Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF RO ALLEN

I, Ro Allen, Commissioner for Gender and Sexuality of Level 45, 80 Collins Street, Melbourne, in the State of Victoria, say as follows:

1. 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.

2. I make this statement in my capacity as the Victorian Commissioner for Gender and Sexuality. This statement responds to the list of questions provided to me by the Royal Commission into Victoria's Mental Health System dated 18 June 2019.

3. It covers the key themes of lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ) mental health and wellbeing, the impact of stigma regarding sexuality, gender identity and intersex status as well as stigma related to mental illness, and access to inclusive services.

4. Language used to describe different LGBTIQ people and by different parts of the LGBTIQ communities changes over time and can differ across cultures and generations. Throughout this statement, I use the initials "LGBTIQ". Some of the organisations, committees and boards I have been involved in (as described in response to questions 1 and 3) use the acronym "LGBTI". I note the Royal Commission's questions use the acronym "LGBTIQ+".

5. Throughout this statement, I refer to documents annexed to this statement and marked sequentially as RA-1, RA-2 and so on.

6. Through my role as Commissioner for Gender and Sexuality, I have encouraged LGBTIQ community members and organisations to make submissions to the Mental Health Royal Commission. This is particularly important, as there is a lack of systematic data regarding LGBTIQ people and their mental health, in part because often data collection does not seek information regarding sexuality, gender identity or intersex status. Furthermore, LGBTIQ people do not feel safe disclosing this information, and may not share this information even when it is sought, for example through service intake. I am also concerned that LGBTIQ people who have experienced discrimination and disrespect within mental health services may choose against making a submission.

7. Based on concerns within the LGBTIQ community regarding privacy and the risks of disclosure, the Mental Health Royal Commission may not receive enough submissions from LGBTIQ community members to develop a full picture of LGBTIQ mental health in Victoria.

BACKGROUND

Questions 1 and 3: Background and experience (including qualifications)

8. I am an experienced and longstanding advocate for LGBTIQ Victorians. I began my career 25 years ago as a Youth Worker and have worked in local government and the Uniting Church in both metropolitan and rural regions.

9. As founding CEO of UnitingCare Cutting Edge, I established Victoria's first rural support group for young LGBTIQ people, allowing me to develop a deep understanding of the issues faced in rural and regional areas.

10. Prior to my appointment as Commissioner for Gender and Sexuality, I was a member of three Victorian Government LGBTIQ ministerial advisory groups and chaired the Ministerial Advisory Committee on LGBTI Health and Wellbeing between 2007 and 2009.

11. I am a former Chair of the Adult, Community and Further Education Board, the Victorian Skills Commission, the Youth Affairs Council of Victoria (YACVIC), and a former member of the Hume Regional Development Australia Committee.

12. I am currently on the board of GOTAFE and sit on the Victorian Government's Family Violence Steering Committee, the Chief Magistrate's Family Violence Taskforce Diverse Communities and Intersectionality Working Group and the AFL Rule 35 (Vilification) Review Committee.

13. In 2003 I received a Centenary Medal and in 2009 I was inducted into the Victorian Government Honour Roll for Women. Recently I was recognised in the Top 50 Public Sector Women (Victoria) 2017 and won Hero of the Year in the 2017 Australian LGBTI Awards.

14. I hold a Diploma in Community Services and am a Fellow of the Australian Institute of Company Directors.

Question 2: Current role and responsibilities

15. In July 2015 I was appointed as Victoria's first Commissioner for Gender and Sexuality, the first such position in Australia. This was the result of both my professional and personal connections to LGBTIQ communities in Victoria and across Australia. My current term is through until mid-2021.

16. I came out myself in my early 20s after time in conversion practices at a Pentecostal church. Since then, I have experienced discrimination and prejudice both in my working and my personal life, as has my family. Accumulated experiences of physical violence and emotional abuse have left me with mild anxiety and infrequent panic attacks. My partner of 13 years and I recently married, and we have an eleven-year-old daughter.

