



*The understanding and prevalence of
depression
in the Polish community*

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Introduction

To the best of our knowledge, this is the first time that a survey regarding the understanding and prevalence of depression has been conducted within the Polish community. Staff from the Australian-Polish Community Services undertook this initiative to develop a better understanding of this illness, particularly in view of the fact that it will become the second largest health issue in the next 20 years. Further, the particular characteristics of the Polish community due to its migration history eg. the large number refugees and of older persons in our community, was an additional factor, which contributed to the final decision of conducting the survey.

Background to the Polish community in Australia

Polish migration to Australia in the twentieth century occurred in two main waves – the late 1940s to the early 1950s following World War II (WW II) and in the early 1980s as a result of martial law being imposed in Poland with the rise of the Solidarity movement. During WW II Poland was occupied by Germany from the west and Russia from the east. Over 4 million Polish citizens (three million Jews and one million ethnic Polish people) died in German concentration camps. Many more were incarcerated in labour camps in Germany and Siberia. It is estimated that six million Polish people died. In the period following WWII an estimated 60,000 migrated to Australia under the Displaced Persons program (Encyklopedia Powszechna PWN, 2000).

After the Second WW II, Poland was forced into a Soviet-backed communist government, which was never accepted by the majority of Polish citizens. This fact caused a series of resistance movements between 1944 and 1989. The last being in 1980, which led to the rise of the Solidarity movement. This resulted in the imposition of martial law and large numbers of Polish citizens seeking political asylum in Western countries. Since 1981, an estimated 25,000 migrated to Australia as a result of the political and economic upheavals in Poland. According to the Australian Bureau of Statistics, in 2001 there were 58,070 Polish people living in Australia. In Victoria, there were 20,409 with 8,275 Poles being over 65 years old.

Migration and mental health

Issues regarding immigration, resettlement and the impact on migrant's mental health were addressed in Australia by the Burdekin report in 1993. Upon the recommendations stemming from that report, all Australian state governments implemented strategies to improve and address mental health services to CALD clients. A number of integrated approaches were initiated in recognition that migration and settlement process in a new country could be distressing and may have great implications on individual's mental health and well being (Burdekin, 1993, Victorian Government, 1996).

Migration and pre-emigration experiences have profound effects on mental health. Studies based on clinical research and community studies have found that migrants who suffered emotional traumas are more likely to demonstrate psychiatric symptoms. (Krupinski & Burrows, 1986, V.Gerrand 1993, Chung & Kagawa-Singer, 1993)

The Australian Health Survey conducted in 1983 reported that the highest proportion of women reporting mental disorders and poor mental and emotional conditions were women from non-English speaking backgrounds. It has been subsequently found that

the peak of incidence of mental health problems occur after 7-15 years of residence in Australia.

The 1988 Australian Survey of Disability and Handicap found psychiatric and emotional conditions accounted for a high proportion of disabilities in NESB women to be greater, than that of the disabilities of women from English-speaking countries of origin.

The study also indicated that two-thirds of refugee women in Australia suffered ongoing forms of serious mental and emotional disability, that arise from their pre-immigration experience symptoms, which persisted for many years after their initial arrival, largely as a result of settlement problems.

Further, that study found that migrants with low family income, receiving public assistance and with poor English-speaking skills, were likely to exhibit depression or anxiety more than other migrants

There were many factors, which contributed to the development of mental health problems experienced by migrants. These include: unemployment, burden of caring for other family members, isolation, loneliness, and of supportive social networks, inadequate command of English, domestic violence, poor access to social resources, housing, transport, lack of participation in public life and taking control of one's life.

The very act of migration challenges the migrant's self concept by removing them from a "right of place" to an unfamiliar place where social, cultural and ethnic references do not accord a rational affirmation or a sense of belonging. The essence of issues associated with the process of migration is well illustrated by this quote:

"By measure, immigration is one of the most stressful events a person can undergo. Most critically, immigration removes individuals from many of their relationships and predictable context-extended families and friends, community ties, jobs, living situations, customs and often language. Immigrants are stripped of many of their relationships, as well of their roles, which provide them with culturally, scripted notions of how they fit into the world. Without a sense of competence, control, and belonging, they may feel marginalized. These chances are highly disorienting and nearly lead to a keen sense of loss." (Suarez-Orozco, 2000, in "Building Realistic View", 2003, author unknown).

