Australian BPD Foundation Limited

Advocacy & Support for Borderline Personality Disorder & Complex Trauma

Submission to the Department of Health and Aged Care

Public Consultation on an Emerging Mental Health Curriculum Framework for Undergraduate Health Degrees

Submitted 18th April 2025 via an online form

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BACKGROUND:

There is a persistent and ongoing mental health workforce shortage across Australia. Upskilling the broader health workforce to identify, respond, refer, and support the mental health of people under their care is a priority. There is little consistency in existing mental health training across undergraduate health degrees, leading to a varying minimum standard of education and level of preparedness among graduating students. Developing a mental health curriculum framework will help provide consistency and a shared understanding of mental health-related knowledge, skills, and capabilities the broader health workforce should learn throughout their undergraduate training.

The Department of Health and Aged Care has commissioned Deloitte to provide *recommendations* to support the development and implementation of a mental health curriculum framework for undergraduate health degrees.

Scope

The focus of this work is on health and allied health professions who do not usually or primarily work in specialised mental health roles, and who have an expected or required level of undergraduate training.

The health professions in scope include:

- Nursing
- Midwifery
- Aboriginal and Torres Strait Island Health Practitioners
- Occupational Therapy
- Paramedicine
- Pharmacy
- Oral Health
- Optometry
- Physiotherapy
- Dietetics and Nutrition
- Social Work
- Exercise Physiology
- Speech Pathology

This submission is part of that broader public feedback.

What activities would be needed to support the development of any mental health curriculum framework?

List the kind of activities needed to support the development of any mental health curriculum framework:

As articulated in the briefing pack there is a vital need to upskill the broader health workforce to identify, respond, refer, and support the mental health of people under their care is therefore a priority area. For people referred to a experiencing complex mental illness this is usually related to a diagnosis of borderline personality disorder, complex trauma and chronic suicidality where research has shown that the literacy and willingness to treat, even amongst mental health professionals, is low.

The development of an effective mental health curriculum framework requires several foundational activities:

1) Comprehensive stakeholder engagement is essential, involving clinicians, educators, people with lived experience of complex mental health conditions, family members, carers, and cultural advisors. This engagement needs to be ongoing throughout development rather than just at the beginning or end.

Adequate time and resources must be allocated to allow the development of a trusting relationship between the diverse stakeholders for true coproduction to occur. It is essential those who have lived with complex mental health

challenges and the carers who've walked beside them have an equal voice in designing and shaping every part of the framework and training.

Yarning circles and story-sharing spaces: Safe, inclusive spaces where service users, their carers, educators, and students can sit together and listen to and learn from one another. Their stories hold wisdom that can't be taught in a textbook.

Review existing curricula both domestically and internationally to identify best practices and any identified gaps. Focus on examining models where cultural safety and working with people in a way that values their humanity have been successfully integrated into the training.

2) Competency mapping exercises would help identify the specific knowledge, skills, and attitudes needed across different professional groups while

maintaining a core focus on relational approaches to care for complex mental illness.

3) Pilot testing of framework components in educational settings would allow for refinement before full implementation, with educators and students providing feedback on practicality and effectiveness. Ideally, also include people with complex mental illness and consistent suicidal thinking who have experienced diverse experiences of care eg public/private.

4) Development of assessment tools for future students specifically designed to evaluate relational competencies would help ensure these skills are properly valued alongside more technical aspects of care.

5) Creation of implementation resources such as teaching materials, case studies featuring holistic care and incorporating mental health presentations with physical conditions eg chronic pain. Simulation scenarios (and virtual reality) as used in healthcare environment allows the consolidation of a greater amount of knowledge in the short term support. It gives students an opportunity to be practising new skills in a safe environment where the cannot inadvertently cause harm.

6) Be open to consider alternatives to the conventional, biomedical wisdom eg cultural consultation done well and ongoing: We must engage meaningfully with First Nations communities and other marginalised voices, making sure their knowledges and ways of healing are honoured, not just added in as a footnote. I feel they have a lot to teach us.

What types of mental health-related competencies should be included in any mental health curriculum framework (noting these should apply to all health professions in scope)?

Identify types of mental health-related competencies should be included in any mental health curriculum framework (noting these should apply to all health professions in scope):

1) Trauma-informed understanding and trauma sensitive practice: Future professionals need to know what trauma is, how it presents, and how the system can either support healing and/or retraumatise. Trauma informed care needs to be more than a buzzword. Too many services and health professionals state they are trauma informed when they aren't

2) Cultural safety and humility: It's not just about knowledge, it's about being willing to reflect, to listen, and to be uncomfortable. We need people who know how to practice in a culturally safe, respectful way.