17. This personal experience informs the work I do. In this role, I advocate for the rights of LGBTIQ Victorians within government. I engage with community stakeholders and provide advice to government and service providers about the needs and priorities of LGBTIQ Victorians, and work to promote their safety and wellbeing.

18. At times throughout this statement, I use the terms 'we' and 'our' to reflect my identification with and connection to LGBTIQ communities. I have also supplied a short glossary at the end of this statement to describe key terms I use.

19. As Commissioner for Gender and Sexuality, I work closely with a number of government working groups, including:

    a. The LGBTI Taskforce, co-chaired by Martin Foley, MP, the Minister for Equality and Brenda Appleton OAM;

    b. The LGBTI Justice Working Group;

    c. The LGBTI Health and Human Services Working Group;

    d. The Intersex Expert Advisory Group, which I chair;

    e. The Trans and Gender Diverse Expert Advisory Group, which I also chair; and

    f. The LGBTI Education Reference group, which I co-chair with Mary-Anne Thomas, MP.

The LGBTI Taskforce and its working groups and advisory groups provide high level, strategic advice on current and emerging LGBTIQ issues, and on government policy, programs and services to address those issues. The Taskforce ensures that government's equality initiatives are informed by LGBTIQ community consultation.

LGBTIQ+ MENTAL HEALTH AND WELLBEING

Question 4: As Victoria's first Gender and Sexuality Commissioner, how does my role consider and respond to issues relating to the mental health of LGBTIQ+ people?

20. In my current role, I am fortunate to engage directly with community members, for example through the Rural and Regional Program, which connects LGBTIQ people and local organisations and services in rural and regional areas to discuss how to make local communities more inclusive.

21. Recurring issues include how to support mental health and how to respond to, and prevent, discrimination and prejudice. Isolation and experiences of prejudice and discrimination have a strong negative impact, and people come to our workshops with stories of rejection from their families, being ostracised from community and experiencing violence. The workshops themselves are a powerful way to create local connections, and people say how important it is to feel recognised, understood and respected.

22. My role also includes working across government bodies to foster respect and inclusion, which supports mental health, and to reduce prejudice and discrimination, which adversely impact mental health. For example, over the last year I have had a focus on working across the justice system to increase awareness of LGBTIQ issues and improve responses to LGBTIQ people involved in the justice system.

23. Another example of how my role considers and responds to mental health issues for LGBTIQ people is specifically related to trans and gender diverse people. Trans and gender diverse Victorians face significant challenges in the difficult process of questioning, defining and affirming their gender identity. Last year, the Victorian Government announced the investment of $3.4 million to expand the health system's capacity to support and better meet the needs of trans and gender diverse people. One element of this initiative is a partnership with Transgender Victoria to develop a peer support program, which will be designed by and delivered with trans and gender diverse

community members. This is an important priority in my current work program, with a focus on wellbeing for trans and gender diverse people.

Questions 5: From my perspective, why do LGBTIQ+ people experience significantly poorer mental health and higher rates of suicide?

Statistics illustrating the differences in mental health outcomes and suicide rates between the LGBTIQ community and the general population

24. Australian and international research demonstrates that LGBTIQ people experience poorer mental health and wellbeing outcomes compared to the general population. Compared to the general population, LGBTIQ people are more likely to be diagnosed with mental illness.

25. The Australian Bureau of Statistics 2007 National Survey of Mental Health and Wellbeing[1] (the survey) found:

    a. 41.4% of gay, lesbian and bisexual people aged 16 and over reported symptoms that met criteria for a mental disorder in the previous 12 months, compared to 19.6% of heterosexual people aged 16 and over;

    b. For anxiety, 31.5% of gay, lesbian and bisexual respondents reported an anxiety disorder, compared to 14.1% of heterosexual respondents; and

    c. For affective disorders, 19.2% of gay, lesbian and bisexual respondents reported an affective disorder, compared to 6.0% of heterosexual respondents.[2]

    Attached to this statement and marked 'RA-1' is a copy of 'The Australian Bureau of Statistics 2007 National Survey of Mental Health and Wellbeing.'