Brief literature review – mental illness and depression

Mental illness had affected every community since the beginning of time. The Diagnostic and Statistical Manual of Mental Disorders (DSM- IV, 1994) has described mental illness as clinically significant behavioural or psychological syndromes, or patterns that occur in individuals.

The following factors may be associated with mental illness:

- ❖ Distress (eg. feeling very sad or very anxious); and /or
- ❖ Disability (eg. problems with work, family or relationships): and/or
- ❖ An increased chance of pain, disability, loss of freedom, death or suffering.

In order for mental illness to be clinically recognised, it must include responses that are not considered 'normal' within the sufferer's culture (eg. feelings of sadness when

a loved one dies is considered a norm). Mental illness can be viewed as either psychological, biological, or behavioural dysfunction in an individual. There is a wide range of problems identified by DSM-IV as mental illness, the more common ones include:

- ❖ Anxiety (eg. agoraphobia, post-traumatic stress disorder),
- ❖ Mood disorders (eg. depression),
- ❖ Personality disorders,
- ❖ Psychotic disorders (involving a loss of touch with reality) such as schizophrenia.

From a prevalence point of view, evidence suggests that around 20 per cent of Australians suffer from clinically significant psychological disorders warranting treatment during their lives. The cost of psychological disorders in Australia was estimated in 1993 at between \$3 billion and \$6 billion per year (Cotton & Jackson, 1996).

It is very important to understand the definition of mental illness as well as key factors that may be underlying the causes of mental health problems significant for culturally and linguistically diverse (CALD) groups. In the CALD context, there are a number of factors to consider, which may be crucial to the mental health of individuals or ethnic communities. These include:

- ❖ Pre-migration life and experiences
- ❖ The process of resettlement;
- ❖ Response to the stressors of the dominant culture.

The most common form of mental illness is **depression**, which is now considered to be among the most important public health concern affecting communities around the world. According to the World Health Organization by 2020, depression is expected to become the world's second largest health problem and one of the greatest causes of loss of life due to disability and mortality. It is estimated that more than 300 million people worldwide experience depression and this number will rise over next ten years. There are over 800,000 suicides recorded worldwide and the majority of these are associated with depression. Every year depression affects one in four women, and one in eight men ([http:// www.mentalhealth.gov.au](http://www.mentalhealth.gov.au))

The National Survey of Mental Health and Wellbeing, conducted in 1997, revealed that overall approximately 2,4 million Australians experienced some form of mental illness and almost 6 per cent experienced depressive disorders in the course of one year. In any given year almost 800,000 Australian adults experience a depressive illness. Research conducted by Mathers et al. (2000) indicated that in 1996 depression was fourth among all diseases to contribute to injuries and disability. Disability due to depression was second to heart disease, stroke and was placed higher than diseases such as lung cancer, dementia, diabetes, asthma and osteoarthritis.

By the year 2020, it is estimated that depression would be the second highest cause of disability in Australia. Depression alone accounts for more days lost per year than those lost to industrial actions. And it has been recently recognized as a painful, disabling and costly illness ([http:// www.mentalhealth.gov.au](http://www.mentalhealth.gov.au))

According to the latest statistics eg. Steve Waldon in *The Age* (Sunday, 14/11/04, p.4), in 2002 there were 2320 suicides committed by Australians, which is 6.5 suicides every day. In gender terms, 79 per cent of these suicides were conducted by men and 21 per cent by women. There is a general agreement amongst the medical profession that 80 per cent of these suicides were related to depression.

Clinical depression, an illness, and a medical condition are defined by presence of five or more (out of nine) specified symptoms. Diagnostic criteria defined by the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV)* concentrate on symptoms of depression. Those symptoms may include:

1. Feelings of sadness or emptiness, tearfulness,
2. Markedly diminished interest or pleasure in all or almost all activities most of the day,
3. Significant weight loss or weight gain, changes in appetite,
4. Insomnia, sleep disturbances,
5. Psychomotor agitation or retardation,
6. Fatigue or loss of energy,
7. Feelings of worthlessness or excessive or inappropriate guilt,
8. Diminished ability to think or concentrate, or indecisiveness,
9. Recurrent thoughts of death, suicidal ideation without a specific plan or a suicide attempt or a plan for committing suicide (DSM–IV, fourth edition, American Psychiatric Association, 1994. p.327)

The most serious outcome of clinical depression is suicide. In 1996, suicide, which associated with depression, was the fourth largest cause of mortality surpassing road accidents, breast cancer and diabetes mellitus. Of all people suffering depression, two-thirds have suicidal ideas or thoughts of dying and 15 per cent take their own lives (Bloch & Singh, 1998).

