Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF ADRIANA MENDOZA

I, Adriana Mendoza, Manager of Victorian Transcultural Mental Health (**VTMH**), of 14 Nicholson Street, Fitzroy, in the State of Victoria, say as follows:

1 I am authorised by VTMH to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

3 On 23 January 2019, VTMH made a submission to the Victorian government on the terms of reference for the Royal Commission into Victoria's Mental Health System. I refer to and adopt this submission. Attached to this statement and marked **AM-1** is a copy of the submission by VTMH dated 23 January 2019.

BACKGROUND AND QUALIFICATIONS

Please tell us about your previous experience in the field of transcultural mental health.

4 I have the following qualifications:

(a) Bachelor of Psychology; and

(b) Master of Counselling and Psychotherapy.

5 I have both national and international experience in the mental health sector and have 10 years of experience working with diverse communities and mentoring mental health teams. Attached to this statement and marked **AM-2** is a copy of my Curriculum Vitae.

6 I commenced as an Education and Service Consultant at VTMH in April 2018 before being promoted to Manager in November 2018. As an Education and Service Consultant, I was responsible for supporting different organisations and mental health workers in strengthening the cultural responsiveness of their procedures. I also designed and conducted forums, training sessions and consultations to generate change at an individual, team and organisational level.

7 Prior to commencing at VTMH:

(a) I was employed at Neami National and undertook a variety of roles within Neami National including Acting Service Manager, Senior Practice Leader of

the Croydon branch, Community Rehabilitation and Support Worker and Cultural Portfolio Holder;

(b) I worked with Royal Flying Doctors and Medicare Local in the Northern Territory, where I co-designed mental health programs in collaboration with other service providers and Aboriginal communities; and

(c) I have approximately three years of experience in Colombia practicing as a Psychologist supporting survivors of political violence and supporting organisations to reflect on and enhance their practices.

VTMH

8 VTMH was formed over 25 years ago as the Victorian Transcultural Psychiatry Unit. It has evolved from a small clinical service to become a state-wide provider of organisational development, community engagement, workforce education and support, and research and evaluation.

9 VTMH is funded by the Mental Health, Drugs and Regions Division of the Victorian Department of Health and Human Services and is administered by St Vincent's Hospital in Melbourne. VTMH consists of four full-time and 10 part-time team members from a range of multidisciplinary backgrounds.

10 VTMH works with organisations and agencies to strengthen their capacity to address inequity in mental health service provision, with the overarching goal of improving the mental health, social and emotional wellbeing of culturally diverse individuals, families and communities. Attached to this statement and marked **AM-3** is a copy of a brochure outlining VTMH's services and program areas.

11 VTMH's main focus areas are as follows:

(a) Organisational Development: Building the capacity of agencies to adopt organisation-wide approaches to improving their responsiveness to diversity. VTMH works collaboratively with mental health service providers and other agencies via its *Partners in Diversity Program* to help organisations reform their processes and implement effective strategies. Partnerships usually involve an intensive engagement with VTMH over a three-year period.

(b) Education, Professional Development and Workforce support: Responding to the learning, practice and information needs of the public mental health workforce and other providers of health and social support services. VTMH facilitates reflection by practitioners, teams and organisations through forums, seminars, workshops, reflective conversations and secondary consultations.

(c) Community Engagement: Working at a community level to address mental health, social and emotional wellbeing as well as helping agencies to engage and empower consumer carers and local communities.

(d) Research, evaluation and projects: Exploring good practice and innovation by collaborating with service providers, key agencies and research units. Within this area, VTMH undertakes projects to improve organisational and community capacity.

12 Further, the *Victorian Cultural Portfolio Holder Program* is a VTMH initiative designed to assist registered Cultural Portfolio Holders (**CPHs**) to champion culturally responsive practice within their respective agencies. The CPH role was first introduced as a requirement for mental health services in the *Cultural Diversity Plan for Victoria's Specialist Mental Health Services 2006-2010*. A CPH undertakes a range of diversity related work such as raising awareness and participating in working groups to address cultural diversity planning and policy development.

13 VTMH focuses on forming collaborative relationships with organisations to guide them in self-assessing or reviewing their cultural responsiveness, as well as assisting them with implementing plans through a long-term consultation model. Attached to this statement and marked **AM-4** is a copy of VTMH's list of factors leading to successful partnership outcomes.

CURRENT ROLE

Please tell us about your role at VTMH.

14 I am currently employed as the Manager of VTMH and have been in this role since November 2018.

15 As Manager of VTMH, I am responsible for overseeing VTMH's services and supporting VTMH in formulating its strategic direction, mission and program areas.

16 I engage with both state and national stakeholders to discuss challenges around how to improve the response to Culturally and Linguistically Diverse (**CALD**) consumers and carers. Further, I support the identification of needs, gaps and strengths in the mental health service system in relation to CALD people and collaborate with agencies and stakeholders regarding inclusive initiatives in the sector.

17 I have assisted organisations in improving their service quality and organisational culture by offering staff mentoring and consultation sessions. I have also assisted mental health clinicians to identify enablers and barriers to working with CALD communities affected by mental health issues.

CHALLENGES

What groups of people fall within the definition of Culturally and Linguistically Diverse (CALD)?

18 The term 'Culturally and Linguistically Diverse' or 'CALD' refers to people who come from a variety of different backgrounds (such as asylum seekers, refugees, international students, skilled migrants as well as emerging and established migrant communities). We are conscious that there are second and third generation migrants who might connect with the term 'CALD' even though they were born in Australia.

19 We suggest considering intersectionality as a framework to respond to diversity. This will assist service providers to identify how overlapping identities can impact on a person's overall sense of self and how they are perceived within different social contexts. People have overlapping identities (such as "female", "migrant", "person of colour") and these identity points do not exist independently of each other. Some identity points can result in privilege, while others can result in disadvantage. This may depend on the particular social context and how a particular identity point is perceived by society.

20 There is a need to recognise "diversity within diversity". For example, you cannot say that all international students will have the same experiences. It is important to consider the intersections between different identities by asking, for example, about their financial situation or level of familial support. Intersectionality, which is the meeting point of all components of one's identity, must be considered in order to understand the complexity of experiences and challenges faced by CALD people.

