about themselves, and about and their identity/ies?
- How do you ask a client about their needs, and centre their agency, choice, and self-knowledge?
- How do you communicate (verbal, or non-verbal) affirmation of those identities?
- How do you incorporate a client's cultural, identity, and lived experience knowledges to explore their experiences and needs?
- How do you explore and acknowledge experiences of systemic barriers, stigma and discrimination?
- If receiving information about a client from a referral, what assumptions do you make about that information and what is known about that person?
- How do you learn about a person/their identities or culture when you are not familiar or comfortable? What channels or resources do you use to engage in reflexive education?

What we heard from community:

"Because I think particularly for minority communities, be it LGBTQA+ or CALD or whatever those intersections might be, there's an experience of we're used to people wanting to know about what boxes we tick and what it means to tick those boxes, but why should I be sharing that with you? Why are you asking me these questions and how is that going to help me in this mental health space with you?"

Community member (co-design group)

Service level considerations

First impressions and engagement at the service level extend beyond direct client interactions into community engagement and proactive efforts to understand what local communities are engaging in services, and what gaps exist in current service provision. This allows service providers to assess the level of safety they have sought to establish with various communities and their workforce mutuality, i.e., how well the workforce represents or reflects the local communities that it serves. Service providers can also consider the channels through which they make first impressions, even before direct interaction or engagement with a client. These include but are not limited to:

- Online materials (website, social media, resources)
- Marketing and promotion
- Organisational reputation (word of mouth)
- Initial enquiries (phone or email) and frontline staff (reception, intake, outreach)
- Data collection (including new client forms, assessments)
- Physical spaces (including reception areas, and clinicians' rooms)

Effective access to, and engagement with, a service occurs when there is an investment in creating a safe environment that enables intersectional practice. It involves proactive community engagement by partnering with community to understand needs and integrate knowledge into service provision. This includes understanding how and where diverse clients are most comfortable engaging with a service and designing intake pathways that meet their needs. Meaningful community engagement is a key strategy for ensuring that services and service systems are more likely to meet community needs, particularly for marginalised communities. It is not up to communities who have experienced harm to come to us. How can we come to them?

What we heard from practitioners:

"All those things that the agency does, tells community members that this is a safe space for them to come in before they even engage with the service."

Practitioner (co-design group)

"So, I think organisations can't rely on clients to come in, I think organisations ... The onus is on them to meet community where they're at and engage with them..."

Practitioner (co-design group)

Engaging community and making a good first impression

- How does the service acknowledge its own position of power as an institution and any historical or ongoing injustices within the broader system?
- How does the service engage with communities and proactively seek support engagement? What kind of approaches are in place (e.g. place based) to privilege the most marginalised communities in service planning, design, and delivery?
- How does the service assess and target the greatest efforts towards the greatest needs in service delivery (i.e., apply proportionate universalism; Marmot, 2010)?
- How does data collection occur? How can it be disaggregated (i.e., capture and reflect intersecting identities) to understand intersectional experiences? How is it used to understand service gaps and include community knowledge?
- Does the service reflect the communities it serves? Are cultural, identity, and lived experience knowledge integrated and represented within leadership and governance?
- How does the service support staff with diverse cultural, identity, and lived experience knowledges? How does it ensure the responsibility to educate staff/ create cultural safety does not fall solely on marginalised staff?
- How does the service understand and work to dismantle overlapping systematic discrimination within the mental health system?
- How does the service support workforce diversity and mutuality through affirmative action employment and lived experience (talent pool, pathways and succession planning)?
- How does the service integrate frameworks such as social justice, inclusiveness, equity and privileging lived and diverse knowledge at every level?
- How are marginalised groups involved in co-designing the service environment?

What we heard from community and practitioners:

"...if you were to hire with the view of affirmative action [not just] because it's a box to be ticked, but because genuinely it was important to the organisation and to [its] values and [...] you can really feel it when it's genuine or not."

Community member (co-design group)

"...when engaging with the service, being able to see yourself in some step of the process. And that could be as simple as, how the organisation or the practitioners hire? Being able to see a diversity of staff..."

Practitioner (co-design group)

Initial assessment

This stage of the client journey presents an opportunity to further build on trust that's begun to form through initial engagement. At initial assessment, it is important to understand context and needs and how to best create safety for the client. An intersectional approach involves a collaborative and reflexive approach wherein a client feels heard and seen as their whole self, beyond and inclusive of their mental health distress.

In practice

Intersectionality can be applied to existing tools and frameworks commonly used for initial assessment. Referring back to the seven elements of intersectionality, this approach centres collaborative and reflexive practice for practitioners and care teams to ensure they understand a client's initial and most immediate needs. It is important to begin to explore the client or consumers contexts and the impact that this context has on their mental health. Tools, such as ecomaps, can be a good way to support practitioners to understand the important relationships within a client's life, including within different contexts.

What we heard from community:

"Because again … not really looking at the person in the environment, not really acknowledging the differences and struggles. It's just too focused on what that mental health diagnosis is, when really it's like, "No, I've got all this family and system stuff that needs to be resolved first rather than …" It's not just I'm depressed."

Community member (co-design group)

Reflection – understanding initial needs

Consider initial assessment within your service and the dynamics within your practice:

- How are you elevating identity, cultural, and lived experience knowledges of both the client and the members of the care team?
- How do we hold space for the whole of person, their intersecting and most immediate needs, and experiences of discrimination and oppression and how these might be impacting their mental health?
- How do we understand a person's identity and symptomology within their relationships and interactions with the world? Who can support their mental health and wellbeing outside of the service?
- How do we prompt consideration of factors across all levels of the socioecological model to begin to understand social context, and client needs, including sources of safety and of barriers in order to ascertain service type and level of care (intensity)?
  How do we work collaboratively to create an integrated response that considers the whole of person, their important relationships and contexts, and their intersecting needs?
- How do you engage the whole care team collaboratively through co-work or consultations to help inform assessment?
- How can the team hold awareness of their own power/privilege, unconscious biases and assumptions to create safety for clients and the care team?