Cross-cultural studies of suicide rates relating to depression in Australia, indicated that several of the overseas-born groups might have a higher risk of suicide than their Australian born peers. Amongst the immigrant groups, the highest suicide rates were found from those born in Eastern European countries, such as Poland, followed by Western Europeans. The same studies found that the lowest rates of suicide were for those born in Southeast Asian countries (Burvill, 1995 & McDonald & Steel, 1997).

According to Burvill (1995), women born in Austria, Poland and the former USSR had three times the rate of suicide than the Australian born.

There is evidence to suggest that vulnerability to mental disorders such as depression is no lesser in ethnic minority than in the main stream Australian community. The *National Survey of Mental Health Wellbeing (1997)* revealed that more than 60 per cent of the community with mental disorders fails to receive appropriate support. In ethnic minority groups due to the language barrier, lack of information and the stigma attached to mental illness, the problem of access mainstream services may be more severe.

Research conducted by the Victorian Trans-cultural Psychiatry Unit (1995), identified the Polish community as being over-represented in admissions to a major psychiatric facility in comparison to other culturally and linguistically diverse groups. Admissions of other ethnic groups were at or below the rate of the Australian-born community in that major psychiatric hospital.

According to Burvill (1995), Polish born women in the over 65 age range have significantly higher contact per capita with community mental health services than Polish born men in the same age range. The number of admissions of Polish born citizens were greater when compared to general Australian born population in comparable age for both genders. Both Polish women and men have significantly higher per capita admissions to psychiatric facilities compared to the same age group of Australian born population.

According to Evert (1996) author of the Polish Community Mental Health Profile, some of the factors, which may contribute to the high proportion of contact with mental health services by the Polish community, are:

- ❖ An aging population and aging related depression, dementia: Alzheimer's disease or multi-infract dementia,
- ❖ Refugee status of early immigrants, most were involuntary migrants who experienced great traumas in earlier life as a result of war experiences,
- ❖ Greater social isolation with limited social support mechanism, not chain migration, small family sizes and many single households,
- ❖ Problems in adjustment to a new system,
- ❖ Unemployment,
- ❖ Lack of recognition of overseas qualification,
- ❖ Decline in social status,
- ❖ Alcohol and substance abuse related problems.

In the context of the above-mentioned data, there is a great need to address mental health problems in the Polish community. According to Evert (1996) clients of Polish welfare organisations in Melbourne have reported that the responses of mainstream mental health services failed to address the needs of the Polish community, especially those who suffered from mental illness such as depression.

Aim of this research study

- ❖ To investigate the understanding and prevalence of depression within the Polish community as the first step in working towards developing culturally appropriate response and intervention.
- ❖ To contribute to the knowledge about depression experienced by members of ethnic communities in Victoria.
- ❖ To develop appropriate recommendations based on the results of this study.

In order to respond to growing mental health problems faced by Polish migrants in Victoria, the Australian Polish Community Services conducted the depression survey, which was piloted among randomly chosen males and females of the Polish community.

Methodology

This research study collected 174 surveys, 122 completed by women and 52 by men. Survey collection was largely done by staff from the Australian-Polish Community Services. Survey participants came from a variety of sources incl. Polish senior citizens clubs, personal contacts, students from English language classes and by direct mail out. The survey design took into consideration all possible levels of education and language mastery of the potential participants, and it included the A.T. Beck Depression Inventory test, which aims to determine the occurrence and extent of depression in a given person. APCS staff member was available for clarification and assistance during club meetings when surveys were being filled out.

The survey consisted of 21 questions. Questions 1-10 included personal data such as gender, age, place of birth, marital status, year of arrival to Australia, education, and employment situation. Questions 12-15 examined self-awareness in relation to symptoms of depression by using adopted and translated A.T Beck Depression Inventory BDII. The last group of questions 16-21 examined the participant's knowledge and evaluation of existing mental health services, including feedback in relation to services provided by the Australian Polish Community Services.

Analysis of results

Socio-demographic characteristics of participants

Amongst the 174 study participants, 70 per cent were women and 30 per cent men. The age group of the participants was reflective of all age groups ranging from 18 – 75+ years of age. Thirty six per cent were over 75+, which is reflective of the demographic characteristic of the Polish community. The second largest age group was amongst those who were 56-75. The remaining age category (18-55) totalled 31 per cent.