21 Sometimes there is the association between 'culture' and 'ethnicity' which we need to approach with caution. There is the danger of generalising that people who are from the same country will have the same views and experiences, which is not necessarily the case. Instead, in addition to ethnicity, culture comprises many other intersecting socio-political factors including sexual and gender diversity, religion, spirituality, class, economic status and lived experiences.

What is the level of engagement by CALD people with the mental health system, as compared with the general population? Does the level of engagement vary among the different CALD groups? If so, how?

22 CALD people are less represented in mental health services across the continuum from acute services to community care. As a result of not seeking, or difficulty accessing, mental health services, CALD people often do not receive the assistance they require. When they do finally access mental health services, this contact is often involuntary and

accompanied by higher rates of involuntary admissions and extended periods of time in acute units.

23 Compared to the general population, the level of engagement by CALD people with the mental health system is lower for many reasons. For example, they often do not feel understood (in a deeper sense beyond a simple language barrier) and may also have difficulties understanding the information provided to them.

24 Within the CALD community, the level of engagement with the mental health system sometimes varies. In my experience, people who do not speak English, have previously had bad experiences with the mental health sector or are located in rural areas tend to engage with the system less than other CALD groups. The concept 'mental health' may also be foreign to some CALD groups, particularly in communities where mental health is quite stigmatised.

How do mental health outcomes of CALD persons compare with the general population? Do the mental health outcomes vary among the different CALD groups? If so, how?

25 The mental health outcomes of CALD people are informed by a range of additional factors compared to the general population. Further, the mental health outcomes vary among the different CALD groups due to the fact that such outcomes depend on factors including the level of English language skills, connections with service providers, geographical distance from service providers, level of support for those located in rural areas, the cultural responsiveness of the service providers with whom they interact and the capacity of society to embrace CALD people.

26 When service providers are culturally responsive and informed, this is likely to improve the mental health outcomes of CALD people who approach these service providers. Improved mental health outcomes are particularly evident where service providers focus on building relationships with CALD groups and embrace multiple perspectives when interacting with CALD groups.

27 Within the mental health sector, the concept of 'diversity' also concerns professional services, disciplines and training. Different service providers have particular views on mental health, illness and recovery. Accordingly, it is important to reflect on how service providers collaborate, co-design and incorporate multiple perspectives.

What are the barriers for CALD persons to access the mental health system?

Lack of consultation and recognition of lived experiences

28 One barrier hindering CALD people from accessing the mental health system stems from the lack of consultation between the mental health sector and the CALD community. VTMH aims to encourage the mental health sector to invest more energy

into creating safe spaces to consult with CALD people in order to find out what support they require. I am referring not just to individuals who engage with the system but also those who choose not to engage with the system.

29 Another by-product of the lack of consultation with CALD people is that the mental health system fails to validate individual voices and lived experiences. More engagement with lived experience practitioners such as peer support workers and consumer and carer consultants is necessary to provide a voice for the CALD community. It is crucial to acknowledge the expertise of lived experience practitioners.

Difficulty of navigating the system

30 Within the mental health system, there are problems with how services have been designed and a lack of service options. Many CALD people find that the mental health system is segregated and hard to navigate. As a result, significant proportions of diverse communities do not have access to appropriate, acceptable psychosocial support services.

31 In particular, consumers are sometimes responsible for building their own bridge between primary and tertiary services in Victoria's mental health system. This may require consumers to transfer information between services, which adds complexity to the process and discourages consumers from progressing through the system.

32 The difficulties in navigating or engaging with the mental health system are exacerbated by the lack of accessible information relevant to the experiences of CALD people. From my perspective, the mental health system needs to work on how to adequately support or address aspects such as feelings of social isolation, shame and stigma or complexities in cultural attitudes, values and beliefs.

How do language barriers affect access to the mental health system?

Use of interpreters

33 One of the barriers to accessing the mental health system stems from the difficulties in consumers and mental health providers effectively communicating with each other. Practitioners have expressed the difficulty in expressing a clinical view in a respectful and sensitive way, without detracting from the substance of what they need to convey.

34 The presence of an interpreter does not by itself lead to a meaningful and respectful conversation. When engaging with organisations, I have observed that both mental health clinicians and professional interpreters need training sessions as well as reflective conversations to consider how to effectively work with each other.

35 Speaking a language apart from English should not be a barrier to accessing mental health services given the existence of professional interpreters. However, the inclusion of an interpreter poses both a challenge and opportunity to sustain a meaningful and respectful relationship between the CALD person and a mental health clinician. It is important to reflect on ways to maximise the opportunity to create a culturally safe space and facilitate fluent communication during the encounter.

36 Building a safe and respectful relationship may be particularly difficult where emotional safety is not addressed. When leveraged correctly, the skills of professional interpreters have the potential to ensure accurate risk assessments (enabling consumers and their carers or families to discuss personal information and psychological wellbeing), accurate understandings of the consumer's needs and concerns and avoidance of misunderstandings.

Feeling misunderstood or emotionally unsafe

37 CALD people are often conscious that their understanding of or views on mental health issues may be different to those of the mental health clinicians. This arises due to the existence of different explanatory models – that is, different ways of understanding what is happening in our body, our minds and what responses are needed.

38 CALD people may associate their mental health outcomes with their own beliefs, which are often connected to the individual's culture or religion. For example, a CALD person may believe that a challenge in their life reflects their relationship with God, whereas the relevant mental health clinician may not understand this association and approach the situation from another perspective. The result is that there are two different narratives with the potential to cause misunderstandings and barriers to effective service provision.

39 It can be challenging to translate what is being conveyed (not simply into English but to understand the substance of the message). For this reason, VTMH believes there is a need for the mental health sector to focus on acknowledging different explanatory models.

Social stigma

How does fear of discrimination/stigma act as a barrier for CALD people from accessing the mental health system? Consider in the context of:

- **discrimination by the mental health workforce; and**
- **stigma within the relevant CALD community.**

40 The experience of stigma, structural inequity and discrimination in society impacts on whether CALD people engage or disengage with the mental health system. It is crucial to recognise the impact of discrimination on mental health outcomes of CALD people.

Once again, there is limited direct consultation with CALD people to understand their concerns and consider options that resonate with them.

41 There can also be stigma *within* the relevant CALD community which further discourages people from seeking help before the need becomes acute. The relevant CALD community may have multiple perspectives on mental health and how to respond to different challenges.