Applying an intersectional lens to IAR-DST

The Initial Assessment and Referral Guidance and Decision Support Tool (IAR-DST) provides a current framework for practitioners to match clients with a level of service intensity. The table below considers the eight domains of the IAR-DST and provides some guidance for care teams to reflect on how to apply an intersectional lens to this commonly used tool, as well as example questions for each domain, noting this is not an exhaustive list.

It is important here to be culturally aware and trauma-informed, understanding that some clients may have never been asked these types of questions. One way to do this is by introducing the domains, acknowledging some might be sensitive, and providing prompts about the types of questions clients will be asked. It is important to check in with the client regularly throughout this process.

For example, before asking questions that assess Risk of Harm: "I'm going to ask some questions about your safety, what that means for you and how you're feeling about it at the moment. Some of the questions I'm about to ask might feel a bit sensitive, and please only share what you feel comfortable sharing. I'm asking these questions so I can provide you with the support you need or link you in with supports. If at any point you need to pause or ask a question, please let me know. Do you have any questions about this?"

IAR-DST Domain	Existing guidance	Applying an intersectional lens	Example Questions
Symptom severity and distress	Primary domain, includes current and past symptoms and duration, level of distress attributable to mental health condition, experience of mental health condition and symptom trajectory.	• Shift focus from individual to broader socio-ecological factors contributing to symptom duration, level of distress, experience of mental health condition and trajectory. • Situate symptom severity and distress within co-existing conditions and contextual assessment domains.	•How are you feeling and what's going on in your life that is contributing to that feeling? •Describe what's been going on in your world that's prompted you to access support? •Describe what would be helpful or what help looks like for you?
Risk of harm	Primary domain, includes past and current suicidal ideation and attempts, past and current NSSI, impulsive and dangerous behaviours with potential for harm to self/others, and unintentional harm to self/others arising from severe symptoms or self-neglect.	• Consider structural and systemic factors that undermine safety. • Consider barriers to accessing support. • Situate risk of harm within contextual domains of assessment.	• What's your understanding of safety? • Are there any times, situations, or environments where you feel unsafe? (This could be either external to or within yourself).
Impact on functioning	Primary domain, includes ability to fulfil usual roles/responsibilities, impact on or disruption to areas of life, capacity for self-care.	• Consider intersecting and compounding needs that impact functioning.	• Is there anything you've noticed or feel like is harder to do at the moment? This could be things like going to work, or household chores, daily living, or caring/parenting or relationships. What's making this harder?
Impact of co-existing conditions	This is a primary domain and includes substance use/misuse, physical health condition, intellectual disability/cognitive impairment.	• Acknowledge that co-existing conditions are interrelated and influence each other.	• Is there anything else that is happening at the moment that is impacting you? This could be things like other health related conditions, drinking more alcohol, drug use, overuse of prescribed medications. • Have you received any support around or spoken to anybody about this? • Are there any other areas of your life or things that you're experiencing that you feel like you need support with?
Treatment and recovery history	Contextual domain, includes previous treatment (including specialist or mental health inpatient treatment), current engagement in treatment, response to past/current treatment.	• Consider barriers to seeking support and the potential for people from diverse and intersectional communities to have negative service and help seeking experiences which might impact their previous support or lack of support.	• Are there any other services that you have been to or that you are currently engaged with? How did that go – what went well and what could have been improved? Have you spoken to anyone about this? • Has anything prevented you from accessing support before? What can we do to support you?
Social and environmental stressors	Contextual domain, includes life circumstances such as significant transitions, trauma, harm from others, interpersonal/social difficulties, performance related pressure, difficulty having basic needs met, illness, legal issues.	• Recognise experiences of discrimination or oppression and how they overlap. • Integrate stressors across social and environmental contexts and their impacts on mental health. • Consider relationships that are important to the person and their impacts on mental health.	• Have you ever been discriminated against? This could include things about your race, gender, sexuality, physical or intellectual ability, age, etc. What were the impacts of this? • Have there been times or things in your life that have been challenging/that you've struggled with? • Do you have important people in your life? If yes, who are they? Is there someone you feel closest to? What words would you use to describe your relationships with these people?
Family and other supports	Contextual domain, includes the presence of informal supports and their potential to contribute to recovery.	• Use a broad definition of family that centres the client's understanding of family and the significant relationships in their life. • Recognise community supports that move beyond western notions of immediate family.	• Are there people in your life that you describe as family? This could be your biological family, friends/chosen family, your partner, kids, pets etc. If yes, who are they? • What words would you use to describe your relationships with these people?
Engagement and motivation	Contextual domain, includes the individual's understanding of the symptoms, condition, and its impact. The person's ability/capacity to manage the condition and motivation to access the necessary support.	• Consider structural and systemic factors that undermine a person's ability/capacity to understanding their symptoms, manage their condition(s) or access the necessary support. • Acknowledge socio-cultural factors that influence understanding of symptoms and mental health and may differ from western and settler-colonial understandings.	• Have you had similar experiences in the past? What has helped you and what hasn't helped? • What have your experiences with services been like? What supported you to get the help you need/stay connected to the service? • Has anything prevented you from reaching out for support before? What can we do to be more helpful/easier for you to connect and stay connected?