Poland was the place of birth for 95 per cent of the study group. The time of arrival was categorized according to the migration waves of the Polish community in Australia i.e. in the period between 1942-55 to Australia arrived 33 per cent of participants of the survey. The second largest group were those arrived between 1981-89 (21 per cent) and 24 per cent who arrived between 1990-2002.

In terms of geographical location, each region of Melbourne was represented, with the western suburbs being most prominent. The study also well captured people of Polish background residing in country Victoria.

Fifty three per cent of the study participants completed secondary or higher education.

Forty nine per cent were married and 33 per cent were widowed, which was also reflective of living arrangements of these participants. What is noticeable is the high promotion of lone households amongst the participants i.e. 36 per cent. This can be

attributed to the fact that so many from the study group were older persons and widowed. Similarly, 58 per cent were pensioners. Twenty one per cent were working either full- or part-time.

Prevalence of depression amongst respondents

One of the most important findings was self-identification of depression. Thirty two per cent self-identified as having depression. A further nine per cent were not sure if they suffer from depression. Forty percent either were suffers of depression or were not sure if they have depression. On the other hand, 60 per cent answered that they do not suffer from depression.

According to the BDII (Beck's Depression Inventory), admission of depressive symptoms (i.e. indicating high or very high occurrence) varied between 7 and 35 per cent. Eleven per cent stated that they have had suicidal thoughts either often or sometimes.

Thirty five per cent showed strong symptoms regarding tiredness, 25 per cent sleeplessness, agitation 23 per cent, sadness 22 per cent, difficulties with concentration 21 per cent, and feeling as a failure 17 per cent. Only seven per cent indicated feeling guilty.

The above results clearly indicate a significant prevalence of depression in the Polish community. Further, study results showed that understanding depression in the Polish community is limited. Furthermore, 27 per cent simply omitted this question; hence it can be partially assumed that they did not know what depression is.

Understanding of depression in the Polish community

From those who have responded to the question of '*What is depression?*', 21 percent stated that it is an illness and 78 percent described it as a "bad state of mind".

The responses can be grouped as follows:

A: Full and correct understanding of depression i.e. describing it as an illness, which needs to be treated.

Perhaps the best way to illustrate these group's of participants understanding of depression can be through the following quotations:

" Depression is an illness, which should be cured as quickly as possible. It is very important to have the support of other people and to be able to talk to them in an open way. One should not be ashamed of depression. It is important to fight it".

"Depression is a community problem, an illness often ignored".

"It is an illness which results in psychological and behavioural changes".

"Depression is the effect of prolonged stressful situations. Sometimes people who are not well immune psychologically, in all difficult life situations, react with depression, and this is a very difficult and prolonged illness".

"Depression is the result of brain disfunctioning".

"It is an illness and suffering that nobody understands".

"It is my own hell on earth".

B: The second group of participants saw depression as one of the stages in our mental health i.e. transitory feeling, which will pass. Examples:

"I associate depression with loneliness, lack of confidence, feeling quality, and lack of any interests".

"Depression is a feeling of sadness, melancholy, hopelessness, lack of motivation to act".

"In my view, depression is a constant feeling of not wanting to live, feeling of sadness and uselessness".

"When I feel depressed, I cannot concentrate, I cannot sleep or eat, and I become upset easily".

"Depression is a psychological state, in which one feels unhappy. A state in which one does not want to be with other people, becomes aggressive at times and cannot trust anybody".

"Depression is a feeling of lack a purpose in life, extreme pessimism, no hope for the future, and not being motivated to deal with life problems. Sometimes, experiencing suicidal thoughts".

"Depression occurs when a person does not know what to do with oneself, lives in isolation and does not have a job. People should not be by themselves because they can start drinking heavily. It is dangerous when a person in such state suffers in silence and does not ask for help".

C: The third type of study respondents downplayed depression as an illness or were not aware of what it is, eg.

"Depression can be described as stupidity and a weakness of personality".

"I don't know what depression is but I think it is something bad".

"Depression is the result of bad long-term eating habits, lack of minerals, bad digestion, all resulting in hyperacidity".

