CREATIVE WOMEN'S ASSOCIATION

STEPPED ECONOMIC PARTICIPATION MODEL

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A Graduated Economic Participation Framework for Women Whose Workforce Entry Has Been Shaped by Domestic and Care Load

PART OF THE CWA STRUCTURAL MEASUREMENT SUITE

DCL Index • ILV Index • CWI™ • Stepped Economic Participation Model

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A Note on This Document

The Stepped Economic Participation Model (SEPM) is the fourth component of the CWA Structural Measurement Suite, sitting alongside the Domestic & Care Load (DCL) Index, the Intangible Labour Value (ILV) Index, and the Cultural Workforce Index™ (CWI). Where the first three instruments establish the evidential case for an Australian Cultural Work & Provenance Act, the SEPM is the operational delivery framework — the tool that puts those instruments to work in the lives of women.

The model is directly modelled on the Mental Health Stepped Care framework operated by Primary Health Networks across Australia, including Eastern Melbourne PHN. That model has proven highly successful because it operates on a single foundational principle: that people require different levels of support, and that the system should meet them where they are rather than requiring them to fit a single program structure. The SEPM applies exactly that logic to economic participation.

The SEPM is presented here as a framework seeking academic validation, pilot funding, and implementation partnership. It is grounded in established structural measurement.

Executive Summary

The Stepped Economic Participation Model is a graduated economic participation framework designed to activate women's workforce entry, cultural enterprise development, and income generation — matched precisely to where each woman actually is in her economic journey, not where policy assumes she should be.

Women's workforce exclusion is not a motivation problem. It is a structural load problem. Women perform 76% of Australia's unpaid domestic labour and 71.8% of primary caregiving (ABS 2022; WGEA 2024). This structural arrangement shapes — and in many cases prevents — economic participation. No existing program framework measures this load and uses it to determine the right level of support. The SEPM does.

> ***The right support. The right time. The right intensity — matched to where each woman actually is.***

The model operates across five levels, calibrated using the DCL (Domestic & Care Load) Index score. Women move between levels — stepped up or down — as their structural load and economic participation capacity changes. This is the same principle that underpins the Mental Health Stepped Care model operated by Primary Health Networks, which has proven effective precisely because it treats need as variable and response as adaptive.

The SEPM prioritises access for CALD women, First Nations women, women with disability, and women in regional communities. Initial pilot delivery is focused in South-West Sydney Local Government Areas, identified through national policy and demographic data as areas of high need.

The model is designed to scale nationally through Local Government, PHN, and community infrastructure — the same delivery architecture that has made Mental Health Stepped Care nationally operative.

The Problem

Australia's economic and workforce frameworks have not caught up with the structural reality of women's lives. The data is unambiguous:

- Women perform 76% of unpaid domestic labour and 71.8% of primary caregiving nationally (ABS 2022; WGEA 2024)
- Women perform 30–50 additional hours per week of unpaid labour above their paid work (ABS 2022)
- The superannuation gap stands at 31% — the direct lifetime financial penalty for unpaid cultural labour (WGEA 2024)
- 0% of Australia's cultural workforce currently operates under nationally recognised standards
- Women's unpaid care work is conservatively valued at $650 billion annually — equivalent to 50.6% of GDP (ABS 2020; Deloitte Access Economics 2020) — yet none of it is classified, certified, or economically protected

The structural consequence is not a participation gap. It is a system design failure. Existing workforce programs assume women are at a single point — ready for employment, enterprise, or training — and offer a single intervention. Women whose economic participation has been shaped by years of high domestic and care load are not at a single point. They are at five different points. A program that does not account for this will not reach the women who most need it.

This is the same problem the Mental Health Stepped Care model solved for mental health: the recognition that need is not uniform, and that a single-intensity program leaves the highest-need cohorts behind. The SEPM applies that lesson to economic participation.

Theoretical Foundation

Mental Health Stepped Care: The Proven Model

The Mental Health Stepped Care framework, commissioned by Primary Health Networks across Australia, delivers mental health support tailored to individual need. The model's foundational principle, as articulated by Eastern Melbourne PHN and replicated nationally, is that people may be stepped up and down through different levels of care within the service, guided by their needs.

The model works because it:

- Uses a validated assessment instrument (the IAR-DST — Initial Assessment and Referral Decision Support Tool) to determine starting level
- Provides different types and intensities of support at each level — not the same support at different volumes
- Allows movement between levels as need changes — up and down, without penalty or administrative barrier
- Specifically targets under-represented communities who are least likely to access single-intensity programs
- Integrates with existing health infrastructure — GPs, community health, peer support — rather than requiring new systems

The SEPM is built on exactly this architecture, substituting the DCL Index for the IAR-DST, economic participation for mental health treatment, and the CWA cultural workforce pathway for the clinical intervention suite.