Service level considerations

To create an environment that supports intersectional practice at the point of initial assessment, services should assess:

- how staff are trained
- how they are supported within their role to self-reflect and learn
- the structure of care teams

Services should play an active role in supporting staff to develop affirming and intersectional service responses and should play a top down role in valuing cultural, lived experience, and identity knowledge.

Where the direct implementation at the care team level is not possible, due to service funding or capacity constraints, services should examine processes around secondary consultations, partnerships and referral pathways.

It is not just the responsibility of specialist organisations to support diverse communities. All services and organisations must work harder to create safe, affirming and accessible services to better support the needs of all clients.

What we heard from community:

"...it's really important to be culturally safe. I think one way to address that is whether in conversation or whether it's in forms [...] how can we support you? [...] Anything that we should be aware of [...] but just to make the person feel that, "Okay, I can express things that I need to in conversation that I'm not comfortable with or that I need," ... I think that would really make a big difference because there's a lot of things others may not know about your culture or your religion that you may feel really uncomfortable with or you need or whatever, so I think it's essential".

Community member (co-design group)

Understanding and addressing initial needs

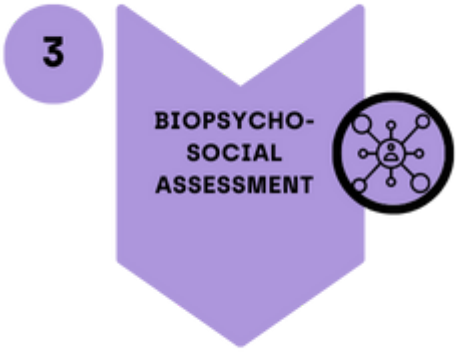
Service providers can consider:

- How can staff be supported to upskill to provide inclusive practice with diverse community members with unique access and accessibility needs?
- How can staff practice in a way that supports them to be self-reflective?
- What assessment tools are currently used and how are staff trained to apply an intersectional lens to understand context across all levels of the socio-ecological model?
- What is the structure of care teams and processes at assessment? How is cultural, lived experience, and identity knowledge integrated into these processes, training and capacity building for service delivery staff? What processes are in place to support staff to learn from and support each other to develop skills and experience across different areas of knowledge and expertise?
- Continuity of care from initial engagement to initial assessment – building on trust from initial engagement and ensuring that there is safety in familiarity and choice for the client on who they engage with?
- Secondary consults and referral pathways – building partnerships with culturally specific organisations and specialist service organisations, and supporting clients to access other services to meet their diverse needs
- Implementing a person-centred, trauma-informed, and intersectional approach to initial assessment that ensures clients are able to access care, treatment and support for all their needs.

What we heard from community:

"I think they really need to have … strong cultural awareness training and it needs to be ongoing. It's not something like I did one module and that's it […] I think that [it] would be really important for those practitioners to also make a commitment … to work on challenging their biases and improving them."

Community member (co-design group)



Biopsychosocial assessment

An intersectional approach to biopsychosocial assessments enables practitioners and care teams to unpack more of the client's intersecting experiences and needs. Centring a client's agency and considering factors that span across all levels of the socio-ecological model can be useful in better understanding the intersectional experiences that are impacting a client's mental health and the contexts within which they are occurring, the kinds of supports they may need, as well as existing important relationships in a person's life.

In practice

While respectful curiosity, reflexivity and collaboration are important at every stage, they are especially important to create safety at this stage. A reflexive approach that is mindful of client-care team/practitioner power dynamics that centres client agency through collaboration is important to gain a full understanding of intersecting issues, needs, and contexts. A comprehensive and holistic biopsychosocial assessment enables more effective and informed integrated care planning that considers diverse supports to meet intersecting needs.

What we heard from community and practitioners:

"Prioritise lived experience – knowing that learned experience has its place but needs to be done in conjunction with lived experience, both in a practical sense where lived experience workers (e.g. peer workers, advocates etc.) work alongside a learned experience professional (e.g. psychologist, counsellor, social worker etc.) but also in the way of training and learning from each other. It's important learned experience professionals are embedding knowledge from people with lived experience in their support via co-reflection spaces, co-design, co-production, consultation etc."

Practitioner (co-design group)

Reflection – biopsychosocial assessment

Reflect on your current practice and practices in as an individual practitioner, within your care teams and within your service:

- How can you make the service accessible for people from diverse communities?
- How can you advocate for clients to elevate their voice, ensuring they have power, choice, and agency in sharing their experiences, contexts, issues, needs and how these overlap?
- How do you work collaboratively in a way that elevates knowledges that are important for each case within and across care teams, cultural knowledge, identity knowledge and lived experience?
- Do you recall a client's use of language to reflect it back to them?
- How can you empower clients to express their voice through feedback processes which allows them to raise whether their needs are being met and understood? How can you respond to this feedback?
- How can you critically analyse information from initial assessment to assess the gaps and explore them with clients?
- How do you ask about the roles that the client plays within their family and how these impact their mental health and wellbeing?
- How do you gain an understanding of the intersecting needs, identities, and contexts for each family member and what the intersecting needs and experiences are across the whole-of family? How do we address these needs through our collaborative practice (i.e. within our roles and also through links to other practitioners/services)?
- How can you bring awareness of unconscious biases and assumptions, and leverage resources to learn about what you might not understand, removing some of the burden from clients to educate about their identity(ies)? How can you upskill in new areas of knowledge?
- How can you use the socioecological model to guide an in-depth exploration of factors and significant relationships at play in a person's life that may be impacting on their mental health or indicate other areas of need for support?