42 When connecting with CALD people, mental health clinicians should be aware of other terms that may be used by particular CALD groups when expressing or addressing their wellbeing concerns. For example, some CALD groups may not recognise the word 'mental health' or that term may have a negative connotation within the CALD group. Fear of discrimination and stigma stands as a barrier for CALD people as service providers do not currently work with family members or community leaders to overcome this fear.

Do CALD persons get caught in the compulsory treatment system more than the general population? If so, why is that? Does the pattern of compulsory treatment vary among the different CALD groups? If so, how and why?

43 The reality is that when CALD people turn up at the emergency department (**ED**) of a hospital, most of the time it is not because they are doing so willingly, but because they are in crisis or are subject to involuntary intervention.

44 Further, it is common that CALD people leave the hospital and are readmitted at a later stage. In my opinion, this pattern of compulsory treatment shows a lack of service options available to CALD people.

Opportunities for reform

How do language barriers impact the effectiveness of treatment? For example, can cognitive behavioural therapy be provided effectively through interpreters?

45 Cognitive behavioural therapy can be provided effectively through interpreters if both the clinician and the interpreter know how to work with each other. In fact, regardless of the name given to the therapeutic technique, it has the potential to work if the clinician and interpreter know how to interact with each other and the CALD person in a way that is meaningful and creates a safe space for the CALD person to share their experiences.

46 While a part of this is pure luck with respect to the pairing of the interpreter and clinician, it would be beneficial to continue supporting the mental health system to formulate guidance on how clinicians and interpreters work together prior, during and after the encounter with the CALD person. VTMH has various online resources and has facilitated workshops and reflective conversations on this topic.

In what ways does the mental health system provide culturally appropriate services? Considering the significant differences between different cultures, is it possible for the system to provide services that are culturally appropriate in all instances?

Cultural responsiveness and recovery oriented services

47 The mental health system seems to be becoming more recovery oriented, which is a step in the right direction. Whilst 'recovery' was traditionally understood as the absence of symptoms, it is now more associated with the possibility of having a meaningful life with the existence of symptoms.

48 Recovery occurs within relationships and is contextualised by culture, language, history, privilege, oppression and the social determinants of health. The mental health system can provide culturally responsive and recovery oriented services by undertaking comprehensive assessments, using language services effectively and exploring non-medical and non-psychological explanations for distress. These principles should not be regarded as optional considerations, but essential to every encounter with consumers.

Community partnerships

49 The mental health system can provide culturally appropriate services through pursuing meaningful partnerships between community mental health organisations. Nowadays where there is a tender for services, we see organisations identifying limitations in its services and choosing to collaborate with other organisations with the appropriate expertise. This in itself shows cultural humility, which is the awareness that we do not have all the answers and need to learn from each other.

Willingness to adopt the intersectionality framework

50 Culturally responsive practice recognises a dynamic and ongoing process of responding to diversity rather than previous concepts of cultural competency. As the Victorian population continues to grow, so does our diversity as people express multiple forms of identity and belonging. An intersectional approach recognises that identities are interconnected and that they cumulatively impact a person's visibility and access to equitable and inclusive services.

51 VTMH has noticed an increasing number of organisations and mental health clinicians becoming interested in increasing their knowledge around the intersectionality framework and building their capacity to be culturally responsive. In particular, this change can be seen within:

(a) VTMH's cultural conversation services, where teams have consistently considered trauma informed approaches when looking at distress and recovery; and

(b) VTMH's transcultural clinical discussions, where teams have taken the initiative to understand the cultural identity of their clients and how to undertake mental health assessments in a manner consistent with each client's cultural identity.

52 While it is promising to see positive steps being taken by the mental health sector, this has not been standardised across the mental health system. This means that culturally appropriate services are currently driven by individual champions of change rather than by entire organisations or state-wide policies. Sometimes the authorising environment does not oblige or encourage organisations to adopt such services.

What is the role of VTMH in making the mental health system more accessible and suitable for CALD groups?

53 VTMH has an important role in making the mental health system more accessible and suitable for CALD groups. VTMH works with organisations and agencies to strengthen their capacities to become more culturally responsive and to address inequities in the provision of mental health services.

54 More specifically, VTMH's role currently involves:

(a) assisting the development and implementation of policies related to improving culturally responsive mental health service systems;

(b) promoting greater understanding of cultural diversity in health and social service systems and advocate for the adoption of strategies that address inequity in service delivery;

(c) facilitating the delivery of culturally responsive mental health services by engaging service providers and other agencies as partners;

(d) developing a culturally responsive mental health workforce through education and reflective learning, providing resources and responding to enquiries;

(e) assisting CALD people, and their families and carers, to share their experiences and participate in policy and service reform debates; and

(f) engaging CALD communities in addressing mental health, social and emotional wellbeing.

55 VTMH's focus is on culture, as we believe culture provides the perspective through which CALD people view themselves and the world. Culture has a significant impact on a person's mental health outcomes ad how mental health practices are structured.

Supporting a culturally responsive system

56 VTMH supports a culturally responsive system through its four program areas outlined in **paragraphs 11-13** of this statement. In particular, VTMH conducts the following:

(a) three-year *Partners in Diversity Program* partnerships with a focus of 'sustainability' during the final year of engagement. This reflects VTMH's ultimate aim, which is to support organisations and mental health service providers in a way that leads them towards self-sufficiency;

(b) face-to-face workshops and online training sessions to assist the mental health sector in putting concepts such as intersectionality and cultural responsiveness into practice;

(c) reflective conversations on topics that are challenging for service providers when attempting to be culturally responsive (for example, how to acknowledge different explanatory models during encounters with CALD people); and

(d) Transcultural Clinical Discussions to support organisations in considering the cultural relevance of a specific client's symptoms or challenges with engagement. While there may be other consultations concentrating on the medical diagnosis of the consumer, Transcultural Clinical Discussions with VTMH concentrate on the cultural identity of the client and how this has a bearing on mental health assessment or treatment options.

POTENTIAL SOLUTIONS

What are your recommendations for making the mental health system more suitable for and inclusive of CALD groups? In what ways can the barriers of fear of discrimination and stigma be addressed?

Systemic practices and sustainable policies

57 Firstly, the mental health system should develop policies and guidelines that generate more robust commitment towards addressing cultural responsiveness within organisations. This is required to remove the dependency of good practice on individual workers or champions of change.