Awareness of available services

The next question in the survey inquired about the awareness of available services for people who suffer from depression. Forty one percent said that they did not know of such services. Although 59 percent stated that they are aware of such services, study participants had difficulty identifying these services. For example, 52 percent either could not describe these services or did not respond to the question, which could be interpreted as lack of knowledge of such services. Amongst those who could describe the various available services, 30 percent stated that such services are available through a GP, whilst 12 percent referred to community services. A small number of participants also referred to phone help lines, support groups and assistance from a church/priest.

The most common source of information about such assistance was obtained from media (TV, radio, newspapers), followed by GPs and other specialists, then family and friends. Only six percent referred to Polish bureaus as a source of such information, which is reflective of the fact that such bureaus do not receive funding to provide this information.

The study showed that Polish people associate GPs and other specialists as the first point of contact for people suffering from depression (67 per cent) and 21 per cent would not know who to turn to for assistance.

Adequacy of existing services and potential solutions

Sixty six per cent stated that existing services are inadequate or they were not sure how to validate their professional competency. The same number of respondents stated that they do know what changes have to be implemented to improve understanding of depression and accessibility to existing support services by people of Polish background who suffer from depression.

The study questionnaire included open questions, to which participants provided qualitative answers about what can be done to improve the current situation. Examples of such suggestions:

“It is important that the depressed person was supported by the community, to break the cycle of isolation”.

“It is important to ensure better access to psychiatrists, psychologists and psychotherapists, paid by Medicare”.

“It is necessary to increase the interest of the government to want to help people who suffer from depression”.

“Information should be provided about where help is available, which may help to reduce the number of suicides”.

“It is important to expand Polish services because that way one can be better understood”.

“Most of all, it is critical to disseminate information about depression, its symptoms, available therapies and very importantly – how it can be prevented”.

“There is a need for more Polish speaking specialists to be available, so the communication can occur without interpreters”.

“Perhaps it would be helpful to establish a Depression Day, which may help to attract donations and funds to deal with depression”.

Those of the respondents who have an understanding and knowledge how to improve current situation pointed out that the ways to improve existing services could be through: providing more information (18%), education of specialists and workers (7%) and prevention. The other ways mentioned by survey participants were: increasing access to specialists, appropriate workers, and funds for community information and education.

Characteristics of sufferers of depression

Particularly interesting results were obtained from the analysis of that group of respondents who recognized that they suffer from depression and/or were not sure if the occurrence of depression- like-symptoms, which are characteristic of depression, are a sure indication of their illness. As was mentioned earlier, the amount of participants in this category totalled 40 per cent, gender-wise it applied to 79 per cent of females and 21 per cent of males.

Correlation of data indicated that the majority of respondents suffering from depression were those who migrated to Australia after World War II or shortly afterwards i.e. between 1942-1955. In terms of age and gender, most were females

between 56-75 years of age or older and amongst men, they were largely between the age of 65-75 or older.

At the time of study, almost a quarter of this group of respondents lived with their spouse or children and 15 per cent lived alone. The rest were in a variety of accommodation arrangements.

Further, analysis of the results indicated that participants who were suffering from depression or those who suspect that they have this illness, had post primary school education (i.e. incomplete or completed secondary education and incomplete or completed university). However, in the case of males, this characteristic did not apply i.e. occurrence of depression amongst Polish men applied to all, regardless of the level of education. This may imply that women who earlier held a higher social status had more difficulty adapting to a new environment, which resulted in higher occurrence of depressive symptoms, compared to men, who may requalify and/or adapt more quickly and more easily, or undertake work below their education level.

Recommendations

In view of the results of this study, authors strongly recommend a number of urgent actions to be undertaken by organizations responsible for responding to the needs of people affected by depression and mental illness.

1. That a public awareness and education campaign be undertaken in the Polish language about depression, its meaning and what depression sufferers can do about it;
2. That the State government develops a strategy to address the issue of depression in the culturally and linguistically diverse communities in Victoria;
3. That funding be sought from any relevant organization including charitable trusts to address this important health issue in CALD communities in Victoria;
4. That the Victorian Transcultural and Psychiatric Unit change its focus and direct some of its resources to community education, prevention, service brokerage and increased advocacy;
5. That the Mental Health Branch in the Department of Human Services reports annually on strategies undertaken to address the needs of CALD Victorians who suffer from mental health;
- 5a. That every organization funded to provide mental health services, reports on initiatives undertaken to respond appropriately to the needs of CALD communities in Victoria;
6. That ongoing government funding be made available for assessment, counselling and support in a culturally sensitive and linguistically appropriate way.

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