Using the socioecological model to guide biopsychosocial assessment

The below figure provides some examples of how to use the socioecological model as a guide to explore and understand psychological, biological, and social needs and how these intersect across different levels:

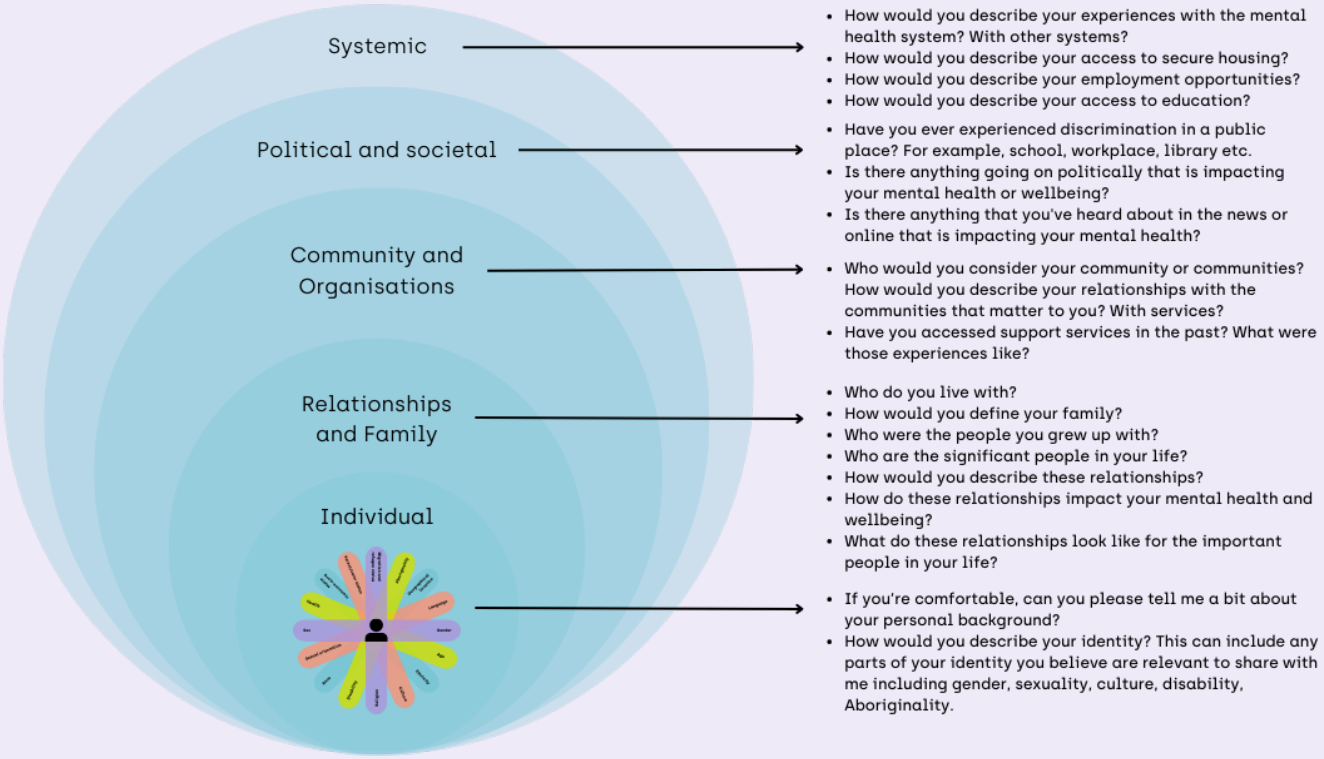


Figure 9 Socio-ecological model to guide biopsychosocial assessment

Service level considerations

Service providers should review and evaluate current processes and frameworks that underpin their approach to biopsychosocial assessment. This includes review whether current assessment processes are accessible to a broad range of people from diverse communities, with unique access and accessibility needs. The suggested approach to practice will require building capacity across the service with staff at all levels to create a collaborative and reflexive culture that supports an integrated way of working and helps build staff capacity and capability. Work within the service should privilege clients' cultural, identity, and lived experience knowledge, as well as that of care team members.

Strong practice leadership and facilitation is needed to create a space for team members and clients to raise any concerns, supporting client agency and choice as central to determining what is important to them, what their intersecting issues and needs are, and what support options they may need to consider at the next stage.

What we heard from community and practitioners:

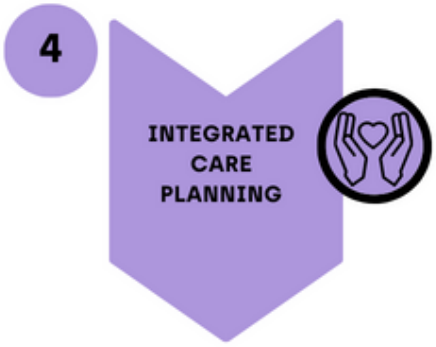
"And I think professional development or cultural training without integration or integrating it within the current policy is very tokenistic. Because it's like, yes, staff members do this training, but then they're not changing their day-to-day work. They're not actually being encouraged by the organisation to attend to shifting in policy."

Practitioner (co-design group)

A holistic approach to biopsychosocial assessment

Considerations for creating an environment that supports intersectional practice at this stage include:

- Are assessment processes accessible? Are there ways of improving accessibility requirements for people from diverse communities, including those with intersectional identities?
- Is there a process for clients to communicate and raise whether their intersecting needs and issues are being understood and met?
- How does the service environment support and facilitate practice leadership – communities of practice, ongoing reflexive education built into care team structure and processes that integration cultural, lived experience, and identity knowledge?
- What are the processes in place to manage dynamics across care teams to enable collaborative integration of knowledge from all team members, including peer workers? How is client voice centred in the work?
- What structures and processes are in place to support all practitioners/workers to raise any concerns disagreements or differences of opinion and work through them in the best interest of the client?
- Are there opportunities for ongoing workforce training, capacity building, and implementation to build a culture that supports an intersectional approaches and practice?