58 Those in leadership roles play a crucial part in developing sustainable policies and practices within the mental health system. By having leaders learn about how their organisation can be more culturally sensitive and responsible, these practices are more likely to continue beyond the tenures of individual clinicians and workers. Clinicians and interpreters who work directly with CALD people need good practices embedded in the system.

59 Notably, the mental health system is currently transitioning to the National Disability Insurance Scheme, which further emphasises the need to develop policies and secure cultural responsiveness as a primary concern in the changing environment. Efforts to continue improving the mental health outcomes of CALD communities need to be integrated into local and state-wide mental health policies.[1] We need to invest in long-term systemic change.

60 There also needs to be increased information sharing practices between services to facilitate the transition of CALD people from primary to tertiary services (if necessary). Such practices are currently lacking within Victoria's mental health system and this impairs the accessibility of the system to CALD people.

Community involvement

61 Secondly, Victoria's current mental health system is insufficiently informed by CALD people, families and carers. The mental health system should be structured in a way so that the mental health sector and the community sector run in parallel and collaborate with each other.[2]

62 To address the barriers experienced by CALD people, the mental health system could involve CALD groups when developing information resources for their use. On one hand, this is about understanding the needs, strengths and prospects of treatment for CALD people. Equally, if there is a CALD group which is reluctant to engage with the mental health system, it would be useful to understand *why* they are choosing not to engage with the system. Many migrants, for example, do not know their rights or how to exercise them.

63 More specific recommendations in relation to engaging the CALD community include:

(a) encouraging the involvement of CALD people who have lived experiences in the design, delivery and evaluation of mental health services – this is necessary as "lasting social change requires more contact with people sharing stories of recovery and more opportunity for people with direct experience to lead efforts to set policies and actions that affect their lives";[3]

(b) introducing a systematic way to collect feedback from CALD people and their carers regarding their experiences of being provided with mental health support,

---

1 VTMH, *Report of an evaluation of a small grants program: Improving the mental health and wellbeing of immigrant and refugee background communities by building capacity* (unpublished, forthcoming).

2 Ibid.

3 S. McDonough and E. Colocci, *People of immigrant and refugee backgrounds sharing experiences of mental health recovery: reflections and recommendations on using digital storytelling* (2019).

identifying the strengths and weaknesses of the system in collaboration with CALD communities; and

(c) encouraging the participation of peer support workers, consumer advocates and community consultants in building an inclusive mental health system. The engagement of these parties and their expertise concerning lived experiences should be incorporated more formally in the design, delivery and evaluation of projects.

Addressing mental health outcomes in a way that resonates with CALD people

64 CALD groups need more options that resonate with their own terms and language. For example, different CALD groups may associate the term 'recovery' with different concepts such as 'mental health freedom' or 'spiritual wellbeing'. One suggestion may be to give the consumer the freedom to write something in their own language, which can then be translated and interpreted by a clinician or carer.

65 CALD people are best placed to identify their own needs and treatment preferences. It is important that service providers seek input from CALD people with the goal of understanding how they care for themselves, support each other and engage with more formal support services. Community engagement and capacity building needs to concentrate on "what is strong" (that is, what *works*) not just "what is wrong" in communities.

66 VTMH believes that the solutions to a community's 'problems' should come from voices within that community, rather than being imposed by external parties. VTMH also believes that community capacity building is a collective responsibility as multiple factors shape health and social problems including a lack of access to information and support.[4]

Growth of community-based organisations

67 Various smaller agencies, some of which are staffed by volunteers and have minimal financial resources, exist to support newly arrived CALD communities. While these community-based organisations are in a good position to work with CALD communities, they require external support, recognition and capacity building when it comes to responding to mental health, trauma and suicidal behaviour.[5]

68 Bilingual, bicultural, multicultural and multi-faith volunteers play a crucial role in building bridges between community and service providers. This is because they essentially

[4] VTMH, *Report of an evaluation of a small grants program: Improving the mental health and wellbeing of immigrant and refugee background communities by building capacity* (unpublished, forthcoming).

[5] Ibid.

undertake multiple roles such as inter-language communicators, service navigators, community consultants, educators and leaders. It is important to both learn from these people and also support their development.[6]

Recommendations at an organisational level

69 At an organisational level, the mental health system needs to facilitate and encourage cultural responsiveness training and education within organisations and service providers. This should not be a mere "add on" but should be a mandated component for all organisations and service providers.

70 It is notable that a majority of the workers who request training and support on cultural responsiveness are those workers who interact directly with CALD communities. I recommend that the leaders of organisations (including policy makers) become more involved in discussions around cultural responsiveness and how to incorporate this into practice.

71 My final recommendation relates to the continuation of cultural conversations such as through VTMH's Transcultural Clinical Discussions. These practices provide a platform to raise self-awareness and build the skillsets of mental health clinicians in relation to cultural sensitivity. Similarly, they also support mental health clinicians in integrating cultural considerations into mental health assessments and applying different explanatory models as therapeutic tools.

72 Teams that have received this type of support from VTMH have expressed the benefits of exploring therapeutic dilemmas and cultural factors that impact in client health care and outcomes. Further, many of these teams have noted improvements in their level of knowledge and skillsets with respect to addressing client outcomes and health care service needs.[7]

Are there models and strategies for making the mental health system more suitable for and inclusive of CALD groups which have been demonstrated to be effective (in Australia or internationally)? If so, what are they and why are they effective?

73 VTMH has been assisting mental health service providers to improve their capacity to respond to respond to culturally diverse consumers, carers and communities for several years. In doing so, VTMH has designed a Cultural Responsiveness Partnership Planning Framework model to assist specialist mental health services understand and enhance the way in which they respond to CALD communities.

---

6 Ibid.

7 R. Santhanam-Martin et al., 'Evaluation of cultural responsiveness using a transcultural secondary consultation model' (2017) 54 *Transcultural Psychiatry*, 488.

74 This model is based on the *Cultural responsiveness framework* developed by the Victorian Government in 2009,[8] which underlines four areas to be addressed when responding to diversity: organisational effectiveness, risk management, consumer participation and effective workforce. In order to guide organisations to adopt this framework, VTMH has developed the following strategies to address the four areas:

(a) Organisational effectiveness: developing and implementing policies and plans, reflection, evaluation and research, leadership and staff inclusion;

(b) Risk management: including language services and translated service information, assessment and intervention guidelines, case reviews including cultural considerations;

(c) Consumer participation: including inclusive practice, promoting access and participation for CALD people, families and carers, information sharing and partnerships with CALD organisations; and

(d) Effective workforce: introducing CALD related roles (cultural portfolio holders, bilingual workers, cultural consultants and community liaison workers), continuous learning and comprehensive cultural competency training.