3) Compassionate communication and relational skills: So many services users comment on memories of they were spoken to or not spoken to by professionals. Being heard and treated like a person matters as much as clinical expertise. These skills include advanced interpersonal skills, therapeutic presence, emotional attunement, meaning-

making abilities, authentic engagement, and maintaining hope in challenging circumstances. These skills are particularly crucial when working with people experiencing chronic suicidality.

4) Reflective practice capabilities including emotional awareness, recognizing countertransference, managing difficult feelings when working with people who are chronically suicidal and developing professional resilience.

5) Collaborative practice skills for working effectively in multidisciplinary teams while maintaining a cohesive therapeutic approach and avoiding fragmentation of care.

6) Working with lived experience: Students should learn how to genuinely partner with people with lived experience, not just listen to their stories but truly value their expertise as equal experts in any interaction.

7) Big picture thinking – moving beyond symptom checklists. Understanding how things like poverty, racism, intergenerational trauma, and family violence affect people's mental health is crucial. It's not all about diagnoses. Understand the interdependence of mental and physical health. An understanding of the ways that childhood adversity impacts upon their ways of thinking, of responding to situations they deem stressful and their overall physical health. Important to understand how symptoms are experienced subjectively and the impact on identity, relationships, and meaning.

8) Respectful support for complex presentations: Conditions like borderline personality disorder, complex trauma and dissociative identity disorder are often misunderstood and feared. Future professionals need education that helps reduce stigma and builds confidence in supporting people with these experiences and remove the word Complex out of the vernacular – 'No one wants to be called complex, yet every single mental health service has a complex team attached to it' (lived experience quote). Rather see complexity as not located in a person but between people and systems. We need to think more widely about why this person is so complex to us… perhaps we need a wider lens!

9) Ethical reasoning specifically addressing challenges in complex care such as balancing autonomy with risk management, addressing power dynamics, and recognising the limitations of coercive practices.

10) Awareness of the power of language to either hurt and stigmatise or to help break down barriers and develop trust. Avoid 'judgemental/blaming words which are often more related how we are responding to the person rather than their distress eg avoid the use of the terms 'manipulative' , 'too intensive', 'treatment resistant' or 'nuisance' (plus many more) and focus on the why the person may be responding in this particular way OR why we may be interpreting an action a particular way.

Systemic thinking to understand the social determinants of mental health, recognise the potential power imbalances and iatrogenic harms within healthcare systems, and advocate for changes that better support relational approaches to care.

What are some effective ways to teach mental health-related competencies in undergraduate education and training settings?

Effective ways to teach mental health-related competencies in undergraduate education and training settings:

1. Interdisciplinary learning: Bringing students from different health professions together helps create a shared understanding and encourages more holistic care. Teaching mental health-related competencies effectively requires multiple approaches:

2. Experiential learning is critical for developing relational skills. This includes role-playing, supervised clinical placements with gradually increasing complexity, reflective practice groups, and. Listening to and learning through lived experience stories: Nothing replaces hearing directly from those who've been through the system. It brings heart, depth, and humanity to the learning. Virtual reality has been shown to help pharmacy students to learn to communicate with their customers and develop confidence in a safe environment

3. Personal development components encourage students to examine their own values, emotional responses, biases, and assumptions. Regular guided reflection through journaling, small group discussions, and mentoring helps develop emotional awareness and resilience and helps them grow not just as professionals—but as people.

4. Case-based learning using detailed, longitudinal case vignettes embedded throughout the curriculum helps students understand the complexity and non-linear nature of recovery in a more holistic way. It can also help them develop an understanding of the interrelationship of physical and mental health. It's also valuable to include the perspective of the person experiencing mental distress rather than solely professional perspectives.

5. Co-teaching models involving educators with clinical expertise alongside those with lived experience/expertise helps students recognise the equal importance of experiential knowledge and professional knowledge……multiple experts

6. Interdisciplinary learning environments where students from different health professions learn together about complex care encourages cross-disciplinary respect and collaboration from the outset.

7. Peer-led teaching and mentorship: Lived experience educators can model recovery, collaboration, and real connection in ways that challenge stigma and show what's possible.

8. Practice-based assessments that prioritise relational skills alongside knowledge acquisition ensure students recognize these competencies are valued equally with technical skills.

9. Real-life simulations with feedback: Give students the chance to practice having conversations and responding to distress—with feedback from people who've lived it.

Do you have any considerations in relation to interdisciplinary training or practice that could have implications for this piece of work?

Provide considerations in relation to interdisciplinary training or practice that could have implications for this piece of work:

1. Power dynamics between disciplines need explicit attention. Professional hierarchies that prioritise biomedical knowledge over relational skills often inadvertently devalue psychotherapeutic approaches. The curriculum should address these dynamics openly. It's essential to have a consistent focus on dignity, respect, and person-centred care. These values should underpin everything.