The DCL Index as the Assessment Instrument

The Domestic & Care Load (DCL) Index — Instrument One of the CWA Structural Measurement Suite — provides the SEPM with its assessment foundation. As the IAR-DST determines the appropriate level of mental health support, the DCL score determines the appropriate level of economic participation support.

DCL = (U + C + M) × A × F

Where: U = Unpaid Domestic Work | C = Care Work | M = Mental Load | A = Allostatic Load | F = Financial Precarity

The multiplicative structure of the DCL formula reflects evidence that structural pressures compound rather than add — the same principle that makes high DCL scores incompatible with high-intensity economic participation programs, and that makes level-matched support essential rather than optional.

> ***DCL names the damage. The SEPM matches the response to the damage — at the level where the woman actually is.***

The Stepped Economic Participation Model

Five levels · DCL-calibrated · Adaptive by design

The following table presents the full SEPM framework. Each level is calibrated to a DCL score range and specifies who it serves, what is provided, how it is delivered, and what outcomes it targets. Women move between levels as their structural load and economic participation capacity changes.

LEVEL	DCL SCORE	WHO THIS LEVEL SUPPORTS	WHAT IS PROVIDED	HOW IT IS DELIVERED	OUTCOMES
LEVEL 1	**0–20 Low Load**	Women with stable finances, shared household duties, manageable care responsibilities. Ready for direct workforce or enterprise entry.	Cultural workforce certification pathway. Southern Cross Mark registration. Skills recognition assessment. Enterprise development workshops.	Online and in-person. Self-directed with peer cohort support. Monthly group sessions.	Certified cultural practitioner. Southern Cross Mark registered. Income pathway established.
LEVEL 2	**21–40 Moderate Load**	Women managing emerging strain — part-time care, time poverty beginning. Some workforce connection but constrained participation.	Flexible certification pathway with case-managed support. Micro-enterprise development. Part-time workforce placement assistance.	Hybrid delivery. Fortnightly individual check-in plus group cohort. Flexible scheduling around care responsibilities.	Progressing toward certification. Micro-enterprise activity commenced. Part-time income generating.
LEVEL 3	**41–60 High Load**	Primary carers with limited support networks. Moderate financial instability. Significant time constraints on participation.	Case-managed economic participation pathway. DCL-informed support planning. Financial capability building. Referral to care load support services.	Community-based. In-home where needed. Weekly case-managed contact. Integration with PHN, LGA and DFV referral pathways.	Stabilised participation. Financial capability strengthened. Progression pathway to Level 2 established.
LEVEL 4	**61–100 Critical Load**	Single parents, women in financial precarity, high allostatic stress. Complex care responsibilities. Economic exclusion compounded.	Intensive structured support. Coordinated wraparound services across economic, health and DFV systems. Advocacy and systems navigation.	Intensive case management. Multi-agency coordination. In-community delivery. Priority access to all CWA programs.	Crisis stabilised. Wraparound supports activated. Pathway to economic participation established at manageable pace.
LEVEL 5	**100+ Crisis Load**	Women at risk of health deterioration, DV vulnerability, collapse of functioning.	Safety-first economic stabilisation. Emergency financial support. DFV referral. Connection to Primary Health	Emergency response via trusted referral pathways. MP electorate offices, PHNs, DFV services, LGA community	Safety secured. Economic stabilisation commenced. Future pathway to cultural workforce

LEVEL	DCL SCORE	WHO THIS LEVEL SUPPORTS	WHAT IS PROVIDED	HOW IT IS DELIVERED	OUTCOMES
		Cultural workforce participation currently inaccessible.	Network and community health.	hubs. Warm referral only.	participation preserved.

Movement between levels is continuous and non-linear. A woman may move from Level 3 to Level 2 as care responsibilities reduce, or from Level 2 to Level 3 following a health event or financial crisis. The model does not penalise movement in either direction. The goal at every level is to maintain connection to the economic participation pathway and to move each woman toward certification, enterprise activity, and income generation at a pace her structural situation allows.

SEPM and Mental Health Stepped Care: A Structural Comparison

How the two models align

The following table maps the SEPM directly against the Mental Health Stepped Care model operated by Eastern Melbourne PHN and replicated nationally. The structural alignment is deliberate: the SEPM applies the same proven logic to a different domain of structural need.