Integrated care planning

Centring client agency and choice to ensure they feel a sense of control over their own care is critical to effective integrated care planning. This stage builds on the biopsychosocial assessment which should provide in depth information that identifies intersecting needs and possible support to address integrated care planning. Both in practice and at the service level, it is important to see this stage as an ongoing process that is reviewed and adjusted as needed, according to changing intersecting needs, as well as expected and unexpected life events.

In practice

At this stage, care teams should work with clients to complete an integrated care plan that identifies support according to these intersecting needs, including plans for any potential relapse or crisis. In addition to the usual processes for reviewing and adjusting care plans, intersectional practice brings an awareness of the dynamic current discourses across systemic, social and political, community and organisational, family and relational and individual levels that may be impacting on a client's mental health and wellbeing. For example, transphobic rhetoric in politics, the media, in schools, within families; debates around First Nations voice to parliament, Invasion Day, and the impacts of colonisation; social and political discourses around migration and immigration and how those might be impacting on trans, First Nations, migrant and refugee clients respectively.

Reflection – integrated care planning

Reflect on your practice as an individual, within care teams, and within your service:

- How can you use in-depth biopsychosocial assessment to collaborate with clients to understand what is going on in the broader contexts and provide supports as needed?
- How can you link clients to identified supports?
- How can you acknowledge the client/practitioner/care team power dynamics, using respectful curiosity to centre client agency and choice?
- How can you keep prompting and checking in about the current social and political climate and how that might be impacting clients – what's been in the news, what are the potential compounding effects on a person's sense of identity, community, etc?
- How can you elevate identity, cultural, and lived experience knowledges from both team/practitioners/transdisciplinary perspectives and client perspectives – in exploring and asking clients what will support their safety?
- How can you use respectful curiosity both inwards and outwards (what are we leaning into or missing based on our own power and privilege and how are we addressing that within our team and by including the client) to critically assess information?
- How can you build on strengths, supports, interests, and protective factors identified in the biopsychosocial assessment to include community and social supports in an integrated care plan?

Service level considerations

Service providers need to put structures, processes, and supports in place to facilitate effective integrated care planning that centres client agency and choice. This involves creating a culture and environment that enables care teams to utilise and revisit biopsychosocial assessments and collaborate with clients to access the kinds of wellbeing, clinical, peer, community and other types of supports or care that acknowledges and addresses their intersecting needs across all levels of the socioecological model.

As intersectional practice brings an awareness of the dynamic current discourses across systemic, social and political, community and organisational, family and relational and individual levels that may impact health and wellbeing. Examples were given 'In Practice' above to show how discourse and negative debates at all levels of the social ecology can negatively impact the health and wellbeing of members of those communities. It is important to acknowledge at the service level, the impact that social and political discourse may have, not only on clients accessing the service, but also on staff wellbeing. Services can acknowledge and address these needs through working with staff to see what supports might help them, while they are feeling the impacts at the same time as they are providing support to members of their wider communities.

What we heard from community and practitioners:

"Lived experience is valued and at the centre of services. Genuine consultation and review – seeking and acting on feedback, responding to concerns and complaints. Leadership/management buy in."

Practitioner (co-design group)

Supporting integrated and collaborative practice

Service providers should consider:

- How do practice leaders create a culture of valuing and elevating diverse voices to inform assessment and treatment?
- How do practice leaders support staff with cultural knowledge, identity knowledge and lived experience?
- What are the processes in place to ensure regular communication and holistic integration of services, bringing in knowledge from all relevant areas, including cultural, identity, and lived experience knowledge, to ensure continuity of care and synergies across domains of need?
- What are the processes in place to bring together care teams that bring relevant knowledge and experience to support clients' intersecting needs?
- How does the service facilitate regular review of the care plan to meet intersecting needs as they evolve, including reviewing the biopsychosocial assessment as part of this to understand not just what is changed for the individual but also what has changed within their contexts?

Integrated treatment, care, and support

Providing integrated treatment, care and support that is person-centred and holistic puts the integrated care plan into action. This requires the team to adapt to changes in the plan as intersecting needs and contexts evolve. Integration of treatment, care, and support involves partnership with clients and a collaborative approach across all domains, including wellbeing, clinical, social, peer, and care coordination. Knowledge sharing, including elevating cultural, identity, and lived experience knowledge, continues to be an important element at this stage. It is also important to continue to hold space for clients to be able to enact their agency and choice, as well as express any experiences of systemic barriers or discrimination. It is important to keep checking in with clients about what is working, what isn't and what changes need to take place at this stage of the client journey. This enables the process to be ongoing, dynamic and responsive to shifts in client needs and contexts.

In practice

At this stage, care teams and practitioners should continue to apply reflexivity in practice, tuning into unconscious biases and assumptions, centring client agency and choice in treatment, care, and support. This also involves collaborating across teams to leverage strengths and braiding different types of knowledge together, including from across cultural knowledge, identity knowledge, lived experience knowledge and interdisciplinary professional knowledge.

Reflection – integrated treatment, care, and support

Reflect on your practice as an individual, within care teams, and within your service:

- How can you collaborate within and across teams and disciplines as well as with the client to ensure that their intersecting needs are being met and that there are ongoing opportunities to adapt to any shifts or changes in their contexts?
- How can we address and respond to experiences of discrimination or intersecting oppressions, centring client agency in the treatment, care, and support that they receive?
- How can we create space to regularly check in about what's working, what isn't and if there have been any changes to a client's needs or contexts that require revisiting the care plan and subsequent approach to treatment, care and support?
- How does the care team engage in advocacy with other services and systems?