2. Awareness of power dynamics in any interaction: Students need to learn how to work in ways that are collaborative and respectful, not hierarchical. We need to challenge old systems that have silenced or excluded certain voices. It's essential to work WITH the person not TO them.

3. Common language development across disciplines is essential. Different professions often use different terminology for similar concepts, creating barriers to integration. The curriculum should establish shared language around relational approaches to complex mental illness.

4. Lived experience as part of the team: Peer workers and lived experience advocates must be seen as essential members of care teams—not as extras or add-ons. People with mental health issues may already be working in healthcare settings yet reluctant to disclose this due to a fear of stigma and discrimination.

5. Role clarity versus flexibility requires careful balance. While professional boundaries have value, rigid role definitions can create fragmented care for people with multiple needs. The curriculum should promote both discipline-specific expertise and flexible responsiveness.

6. Joint learning opportunities where different disciplines learn together about a person who is experiencing systemic and relational complexity in accessing healthcare can help overcome tribalism that may develop when disciplines are trained in isolation. Case studies that include multiple viewpoints: Learning through, real-world scenarios where different perspectives are valued can help students prepare for real-life work.

7. Integrated placement experiences where students observe and participate in multidisciplinary approaches to complex care demonstrate how different professional contributions complement each other in practice.

8. Assessment of collaborative competencies specifically should be incorporated, evaluating how effectively students engage across disciplinary boundaries rather than solely within their professional silo.

9. Leadership development within the curriculum should emphasise skills for promoting integration and relational approaches within teams and systems that may default to more procedural or medication-focused interventions.

NATIONAL TRAINING STRATEGY FOR BORDERLINE PERSONALITY DISORDER

The Australian BPD Foundation with funding from the NMHC developed a 4 stage national training strategy for BPD including 1) a series of 6 webinars 2) five online eLearning modules 3) BPD Core Competency Workshops & Train the Trainer Workshops 4) communities of practice, supervision and support.

The multidisciplinary curriculum was based on the core competencies that clinicians require to enable them to effectively work with people with BPD (and their carers). They include:

- Understanding the diagnosis of BPD (including symptoms, prevalence, causes and evidence based treatments)
- Co-existing disorders in BPD
- Treatment principles
- Treatment structure
- Therapeutic relationship
- Skills development focus
- Partnering with families, partners and carers
- Working with suicidal and non-suicidal self-injury behaviours
- Clinician self – awareness
- Focus on recovery in BPD

Whilst this strategy had a particular focus on borderline personality disorder it is a diagnosis that is largely synonymous with complexity, complex trauma and chronic suicidality. Both the Core Competency and Train the Trainer manuals can be readily adapted to a diverse cohort of people who are working with people with BPD in some capacity eg Centrelink, NDIS, OTs, physios, GPs etc

Please contact me if you'd like some more information.

What activities would be needed to support the implementation of any mental health curriculum framework?

Advise of any activities needed to support the implementation of any mental health curriculum framework:

1. Faculty development programs to build educator capacity in teaching and assessing relational competencies. Many health educators may themselves have been trained in biomedically-oriented models and need support to confidently teach psychotherapeutic approaches. Some may be experiencing mental health distress which they have not disclosed and may need support themselves—especially when it comes to trauma-informed and recovery-based approaches.

2. Organisational readiness assessments for educational institutions to identify structural barriers to implementation, such as timetabling constraints that limit longer-form relational learning opportunities or assessment systems that favour knowledge testing over skill demonstration.

3. Structural support from institutions: It’s not enough to sprinkle this content here and there. It needs to be built into the heart of training programs.

4. Valuing and supporting lived experience educators: These roles should be secure, well-supported, and treated with the same respect as clinical educators.

5. Communities of practice for educators, clinicians and peer workers an opportunity to learn together, troubleshoot challenges, and the sharing of resources as implementation progresses.

6. Quality improvement cycles with regular feedback from students, educators, lived experience contributors, clinical supervisors, and people with lived experience would help refine implementation over time and ensure this framework is working in practice.

7. Resource development and sharing including teaching materials, assessment tools, case studies, and simulation scenarios would reduce duplication of effort across institutions.

8. Recognition and incentive systems that value excellence in teaching relational approaches would help counter academic environments that may prioritise research outputs over educational quality.

9. Partnership agreements with clinical settings that explicitly support students to practice relational approaches during placements, even when these settings may be pressured toward more rapid intervention models.

What else might be happening in your sector/area of expertise that could have implications for this piece of work?

Advise if there is anything happening in your sector/area of expertise that could have implications for this piece of work:

1. Increasing recognition of the limitations of purely biomedical approaches to complex mental health conditions is creating openness to relational frameworks, but this exists alongside continuing pressure for standardised, brief interventions driven by economic constraints.