(e) Organisations have appreciated this framework and have noted its utility in helping them improve their knowledge, practice and confidence.[9] Additionally, it has helped individuals to increase their own awareness and practice self-reflection, which results in organisations having a clearer understanding about their strengths, gaps and ways to overcome challenges. Ultimately, the feedback to date has demonstrated that support from VTMH through its Cultural Responsiveness Partnership Planning Framework has positively affected the capacity of the mental health system to be more suitable for and inclusive of CALD communities.

(f) VTMH encourages the mental health sector to adopt an explanatory model that supports clinicians and communities in having meaningful communications with each other. This model, which is widely used in North American medical schools, involves asking questions in a way that is respectful and culturally responsive.[10] Questions that guide meaningful conversations include: *'What do you call this problem?', 'What course do you expect it to take?', 'How serious is it?', 'What do you think this problem does inside your body?*', *'How does it affect your mind and body?'* and *'What do you fear most about the treatment?'.*

---

8 Victorian Government, *Cultural responsiveness framework: Guidelines for Victorian health services*, Melbourne (2009).

9 VTMH, *Responding to Diversity: An Evaluation of VTMH Programs and Services*, 2013-2015 (2016).

10 A. Kleinman and P. Benson, *'Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It'* (2006) 3 PLOS Medicine, 294.

(g) The Canadian Psychiatric Association recognised the lack of guidelines on integrating culture into psychiatric education and practice, as well as the potential for cultural psychiatry to become a core aspect of the knowledge and skills of all mental health clinicians.[11] VTMH already draws on these strategies when helping organisations on a case by case basis, however there needs to be state-wide systemic change in Victoria.

sign here ► adriana

print name Adriana Mendoza

date 2 July 2019

[11] L. J. Kirmayer,, *Guidelines for training in Cultural Psychiatry – A position paper developed by the Canadian Psychiatric Association's Section on Transcultural Psychiatry and the Standing Committee on Education and approved by the CPA's Board of Directors* (2011).

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AM-1

This is the attachment marked 'AM-1' referred to in the witness statement of Adriana Mendoza dated 2 July 2019.

Victorian Transcultural
MENTAL HEALTH

23rd January 2019

Mental Health Royal Commission Establishment

Department of Premier and Cabinet

1 Treasury Place

Melbourne Vic 3002

To whom it may Concern

Royal Commission into Mental Health: Terms of Reference

Victorian Transcultural Mental Health welcomes the establishment of the Royal Commission into Mental Health.

We recognise the Royal Commission as an opportunity to hear from and make visible, the lives and experiences of Victorians from diverse communities.

We welcome the invitation to contribute to Royal Commission into mental health and advocate that the Terms of Reference include a focus on cultural safety and responding to diversity.

About Victorian Transcultural Mental Health

Victorian Transcultural Mental Health (VTMH) was formed over 25 years ago as the Victorian Transcultural Psychiatry Unit (VTPU). It has evolved from a small clinical service to become a state-wide provider of organisational development, community engagement, workforce development and research; funded by the Mental Health, Drugs and Regions Division of the Victorian Department of Health and Human Services (DHHS) and administered by St Vincent's Hospital, Melbourne.

The unit works with organisations and agencies to strengthen their capacity to address inequity in mental health service provision, with the overarching goal of improving the mental health, social health and emotional wellbeing of culturally diverse individuals, families and communities.

More specifically, VTMH aims to:

- Assist the development and implementation of policies related to improving culturally responsive mental health service systems.
- Promote greater understanding of cultural diversity in health and social service systems and advocate for the adoption of strategies that address inequity in service delivery.
- Facilitate the delivery of culturally responsive mental health services by engaging service providers and other agencies as partners.
- Develop a culturally responsive mental health workforce through education, providing resources and responding to enquiries.
- Assist consumers from culturally diverse backgrounds, and their families and carers, to share their experiences and participate in policy and service reform debates.
- Engage culturally diverse communities in addressing mental health, social and emotional wellbeing.
- Share experience and knowledge and contribute to research and evaluation.

VTMH's mission is broad and its reach extends beyond the mental health sector to include primary health, social support, ethno-cultural and multicultural agencies, schools and universities, local councils, and institutions that comprise the justice system. Over the years, VTMH has structured its work program so that it aligns with current policy priorities and reflects current international trends in transcultural health research and literature. These include adopting population health principles, conceptualising cultural responsiveness at practitioner, organisational, community and systemic levels, and using theoretical perspectives such as social models of health and post-colonial critiques to understand health inequalities and the operations of power in mental health settings.[1]

Our ongoing work with government, organisations and communities continues to highlight the following themes:

1. **Access, equity and inclusion**
   People from culturally and linguistically diverse backgrounds are less represented in mental health services across the continuum from acute services to community care. For those people who do access mental health services, this contact is more frequently involuntary and further along in the illness experience, with higher rates of involuntary admissions and extended periods of time in acute units.

   There are problems with how services have been designed and a lack of service options. As a result, significant proportions of vulnerable populations do not have access to appropriate, acceptable psychosocial support services

2. **Responding to diversity through the lens of intersectionality**
   Culturally responsive practice recognises a dynamic and ongoing process of recognising and responding to diversity rather than previous concepts of cultural competency. As the Victorian population continues to grow, so does our diversity, as people express multiple forms of identity and belonging.[2] An intersectional approach recognises that identities are interconnected and some may hold more power than others, impacting on peoples visibility and access to equitable and inclusive services.

3. **Identity, discrimination and recovery**
   Identity is complex. People can experience privilege and oppression simultaneously. Structural inequity or experiences of disadvantage interact with contextual factors and social dynamics which can increase the experience of marginalisation, inequity, and health disparity. Research and the voices of lived experience continue to highlight the mental health impacts of structural discrimination inclusive of but not limited to, ethnicity, race, culture or sexual orientation.