26. The National LGBTI Health Alliance has compiled a comprehensive summary of mental health statistics for LGBTIQ people.[3] This shows that compared to the general

[1] Australian Bureau of Statistics. (2007). National Survey of Mental Health and Wellbeing. ABS, Canberra (note this survey, which was valuable as it enabled a comparison of homosexual and bisexual people with heterosexual people, has been discontinued) (Annexure RA-1).
[2] The term 'mental disorder' can be seen as stigmatising, and this statement only uses the term when it has been used in the supporting evidence.
[3] National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney (Annexure RA-2).

population, LGBTIQ people are more likely to be diagnosed with depression in their lifetime:

a. LGBTI people aged 16 and over are nearly three times more likely;

b. People with an Intersex variation are nearly two times more likely;

c. Transgender and Gender Diverse people aged 18 and over are nearly 5 times more likely.

Attached to this statement and marked 'RA-2' is a copy of 'The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia.'

27. In addition, compared to the general population, LGBTIQ people are more likely to attempt to end their lives, to have thoughts of suicide and/or engage in self-harm in their lifetime.[4]

LGBTIQ people and suicidality

28. LGBTIQ people have high rates of suicidality, with particularly high rates among subpopulations, for example trans and gender diverse people, and Aboriginal and Torres Strait Islander people.

29. In terms of life stages, adolescence can be a particularly challenging period for LGBTIQ people as they explore and develop their social, sexual and/or gender identities. For trans and gender diverse young people, puberty is a time of increased vulnerability, especially for those without or with little support.[5] At the other end of the age spectrum, older LGBTIQ people may also have a high risk of suicidality, especially for those with fewer family and social supports.[6]

Attached to this statement and marked 'RA-3' is a copy of 'Recognising and addressing the mental health needs of the LGBTIQ+ population.'

---

[4] National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney (Annexure RA-2).
[5] The Royal Australian and New Zealand College of Psychiatrists (2019) Recognising and addressing the mental health needs of the LGBTIQ+ population. Position Statement 83 (Annexure RA-3).
[6] National LGBTI Health Alliance (2013). LGBTI People. Mental Health and Suicide. Briefing Paper. National LGBTI Health Alliance, Sydney.

30. Actual statistics on the suicide rates of LGBTIQ people are poor, in part because data regarding sexual orientation or gender identity is not consistently captured, for example during a police investigation.[7] Furthermore, even when attempts are made to gather the data, it may be that the person who has died by suicide had not disclosed their sexuality or gender identity to their next of kin.

31. From LGBTIQ people who have attempted to end their own lives, we know that they often attempt suicide before having disclosed their sexuality or gender identity to other people.[8] In other cases, family members or loved ones who do know the sexuality or gender identity of someone who has died by suicide may elect not to share this information with officials.[9] It should be assumed that current Victorian data is an underestimate regarding the suicide rate of LGBTIQ Victorians.

    Attached to this statement and marked 'RA-4' is a copy of 'LGBTI People Mental Health and Suicide.'

<u>Reasons for the differences in mental health outcomes and suicide rates between the LGBTIQ community and the general population</u>

Stigma, discrimination, abuse and prejudice as determinants of poor mental health outcomes for LGBTIQ people

32. LGBTIQ people do not suffer from poorer mental health by virtue of who we are, but rather because of experiences of discrimination and violence based on sexuality, gender identity or intersex status.[10] This can include actual experiences of discrimination or violence, and vigilance against the possibility of discrimination or violence. This is sometimes referred to as 'minority stress'.[11]

---

[7] Sutherland, G; Milner, A; Dwyer, J; Bugeja, L; Woodward, A; Robinson, J; Pirkis, J. (2018). Implementation and evaluation of the Victorian Suicide Register, *Australian and New Zealand Journal of Public Health*, 42 (3), pp. 296 – 302.