DIMENSION	MENTAL HEALTH STEPPED CARE (PHN Model)	STEPPED ECONOMIC PARTICIPATION MODEL (CWA)
Foundational instrument	IAR-DST: Initial Assessment and Referral Decision Support Tool — assesses clinical need and severity	DCL Index: Domestic & Care Load assessment — quantifies structural economic exclusion as the basis for level assignment
Presenting condition measured	Mental health symptom severity (mild → severe)	Structural economic exclusion driven by domestic and care load (Low Load → Crisis Load)
Entry point	Self-referral or GP/health professional referral	Self-referral, MP electorate office, PHN, LGA community hub, DFV service, trusted community pathway
Movement through levels	Stepped up or down based on assessed need and treatment response	Stepped up or down based on DCL score change and economic participation progress
Level 1 (lowest need)	Low-intensity digital and self-directed mental health resources	Certification pathway, Southern Cross Mark registration, enterprise development — for women ready to participate directly
Level 5 (highest need)	Crisis intervention, acute psychiatric care, hospital linkage	Safety-first stabilisation, emergency financial support, DFV referral — economic pathway preserved for future engagement
Workforce delivering support	Peer support workers, psychologists, nurses, social workers, counsellors	CWA case managers, cultural workforce advisers, LGA community development officers, PHN partners, DFV specialists
Under-represented community focus	Children, young people, LGBTIQA+, CALD, First Nations	CALD and migrant women, First Nations women, women with disability, women in regional/rural communities
Integration with health system	GP Mental Health Plans, Medicare, PHN commissioning	PHN referral pathways, DCL Index structural assessment, DFV service coordination
Measuring outcomes	Clinical severity scores, K10, PHQ-9, treatment response	DCL score change, certification achieved, enterprise activity, income generated, CWA Data Dashboard
Goal of the model	Right support, right time, right intensity for mental health need	Right support, right time, right intensity for economic participation — matched to where each woman actually is

The key insight from the Mental Health Stepped Care model — that the assessment instrument determines the level, and the level determines the type and intensity of support — is directly transferred to the SEPM. The DCL

Index is to economic participation what the IAR-DST is to mental health: the objective instrument that removes the assumption that all participants need the same thing.

Delivery Infrastructure

Partners · Pathways · Access points

The SEPM is designed to be delivered through existing infrastructure — not to create new systems. This is the same architecture that makes Mental Health Stepped Care scalable: it commissions delivery through networks that already exist and already have community trust. The SEPM does the same.

PARTNER TYPE	ROLE IN SEPM DELIVERY	LEVELS SERVED
Primary Health Networks	DCL Index screening integration; warm referral for Levels 3–5; health coordination	Levels 3, 4, 5
MP Electorate Offices	Intake and referral across metropolitan, regional, rural communities; CALD, First Nations access points	All levels
Local Government Community Hubs	In-community delivery; community development officers as case support	Levels 2, 3, 4
DFV Services	Crisis referral pathway; safety-first coordination for Level 5; DCL evidence support	Level 5 (primary); Level 4
CWA Cultural Workforce Program	Certification delivery; Southern Cross Mark registration; enterprise development	Levels 1, 2
Monash University / Research Partners	DCL validation; program evaluation; impact measurement; outcomes reporting	All levels
Beyond Blue / NewAccess	Mental health co-referral; small business owner pathways; peer support integration	Levels 3, 4, 5

The geographic focus for initial pilot delivery is South-West Sydney Local Government Areas, identified through national policy and demographic data as areas with high CALD populations, economic disadvantage, and limited culturally relevant workforce pathways. The delivery model is hybrid — in-person, in-community, and online — to ensure metropolitan, regional, and rural access.

Outcomes Framework

NSW Women's Strategy 2023–2026 alignment

The SEPM delivers outcomes across all three pillars of the NSW Women's Strategy 2023–2026. The following table maps SEPM mechanisms to specific strategy outcomes and specifies how each will be measured.

NSW WOMEN'S STRATEGY PILLAR	OUTCOME	SEPM MECHANISM	MEASUREMENT
Pillar 1: Economic Opportunity	Women have increased opportunities to participate in the workforce	Certification pathway; enterprise development; Southern Cross Mark registration	Certifications issued; enterprises created; income generated (CWA Data Dashboard)
Pillar 1: Economic Opportunity	Women experience financial security throughout their lives	Replacement Cost Floor; Care Credit pathway; DCL-informed financial capability	DCL score improvement; superannuation accumulation; income stability indicators
Pillar 2: Health & Wellbeing	Women have access to programs that support their physical, mental and financial health	DCL-informed support planning; PHN integration; DFV referral pathways	DCL score change; PHN referral rates; health service uptake
Pillar 2: Health & Wellbeing	Increased understanding of women's health needs in the community	DCL Index as structural health evidence; practitioner awareness training	DCL assessments conducted; PHN partner engagement; GP awareness
Pillar 3: Participation & Empowerment	Women from diverse communities represented at all levels of leadership	Women in Culture Awards; Cultural Practitioner Register; leadership recognition	Certifications by community; Awards participation; Register diversity data
Pillar 3: Participation & Empowerment	Women have strong connections with their culture and community	Cultural workforce pathway; intangible heritage recognition; community delivery	Cultural enterprise activity; Southern Cross Mark certified outputs; community reach