4. **Collaboration with families and communities including carers**
   In addition to the challenges commonly faced by carers regardless of cultural background, families and communities from culturally and linguistically diverse communities continue to express a lack of accessible information related to their experience, difficulty in understanding information that is provided by mental health services, a lack of understanding about mental illness and services, social isolation and experiences of shame and stigma, and complexity in negotiating cultural attitudes, values and beliefs.[3]

5. **Cultural responsiveness and recovery**

   Recovery occurs within relationships and is contextualised by culture, language, oppression and privilege, history and the social determinants of health.[4, 5] Recovery oriented practice is culturally responsive in approach. Cultural responsiveness and practices promoting cultural safety are foundational rather than 'add on' in recovery oriented services.

   Recovery oriented practices should also be culturally responsive and culturally safe for all individuals regardless of their cultural background or life experiences. Some examples of what this means are: undertaking comprehensive assessments, using language services effectively, exploring non-medical and non-psychological explanations for distress. These principles should not be regarded as optional considerations, but essential to every encounter.

6. **Lived Experience and workforce development** [6, 7, 8, 9]

Cultural responsiveness is an active process which includes:

- Recognising and responding to language barriers including access to and working effectively with interpreters
- Access to and routine use of translated materials, particularly regarding service navigation, legal rights, service responsibilities and complaints processes
- Access to written information in easy to read English or in community languages and/or explained via an interpreter
- Partnering with cultural brokers, refugee settlement workers, bilingual community workers, and faith leaders to support a person's recovery plans
- Recognising and responding to concepts of mental health, mental illness and recovery within diverse communities by routinely integrating culturally responsive practice into mental health assessment, formulation and support, including routine use of cultural assessments and formulations
- An understanding of explanatory models and their impact on help seeking behaviours and continuity of care
- Cultural assessment and cultural formulation as routine practice
- Recognising and responding to the impact of traumatic experiences on the mental health and wellbeing of refugee and asylum seeker communities

7. **Review of the Policy Context**

VTMH's work is informed by national and state mental health standards and practice guidelines and laws and other frameworks related to human rights, access and equity, diversity and language services and multiculturalism. The current Cultural responsiveness framework for Victorian Health Services which determines a minimum level of activity in four broad domains of quality and safety was released in 2009.

Recommendation

That the Victorian Government include in the Royal Commission's Terms of Reference a focus on:

- Recognising and responding to diversity
- Recognising the impact of discrimination on mental health and wellbeing
- Recognising cultural safety and cultural responsiveness as a human right for all Victorians
- Recognising the role of families and communities in mental health recovery and care

Further assistance

Victorian Transcultural Mental Health is available to support and assist the work of the Royal Commission into Mental Health, particularly in relation to meeting the needs of culturally and linguistically diverse individuals and communities across Victoria.

Please contact Adriana Mendoza, Manager, Victorian Transcultural Mental Health on 9231 3302 or at adriana.mendoza@svha.org.au if the unit can be of assistance.

Yours sincerely

Adriana Mendoza
Manager

[1]Victorian Transcultural Mental Health (2016), Responding to Diversity: An Evaluation of VTMH Programs and Services, 2013 – 2015. Fitzroy, Victoria: VTMH.

[2]The Victorian Government (2018) Family Violence Reform: Diversity and Intersectionality Framework Melbourne: Victorian Government

[3]Victorian Transcultural Mental Health. (2014) Our Voices: Stories of carers from refugee and migrant backgrounds [Video]. Fitzroy, Victoria: Victorian Transcultural Mental Health.

[4] Department of Health (2011) Framework for Recovery-Oriented Practice. Melbourne: Victorian Government

[5]Australian Government (2013) National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers. Canberra: Australian Government.

[6]Department of Health (2009) Cultural Responsiveness Framework: Guidelines for Victorian Health Services. Melbourne: Victorian Government.

[7]Department of Health (2013) Victoria's priorities for mental health reform 2013–15. Melbourne: Victorian Government. Mental Health Act. 2014. (Vic.) (Austl.)

[8]Department of Human Services (2014) Language Services Policy. Melbourne: Victorian Government.

[9]Department of Health (2015) Victoria's 10-year Mental Health Plan. Melbourne: Victorian Government.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AM-2

This is the attachment marked 'AM-2' referred to in the witness statement of Adriana Mendoza dated 2 July 2019.

ADRIANA MENDOZA

Bachelor of Psychology and Master of Counselling and Psychotherapy

Relevant skills

-International and national experience in supervising, coaching, training and mentoring mental health teams to enhance their capacity to respond to the needs and resources of different communities.
- Demonstrated experience supporting mental health teams to use person centred counselling approaches and therapeutic tools that are culturally sensitive when working with survivors of violence.
-Experience in supporting organisations to build collaborative relationships.

EDUCATION AND QUALIFICATIONS

2012. Master of Counselling and Psychotherapy. Cairnmillar Institute, School of Psychology, Counselling and Psychotherapy. Scholarship. Melbourne, Australia.

2007. Bachelor in Psychology, Javeriana University. Bogotá, Colombia. Award for Excellence, 2007. Colombia.

WORK EXPERIENCE

November 2018 – Present
Victorian Transcultural Mental Health (VTMH)
Position: Manager
Achievements:
-Supporting VTMH to engage in service development activities to improve the response to culturally and linguistically diverse (CALD) consumers and carers.
-Identifying the needs of the mental health service system in relation to people with CALD background.
-Provide consultancy to team members.
-Ensuring systems are in place for VTMH staff to support collaborative relationships with agencies and stakeholders.
-Participating in budget allocation and monitoring to ensure the most effective use of resources.

April 2018 – October 2018
Victorian Trancultural Mental Health
Position: Education and Service Consultant
Achievements:
-Supporting different organisations and mental health workers to strengthen and improve their procedures to become more culturally responsive and sensitive.
-Developing a booklet for individuals experiencing psychosis and their families, in conjunction with other VTMH members and 2 other organisations.
-Designing and conducting secondary consultations, training sessions and different group/individual conversations to support workers to generate change in an organisational, team, and individual levels.
-Developing partnerships with organisations.
-Liaising with more than 12 organisations s to design a forum program on vocational rehabilitation and diversity.