2. Digital mental health innovations are expanding rapidly. They often focus on symptom monitoring or brief structured interventions rather than relational depth. The curriculum needs to address how technology can supplement rather than replace relational care. There are increasing concerns about the role of Ai in mental healthcare especially if they use AI tools as their only form of support, avoiding real-world connections or professional help.

3. Workforce shortages across mental health disciplines create competing pressures: on one hand, for rapid skills acquisition focused on immediate service needs; on the other, recognition that sustainable practice requires deeper therapeutic capabilities.

4. Growing lived experience workforce is challenging traditional professional boundaries and creating opportunities for new models of care that center experiential knowledge alongside clinical expertise. Many professionals struggle to work alongside lived experience staff effectively. Training must address this.

5. Increasing complexity of presentations with intersecting mental health, substance use, trauma, and social determinants requires practitioners capable of integrating multiple frameworks rather than applying single-model approaches.

6. Stigma still lingers in the system: Especially around complex trauma, personality disorders, and voices or other altered states. This stigma needs to be actively addressed in training.

7. Policy shifts toward trauma-informed systems align well with relational approaches but require workforce development that goes beyond superficial training to develop genuine trauma-responsive capabilities.

8. Growing evidence base for relational and recovery and person-led approaches to complex conditions is emerging, creating opportunities to strengthen the theoretical foundations of the curriculum with contemporary research. This curriculum should reflect and support that change.

9. Wider systemic change is underway: There's a push towards more human, person-first mental health care. Future professionals need to be ready to support—and lead—that change.

Question relevant to lived and living experience / carers and families - Advise if anything needs to be considered for this work based on own lived or living experience in the health and care and support system?:

FOR LIVED EXPERIENCE

It's essential that any consultation includes the direct experience of people experiencing systemic and relational complexity within the health system and is inclusive of disadvantaged minority groups eg first nations, LGBQTI+SB, refugees etc and intersectionality

1. The harm caused by fragmented care approaches where multiple professionals address different aspects of distress without integration, creating a disjointed experience for the person and potentially (inadvertently) reinforcing how unwell they are..

2. The importance of consistency and continuity in therapeutic relationships, especially for people who have experienced childhood adversity where they feel unable to trust others. Trust develops slowly.

3. The need for practitioners who can tolerate emotional intensity without resorting to distancing behaviours, defensive practice, or unnecessary escalation of restrictive interventions.

4. The value of approaches that respect autonomy and agency even during periods of acute distress, working collaboratively rather than coercively whenever possible.

5. The central importance of hope and meaning-making in recovery from complex conditions, which requires practitioners skilled in supporting existential aspects of mental health.

6. The experience of iatrogenic harm from interventions that prioritise risk management over therapeutic relationship, and how this can exacerbate rather than reduce distress.

7. The need for culturally responsive care that honours diverse understandings of distress and healing rather than imposing mainstream clinical frameworks.

FOR CARERS

Carers (family, friends, supporters, kin) have a unique and crucial perspective that must be integrated on shaping a curriculum that truly serves people with complex mental illness (e.g., borderline personality disorder, complex PTSD) and chronic suicidality. A relational, psychotherapeutic, and trauma-informed approach must form the core of this framework. Equipping future health professionals with these skills and understandings will ultimately improve care, reduce harm, and foster healing for those who are too often failed by existing models.

It's important to note here that when a family member is experiencing complex mental illness, especially conditions involving chronic emotional distress and suicidality, traditional family support structures often face significant strain and may become quite dysfunctional and (especially parents) be blamed for the person being unwell eg poor parenting. Families are often thrust into caregiving roles without adequate preparation, support, or recognition, and the emotional intensity of the situation can disrupt usual relational dynamics. Issues around consent commonly occur and must be worked through sensitively.

What carers would like included in such a curriculum framework, (from both practical and values-based lens includes:

1. Understanding carers as key supports and can be valuable partners in the care team: Teach students that carers are often the consistent, long-term relational anchor for people with complex mental health issues.

2. Inclusion in care planning: Educate students about involving carers (with consent) in collaborative treatment plans and decision-making processes.

3. Respect and validation: Ensure the curriculum fosters an understanding that carers often navigate emotional, practical, financial and systemic burdens without much recognition. Vicarious trauma is common.

4. Case studies and testimonies: Inclusion of carer voices in case studies used throughout. Real-life experiences can challenge stereotypes and help future clinicians understand the nuances of long-term emotional pain, suicidality, and recovery.

5. Co-designed learning: Include lived experience educators (both people with complex mental illness and their carers) in curriculum design and delivery.

6. Understanding the maze: Educate students on the real-world challenges families face—long waitlists, fragmented services, lack of continuity, stigma.

7. Family diversity: Recognise that "carers" come in many forms—chosen family, friends, partners—not just biological relatives.

8. Working collaboratively with carers: Teach how to communicate with carers empathetically and ethically, including when navigating consent and privacy.