Scale of Impact

Projected participant reach across a three-year pilot delivery:

- Approximately 20,000 women reached annually
- 60,000 participants over the three-year pilot period
- Participation recorded through the Cultural Work Certification Registry and CWA Data Dashboard
- DCL Index assessments generating structural load data for national economic modelling

The Harris Tweed certification system — the closest international precedent for a provenance-based cultural workforce model — demonstrated employment growth of approximately 570% between 2009 and 2014 following certification implementation. The SEPM applies this logic at national scale: converting currently invisible cultural labour into certified, measurable economic participation.

Evidence Base

Unpaid Labour and Structural Load

ABS (2022) Unpaid Work and Care Report. WGEA (2024) Gender Equality Scorecard. OECD (2023) Gender Data Portal. Deloitte Access Economics (2020) Value of Informal Care in Australia. Strazdins et al. (2016) Time poverty and gendered workforce participation.

Stepped Care Model

Eastern Melbourne PHN: Mental Health Stepped Care Model. Department of Health and Aged Care (2022) PHN Mental Health Stepped Care Guidance. EMPHN (2025) Mental Health Stepped Care: Consumer and GP resources. Bower & Gilbody (2005) Stepped care in psychological therapies — original framework publication.

DCL Index

McEwen (1993–2020) Allostatic load theory. Daminger (2019) Cognitive dimension of household labour, American Sociological Review. Pearlin et al. (1990) Caregiver Stress Process Model. ANROWS (2021) Financial abuse and coercive control. WHO (2001) International Classification of Functioning, Disability and Health.

Cultural Workforce and Provenance

Harris Tweed Authority (2014) Economic impact of certification. UNESCO (2003) Convention for the Safeguarding of the Intangible Cultural Heritage. Japan Law for the Protection of Cultural Properties, Act No. 214 (1950). WGEA (2024) National employer census.

Economic Value

ABS (2020) Unpaid work satellite accounts. ILO (2018) Care work and care jobs for the future of decent work. Women's Economic Equality Taskforce (2023) Final report. Productivity Commission (2023) Care and Support Economy inquiry.

Implementation Pathway

Phase 1 — Pilot (2026–2027)

- South-West Sydney LGA pilot delivery across Levels 1–5
- Partner activation: MP electorate offices, PHNs, LGA community hubs, DFV services
- DCL Index integration as intake assessment instrument
- CWA Data Dashboard implementation for participant tracking
- Women in Culture Awards — national recognition event, Sydney Opera House, 17 October
- Target: 20,000 women reached in year one

Phase 2 — Validation and Scale (2027–2028)

- Independent evaluation through Monash University research partnership
- DCL Index psychometric validation across pilot population
- Peer-reviewed publication of SEPM outcomes data
- Expansion to additional NSW LGAs based on pilot evidence
- ARC Linkage and MRFF funding applications for national validation study

Phase 3 — National Scale (2028–2029)

- National rollout through PHN commissioning framework — equivalent to Mental Health Stepped Care national model
- Cultural Practitioner Register integrated with SEPM certification pathway
- Southern Cross Mark certification operationally linked to SEPM Levels 1–2
- Legislative submission to support Australian Cultural Work & Provenance Act
- UNESCO NGO accreditation establishing CWA as formal safeguarding body

Conclusion

The Mental Health Stepped Care model proved that the right support, at the right intensity, delivered at the right level of need, produces outcomes that single-intensity programs cannot. It works because it meets people where they are. It works because the assessment instrument removes the guesswork. It works because it integrates with existing infrastructure rather than trying to replace it.

The Stepped Economic Participation Model applies that same proven logic to a domain that has never had it: women's economic participation, shaped by the structural reality of their lives.

Women's workforce exclusion is not a motivation problem. It is a structural load problem. The DCL Index measures it. The SEPM responds to it. The Cultural Practitioner Register formalises it. The Southern Cross Mark certifies it. The proposed Australian Cultural Work & Provenance Act protects it.

> ***DCL names the damage. ILV names the debt. CWI names the sector. The SEPM activates the response.***

The model is in development. The pilot is ready. The infrastructure exists. The partners are identified. The outcome data from Mental Health Stepped Care tells us what is possible when a framework is matched to the real shape of human need.

The CWA invites funding partners, delivery agencies, academic collaborators, and government departments to engage with this framework and make its implementation possible.

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