NEAMI National. January 2017 – March 2018
Position: Senior Practice Leader (SPL)-
Achievements:
-Conducting performance reviews that allowed workers to identify their strengths and areas of improvement.
-Supervising, mentoring, training and coaching the team.
-Discussions with workers about the quality of the service delivery and the impact of the projects.
-Designing a program in conjunction with the Migrant Information Centre and leaders of different communities for people with refugee backgrounds.
-Co-designing, supervising and assessing the impact of the projects in the life of clients experiencing serious mental health challenges.
-Training sessions in approaches such as narrative therapy and counselling tools.
-Coordinating the initial needs assessment and intake of all consumers into the service in conjunction with service manager.
-Participating in partnership development.
-Supervising all the service portfolios including: LGBTIQ +, Cultural, Aboriginal and Torres strait Islanders and consumer participation.
- Encouraging self-care conversations and developing creative activities for workers.
-Supervising, mentoring and supporting workers to build collaborative relationships with other services.

NEAMI National.
Position: Acting Service manager - Croydon
During my time as the Senior Practice Leader, I worked as an Acting Manager in various occasions:
Achievements:
-Responsible for the establishment, ongoing management and further develop of the programs in the site.
-Working collaboratively with partners to improve and develop the overall service response to people living with a mental illness within the community.
-Ongoing evaluation, planning, implementation and review of service outcomes.
-Mentoring and supervising the Croydon team.
-Monitoring that budgeting were consistent with the initial plan approved by regional manager.

NEAMI National. Sept 2016 – November 2016
Position: Acting Senior Practice leader
(Achievements and responsibilities as written in the SPL position above)

NEAMI National. August 2014 – September 2016
Position: Community Rehabilitation and Support Worker and Cultural Portfolio Holder (CPH)
Achievements:
-Developing a plan for the cultural portfolio.
-Working closely with VTMH to continue enhancing the capacity of the Neami team to respond to diversity across the mental health service.
- Developing a series of sessions for the Neami team to increase the cultural responsiveness practice and awareness regarding social stereotypes and the impact of personal beliefs in their work.
-Providing coaching sessions and practical support towards the recovery process of consumers utilising the Collaborative Recovery Model.

Royal Flying Doctor Service. July 2013-August 2014
Alice Springs and Aboriginal Communities. NT, Australia.
Position: Rural and Remote Mental Health Clinician.
Achievements: (Work with the same clients and team when employed by Medicare Local due to funding moved from NT Medicare Local to Royal Flying Doctor Service)

Northern Territory Medicare Local. January 2013 – June 2013

Alice Springs and aboriginal communities. NT, Australia
Position: Rural and Remote Mental Health Worker. Full time.
Achievements:
-Providing mentoring and coaching sessions to the staff working at the respite centre.
-Making partnerships with nongovernment and government organisations.
-Liaising and consulting with the Central Australia Mental Health Service (CAMHS) and other local and visiting service providers.
-Designing, delivering and evaluating mental health primary services in three different aboriginal communities.
-Providing counselling to aboriginal communities and organisations that support the communties in remote and rural areas.
-Co-design a mental health program with other organisations such as schools and clinics.
-Developing mental health programs for families, individuals and groups; according to their needs and resources.

NEAMI National – Box Hill . August 2012 – December 2012
Position: Community Rehabilitation and Support Worker. Cultural portfolio holder .
Achievements:
Same as the Community rehabilitation position mentioned above.

Cairnmillar Institute. School of Psychology, Counselling and Psychotherapy. November 2011- July 2012
Position: Community Engagement and Mental Health Officer.
Achievements:
-Making partnerships with organisations. Writing Memorandum of Understandings.
-Receiving clients´ feedback and supporting the clinic to increase their quality services and capacity to respond to diversity.
- Engaging communities from diverse cultural backgrounds to promote mental health awareness.

Mingary Counselling Services –Counselling and Psychotherapy Internship. March 2011 – February 2012
Position: Trainee in Psychotherapy as part of the Master of Psychotherapy.
- Individual, couple and family counselling sessions for clients who have diverse cultural backgrounds and ages.
- Supervised practice using a range of techniques and approaches.

June 2010 – December 2012
Master of Counselling and Psychotherapy at Cairnmillar Insitute, College of Psychology, Counselling and Psychotherapy.

AVRE – "Psychosocial and therapeutic support to victims of political violence. Bogotá, Colombia.
March 2008 – December 2008
Position: Psychologist.
Achievements:
-Training mental health teams in different cities and rural areas of Colombia in trauma, self- care and recovery.
-Planning, developing and evaluating mental health workshops for professionals who work with survivors of political violence to prevent vicarious trauma.
-Contributing to the process of making education materials for mental health organisations to support survivors of violence.
- Individual, family and group coaching and counselling sessions for survivors of political violence in different states of Colombia.
-Planning, developing and evaluating group coaching, counselling and workshops for survivors of kidnapping, forced displacement and torture.

-Increasing the network of government and non-government organisations that support the mental health of survivors of political violence.

FEDES- Foundation for Education and Development. Colombia. 2007
Position: Psychologist.
Achievements: :
-Training self-care and trauma informed practice sessions for educators.
-Conducting counselling sessions and workshops for children in forced displacement situation
-Designing and developing mental health projects in schools and community centres aimed at children and parents displaced by the armed conflict in Colombia.
-Develop workshops with children from various indigenous groups to promote cultural diversity, empowerment and improvement of mental health.
Diocese of Soacha - Colombia. March 2006 – December 2006
Position: Psychologist of the project "Humanity Support of Emergence to Victims of Armed Conflict in Colombia. Toledo Diocese Caritas.
Responsibilities:
-80 sessions for survivors of political violence.
-Crisis intervention.
-Supporting the communities by strengthening their networks with local organisations.
-Documenting results from the individual, family and couple sessions.

SUPERVISED PLACEMENTS IN COLOMBIA

-FUNDECOM. Foundation for community development. Jul 2006 – Jun 2007
Position: Trainee Psychologist

-FEDES. Jan 2006 – Jun 2006
Position: Trainee Psychologist
-School San Luis Gonzaga. Jul 2005 – Dec 2005
Position: Trainee Psychologist

REFEREES
Upon request.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AM-3

This is the attachment marked 'AM-3' referred to in the witness statement of Adriana Mendoza dated 2 July 2019.

Victorian Transcultural
MENTAL HEALTH

Working together to innovate in mental health care
to support the well-being of all Victorians because diversity matters

Victorian Transcultural Mental Health (VTMH)

OUR AIM

Victorian Transcultural Mental Health (VTMH) aims to strengthen the capacity of organisations to address inequity in mental health service provision and improve the mental health, social and emotional wellbeing of culturally diverse individuals, families and communities.