What we heard from practitioners:

> "One thing I've noticed that helps is invoking self-reflection in clinicians … Talk about your experiences, your own cultural identity … I think invoking those lived experiences, giving them time to pause and reflect really helps them get in touch more with some of these important aspects and makes them realise they're just as important a part of intersectional treatment, of safety, of inclusion, of diversity as consumers or anyone else."
>
> **Practitioner (co-design group)**

Service level considerations

Service providers have a big role to play in supporting an intersectional approach to practice at this stage of the client journey. Service providers need to review how they enable collaboration within and across teams and disciplines to create synergies within service provision that are responsive to diverse needs and holistic in approach.

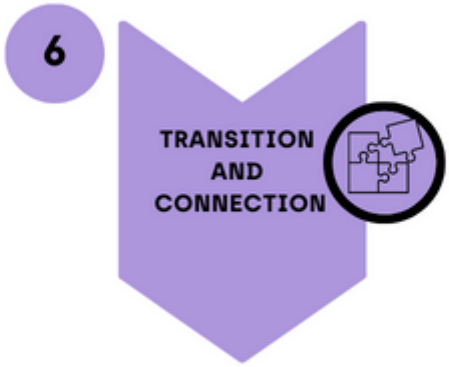
In addition to providing ongoing professional and practice development to staff, there should also be a revisiting of partnerships and referral pathways to facilitate access to other services to meet a diverse range of client needs.

Services can and should support advocacy efforts of diverse community members. Advocacy could happen at the client level- supporting clients to navigate service systems; at the service level- supporting services to become more inclusive and affirming for people from diverse communities; and at the structural and societal level- advocating for structural and attitudinal change alongside community.

Supporting integrated treatment, care, and support

Some considerations to support intersectional practice at the integrated treatment, care, and support stage include:

- What partnerships are in place – including with other service types or across care teams and disciplines within service to support diverse and intersecting client and community needs?
- What processes are in place to support practitioners and care teams to engage in collaborative and dynamic approaches to treatment, care, and support that adapt to shifts in client needs and contexts? How can we support collaborative case discussions ongoingly? Including a culture of awareness-raising that is continuously elevating diverse voices?
- What are the current structures for care team meetings or case reviews – how can we support staff to keep abreast of current issues that may impact clients (i.e. political climate etc)?
- How do we meet all aspects of a client's needs or, if we can't, acknowledge that, and support them to access other services?
- How do we support integrated care – communication and creating spaces for reflexive and collaborative care and support for clients – how do different care teams and practitioners/clinicians communicate?



Transition and connection

Transition and connection should be viewed as part of a cycle of continuous improvement, continuity of care and engagement, rather than an end point. This reinforces the notion of progressing towards system level change that addresses the intersecting needs and issues, especially for more marginalised communities and identities. In line with recovery-oriented practice, an empowerment framework guides the transition and connection process through proactively centring client agency/self-determination. This means meeting clients where they are at, and journeying alongside them, in their own time and on their own terms, elevating their position as an expert in their own lives.

Crucial to the success of intersectional transition and connection are solid quality assurance processes, centring client experiences in the continual improvement of service delivery and the use of lived experience knowledge to support the development of partnerships and linkages with other supportive services. This involves proactively seeking client and community feedback, being accountable to the feedback, and leveraging connections made through community engagement to understand how to better design, deliver and review services.

What we heard from practitioners:

"...just a continuity of care and the responsibility being placed on the client to initiate contact when they've already accessed the service ... But I think that having a dedicated worker or someone who holds your case through referrals or through engagement and not having pressure to close is a huge deal and can make a big difference if people remain engaged with us or with another service."

Practitioner (co-design group)

In practice

At this stage in the client journey, care teams including peer support workers prioritise follow up with clients and continuity of care. It is critical that this process includes supporting the whole person in an intersectional way to address their whole identity, in addition to their cooccurring needs. Leveraging elements of care, treatment, and support that worked well for clients, care teams can collaborate with them to create a comprehensive transition plan outside of the service and know that the door remains open if they need to return.

Reflection – transition and connection

When understanding a client's intersecting needs alongside a client's access to supports to meet their needs beyond your service, reflect on your current practice individually, within your care teams and within your service:

- What does effective continuity of care need to address for people with experiences of intersecting oppressions?
- How do we check in with our clients about the whole-of family and their community, social, political, and systemic contexts at this stage?
- What are existing supports to tap into, what types of supports do they still require, and what can we connect them with or refer them to?
- How can we support clients to sustain safety and support beyond our service?
- How do we communicate to clients that their feedback is important, and their identity, culture, and lived experience is valued, helping us learn about what worked, what didn't and how we can improve our practice?
- Have opportunities been provided and/or facilitated to empower clients to connect with community where they have a voice?

What we heard from practitioners:

"I think one thing that is really difficult with that is with the services just handing clients if different parts of their identities are really siloed. […] "Oh, there's AOD issues. And so this person needs to go to an AOD service." [or] "Oh, there's an increased risk of suicidality and self harms. They need to get triage, but they can't

because of their risky behavior." And so they get booted out of that. So it's just [...], "Oh, they're LGBT, so they can't access mainstream services or there's family violence." They just kind of get tossed around services, which is really, really common."