WHY FOCUS ON CULTURE?

Culture plays a significant role in how people experience mental health issues. Culture also shapes mental health practice, and how services are structured.

Culture is formed by many intersecting socio-political factors, including ethnicity, sexual and gender diversity, religion, spirituality, class, economic status, power, and life experience.

HOW WE WORK

Our team works across the state of Victoria, delivering services in line with four program areas.

Please see overleaf for further details on each of these areas.

Our work sees us engage with a variety of stakeholders, including mental health services, other agencies, local communities, consumers and carers, and research partners.

OUR WORK INCLUDES:

- Forming partnerships with organisations and assisting service providers to implement culturally responsive strategies
- Providing workforce education, and coordinating networks and events
- Listening to and working alongside consumers and carers from culturally diverse backgrounds and engaging with culturally diverse communities
- Undertaking projects and conducting research and evaluation
- Consulting on policy reform and development

Collectively, our team has knowledge of lived experience of mental health issues and service use, mental health practice and supervision, community development, service development, research and evaluation, project management, and advocacy.

Victorian Transcultural Mental Health Program Areas

ORGANISATIONAL DEVELOPMENT

We work with mental health service providers and other organisations to implement strategies to improve their cultural responsiveness

Collaboration takes a variety of forms. We partner with services to undertake whole-of-organisation reforms via The Partners in Diversity Program. We can also provide services with more targeted assistance to address strategic objectives or conduct projects.

COMMUNITY ENGAGEMENT

A community engagement framework is used across all our program areas.

We educate mental health service providers about ways to involve people in decision making and service delivery.

We also work directly with community groups and organisations.

WORKFORCE EDUCATION AND PRACTICE SUPPORT

We offer:

- Free online learning modules
- Workshops
- Seminars and Forums
- Reflective practice sessions
- Secondary consultation

We also coordinate the Victorian Cultural Portfolio Holder Program. The Program supports diversity champions by providing opportunities for networking, learning, and mentoring.

RESEARCH, EVALUATION & PROJECTS

We undertake research and evaluation projects in collaboration with service providers and research units.

Recent projects include:

- Using audio-visual methods to tell stories of lived experience
- Leading consultations
- Conducting project evaluations
- Co-designing resources

FURTHER INFORMATION

For more information please visit our website or contact us by phone or email to speak with an Education and Service Development Consultant.

VTMH is funded by the Mental Health, Drugs and Regions Division of the Victorian Department of Health and Human Services and administered by St Vincent's Hospital, Melbourne.

Victorian Transcultural Mental Health (VTMH)
Level 1 Bolte Wing (Building F)
St Vincent's Hospital, Melbourne
14 Nicholson Street, Fitzroy
p. (03) 9231 3300
w. www.vtmh.org.au
e. vtmh@svha.org.au

VTMH

ST VINCENT'S HOSPITAL MELBOURNE

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AM-4

This is the attachment marked 'AM-4' referred to in the witness statement of Adriana Mendoza dated 2 July 2019.

Partnership Factors

The following is a list of output and process factors that VTMH staff consultants have observed lead to successful partnership outcomes. These themes are drawn from service development evaluation and documentation. Consider which of these factors are most valuable to your service since their inclusion is likely to strengthen the sustainability plan.

Partnership Enabling Factors	Examples
1. Relational	Long term contact with people at VTMH; Having a consistent person to contact. Frequency of contact with VTMH staff consultants.
2. Reciprocal	Availability of training resources and information; Liaising to ensure needs are met in a non-intrusive, minimal, on-going way. Co-training development; Shared information and visible processes. A routine of engagement and resource building.
3. Leadership	Pacing the project to meet service needs; managing complexity in systems. Writing a letter of introduction; Gentle flow of information and ideas. Development of a partnership plan – a well-intentioned initiative – setting the agenda. Mature level of engagement.
4. Authorising Environment	Mentoring and Supervision; Internal need; Departmental pressure to Improve statistics; Quality and Assurance requirements. Quality and Assurance manager involved; Well-resourced organisation.
5. Shared Leadership	Awareness of CR issues prior to partnership engagement; Internal reflection of different domains in the organisation. Dedicated CR position; Structured working groups; Balancing directives and expectations to meet service needs.
6. Reflection	Regular review of policies; Lots of training; Being clear about outputs vs outcomes – realistic goals. Discussion of sustainability goals.
7. Inclusiveness	Providing a language and tool to enable conversations; Engaging organisational training units. Shared goals; Collaborative negotiation.

Appendix – References

S. McDonough and Colocci, E., *People of immigrant and refugee backgrounds sharing experiences of mental health recovery: reflections and recommendations on using digital storytelling* (2019).

Kirmayer, L. J., *Guidelines for training in Cultural Psychiatry – A position paper developed by the Canadian Psychiatric Association's Section on Transcultural Psychiatry and the Standing Committee on Education and approved by the CPA's Board of Directors* (2011).

Kleinman A., P. Benson, 'Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It' (2006) 3 *PLOS Medicine*, 294.

Roper, Cath, *Coproduction as a methodology* (2016).

Santhanam-Martin, R. et al., 'Evaluation of cultural responsiveness using a transcultural secondary consultation model' (2017) 54 *Transcultural Psychiatry*, 488.

Tandem Inc., Submission to the Productivity Commission Inquiry into Mental Health, Representing Victorian mental health carers, *Royal Commission into Mental Health – Terms of Reference Consultation* (2019).

Victorian Government, *Cultural responsiveness framework: Guidelines for Victorian health services*, Melbourne (2009).

Victorian Government, *Family Violence Reform: Diversity and Intersectionality framework,* Melbourne (2018).

VMIAC, Submission to the Victorian Department of Premier and Cabinet, *Royal Commission into Mental Health – Terms of Reference Consultation* (2019).

VTMH, *Cultural diversity and assessment – online learning resource* (2018).

VTMH, *LGBITQ Intersect – online learning resource* (2019).

VTMH, *Orientation to cultural responsiveness – online learning resource* (2015).

VTMH, *Responding to Diversity: An Evaluation of VTMH Programs and Services, 2013-2015* (2016).

VTMH, *Report of an evaluation of a small grants program: Improving the mental health and wellbeing of immigrant and refugee background communities by building capacity* (unpublished, forthcoming).

VTMH, *Working with Interpreters – online learning resource* (2017).