Practitioner (co-design group)

Service level considerations

Service providers build trust and a culture that applies an intersectional lens to practice and to service design and delivery by providing channels through which clients, communities, staff, and other relevant stakeholders can provide feedback on their needs and experiences of the service. Having a transparent process of accountability to the feedback received can support services and service leaders to collect evidence and better understand needs related to service design and delivery and will enable them to review service provision as needed.

Co-production models can guide quality assurance and quality improvement processes to allow services to evolve to meet the evolving needs of communities, taking into consideration all levels of social ecology, including broader systemic, structural and political considerations. Ongoing community engagement initiatives are important throughout this process, encouraging services to think of the client journey as a loop, with the transition and connection piece tying back to initial engagement.

What we heard from community:

"More processes [...] around how clients provide feedback and that feedback informs their practice. I think it's unfortunate that practitioners often are required to do things in certain ways [...] that doesn't necessarily align with what the client wants and then that isn't captured or the feedback isn't given to change the model in that way."

Community member (co-design group)

Co-production, feedback, and accountability

This stage of the client journey involves supporting clients to have input into the way services are shaped to meet diverse needs. A co-production model is a useful way of thinking about seeking client, community, and staff feedback, giving them a platform for their voice to be heard, and then using this feedback to inform continuous service development and improvement. By including diverse client, community, and staff voices, services can ensure that clients feel supported to re-engage with the service if needed.

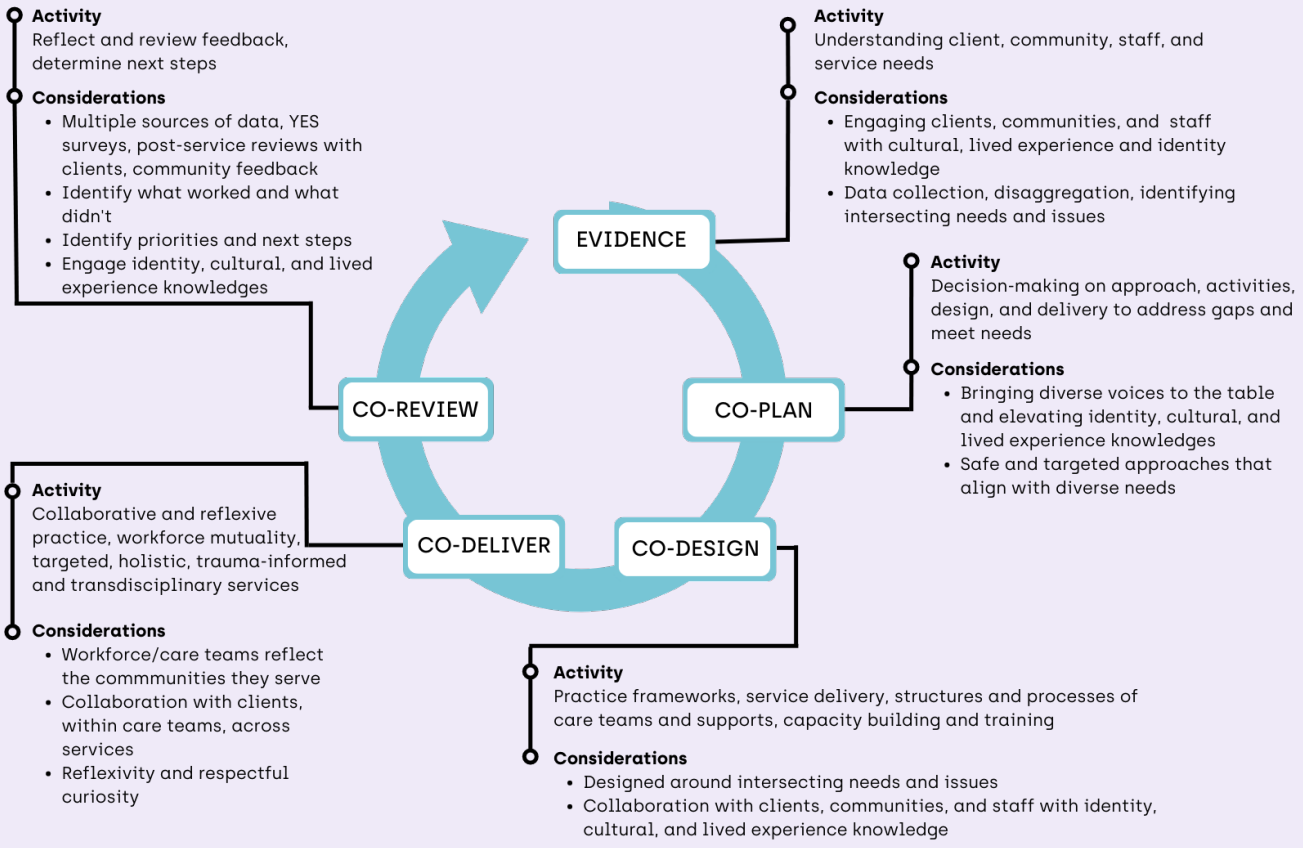


Figure 10 Co-production model with activities and considerations

Empowering transition and connection

At this stage, services should consider:

- How can we target community engagement activities to ensure we can support clients to reach into resources and community supports as part of their transition and connection beyond our service?
- How can we engage in advocacy and proactive partnerships with other services, sectors, communities and social supports, to meet diverse needs?
- What are our current processes for feedback from clients, communities, and staff and accountability towards that feedback?
- How do we use feedback, data collection and assessment of service gaps and community needs to engage in continuous improvement?
- How can we set targets and measure our progress towards intersectionality in practice?
- How can we engage in policy-sector activism that provides both a platform for intersectional voices and ensure all voices are heard?

Wrapping up

Building intersectional practice within a mental health service requires an ongoing whole of service response that is adaptive to social and political contexts, and we all have a role to play. There is a strong commitment within the sector and ongoing reforms to implement this approach, building on the strong foundation of the peer-worker movement and the recovery-oriented framework, and contribution of diverse identity, cultural, and lived experience knowledges.

Below are other helpful resources for practitioners and service providers to consider for further support in this work.

Helpful Resources

Intersectionality Research (2015) by the International LGBTQ Youth and Student Organisation. A research report that highlights best practice in intersectional approaches.

Ten Tips for Putting Intersectionality into Practice (2017) by the Opportunity Agenda. A list of ways to put intersectionality into practice that can be a starting point for any individual, community or organisation interested in incorporating an intersectional approach to their practice.

Intersectionality Resource Guide and Toolkit (2020) by UN Women. A resource guide and toolkit for organisations and individual practitioners and experts to acknowledge and respond to intersectionality in policies and programs.

An Intersectional Feminist Toolkit (2020) by Young Women's Charity Australia. Toolkit including information and advice based on a multitude of resources written by policy and advocacy experts.

White Privilege: Unpacking the Invisible Knapsack by Peggy McIntosh. Excerpts from a working paper designed to recognise and unpack white privilege.

Intersectionality and Youth Mental Health (2021) by Orygen. A fact sheet that aims to build fundamental knowledge about intersectionality particularly for professionals that work with young people.

References

Akibar, A. P., & Langroudi, K. F. (2021). Intersectionality, Lived Social Realities, and LGBTQ PoC Health. *Heart, Brain and Mental Health Disparities for LGBTQ People of Color*, 27–39. https://doi.org/10.1007/978-3-030-70060-7_3

Autret, M., & Eeden-Moorefield, B. van. (2021). Implications of inclusion and intersectionality for clinical practice. *Treating Contemporary Families: Toward a More Inclusive Clinical Practice.*, 17–28. https://doi.org/10.1037/0000280-002

Butler, C. (2015). Intersectionality in family therapy training: Inviting students to embrace the complexities of lived experience. *Journal of Family Therapy*, *37*(4), 583–589. https://doi.org/10.1111/1467-6427.12090

Commonwealth of Australia. (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Department of Health & Ageing, Commonwealth of Australia. https://www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers.pdf

Correro, A. N., & Nielson, K. A. (2020). A review of minority stress as a risk factor for cognitive decline in lesbian, gay, bisexual, and transgender (LGBT) elders. *Journal of Gay & Lesbian Mental Health*, *24*(1), 2–19. https://doi.org/10.1080/19359705.2019.1644570

Crenshaw, K. (1989). *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics Recommended Citation Crenshaw, Kimberle () "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics* (University of Chicago Legal Forum, Vol. 1989, Issue 1).

http://chicagounbound.uchicago.edu/uclfhttp://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241–1241. https://doi.org/10.2307/1229039

Department of Health, State of Victoria. (2011). *Framework for recovery oriented practice*. Mental Health, Drugs & Regions branch, Victorian Government. https://www.health.vic.gov.au/publications/framework-for-recovery-oriented-practice

Department of Health, State of Victoria. (2021). *The Victorian Mental Health and Wellbeing Workforce Capability Framework*. Victorian State Government. https://www.health.vic.gov.au/sites/default/files/2021-12/victorian-mh-and-wellbeing-workforce-capability-framework-pdf.pdf

Duckworth, S. (2020). *Wheel of Power Privilege and Marginalization*. https://ecampusontario.pressbooks.pub/universaldesign/chapter/positionality-intersectionality/

Hill, A., Lyons, A., Jones, J., McGowan, I., Carman, M., Parsons, M., Power, J., & Bourne, A. (2021). *Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia. National report.* (p. 9920053 Bytes). La Trobe. https://doi.org/10.26181/6010FAD9B244B

Hill, A. O., Bourne, A., Mcnair, R., Carman, M., Lyons, A., Hill, A. O., Bourne, A., Mcnair, R., Carman, M. &, & Lyons, A. (2020). *PRIVATE LIVES 3 THE HEALTH AND WELLBEING OF LGBTIQ PEOPLE IN AUSTRALIA* (No. 978-0-6488887-4–1).

McCann, B., Gibson, M., Donnelly, A., & Miles, F. (2023). *LGBTIQA+ Mental Health and Wellbeing: Key Findings and Considerations.* The Centre for Family Research & Evaluation, Drummond Street Services.

Nicholson et al. (2022). A systematic review of the neural correlates of sexual minority stress: towards an intersectional minority mosaic framework with implications for a future research agenda. *European Journal of Psychotraumatology, 13*(1), 2002572. https://doi.org/10.1080/20008198.2021.2002572

Pallotta-Chiarolli, M., Sudarto, B., Training, A., Committee Member Judy Tang, A., Health, J., President, A., Commissioner, V., Richards, K., Professor Adam Bourne, A., & Lim, G. (2021). *Navigating Intersectionality: Multicultural and Multifaith LGBTIQ+ Victorians talk about Discrimination and Affirmation Project Manager and Principal Researcher Co-Researchers Initial Literature Review Survey Co-Design and Analysis Citation*.

State of Victoria. (2021). *Royal Commission into Victoria's Mental Health System: Final Report – Summary and recommendations* (Parl Paper No. 202; p. Session 2018-21 (document 1 of 6)).

Tang et al. (2020). *Intersectionality in psychology APS*. https://www.researchgate.net/publication/341725442

Williams, G. (Hon). (2023). *Marking two years of critical mental health reform [media release]*. Victorian State Government. https://www.premier.vic.gov.au/site-4/marking-two-years-critical-mental-health-reform