[8] Rosenstreich, G. (2013). LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance, Sydney (Annexure RA-4).

[9] Community Affairs References Group. (2010). The Hidden Toll: Suicide in Australia. Commonwealth of Australia, Canberra.

[10] Rosenstreich, G. (2013). LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance, Sydney (Annexure RA-4).

[11] Rosenstreich, G. (2013). LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance, Sydney (Annexure RA-4).

33. Discrimination and prejudice can be overtly expressed through verbal, physical or psychological abuse including harassment, violence, negative stereotypes, exclusion or other forms of negative treatment based on sexuality, gender identity or intersex status.

34. Discrimination can also be indirect, for example, only including heterosexual relationship configurations in marketing material for a service may indicate to LGBTIQ people that we will not be welcomed.

35. Research has found that up to 80% of same-sex attracted and gender questioning young Australians have experienced insulting behaviour in public, 20% have experienced explicit threats, 18% physical abuse and 26% have experienced 'other' forms of homophobia.[12]

36. For trans and gender diverse people, rates of almost all types of violence are high. Approximately 50% of adult trans Australians have experienced verbal abuse and discrimination, and around 30% have been threatened with violence.[13]

37. Experiences of prejudice and discrimination can result in intensely negative feelings such as shame, hostility and self-hatred.[14] Furthermore, lesbian, gay and bisexual Australians are twice as likely as heterosexual Australians to have no contact with their family or minimal contact with little to no support.[15] This is likely to be higher for trans and gender diverse people.

38. Rejection by a family member, particularly a parent, can have a significant impact on LGBTIQ people's mental health, and is associated with higher rates of self-harm and suicide among young people. The opposite is also true; LGBTIQ people who are supported by family are less likely to self-harm or attempt suicide.[16]

---

[12] Rosenstreich, G (2013) LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance. Sydney (Annexure RA-4).
[13] Rosenstreich, G. (2013) LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance. Sydney (Annexure RA-4).
[14] Skerrett, D. M. (2014) Mental Health and Suicidal Behaviours: LGBTI Populations and Access to Care in Australia: A Literature Review.
[15] Rosenstreich, G. (2013) LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance. Sydney (Annexure RA-4).
[16] Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., & Mitchell, A. (2010). Writing themselves in 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people. LaTrobe University, Melbourne.

39. Experiences of discrimination, abuse and family rejection have long-lasting impacts on mental health.

40. LGBTIQ people also have high rates of other risk factors which influence mental ill-health and suicidality, including:

    a. higher rates of alcohol and other drug misuse;

    b. homelessness and poverty;

    c. disengagement from school;

    d. chronic health conditions.[17]

41. With regard to suicide, research shows that acceptance, including self-acceptance, is a vital protective factor. The converse is also true – not feeling accepted for who you are is a major risk factor for suicide and suicidality. A recent Australian study showed that unique factors relating to suicide in LGBT people include a lack of acceptance by family and self (reflected in higher internalized homophobia and shame), negative feelings about own sexuality/gender, and dissatisfaction with appearance.[18]

Question 6: Which groups within LGBTIQ+ communities experience or are at greater risk of experiencing poor mental health outcomes? Why is this the case?

Statistics illustrating the differences in mental health and wellbeing outcomes between sub-groups within LGBTIQ communities, and reasons for these differences

42. There are differences in mental health and wellbeing outcomes between sub-groups within LGBTIQ communities.

43. Lesbian women are more likely to be diagnosed and treated for a mental disorder or anxiety than gay men. They are also more likely to engage in self-harm and attempt

[17] Rosenstreich, G. (2013) LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance, Sydney (Annexure RA-4).

[18] Skerrett, D. M., Kõlves, K., & De Leo, D. (2016). Factors related to suicide in LGBT populations: A psychological autopsy case-control study in Australia. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 37*(5), 361-369.

suicide than gay men, although gay men are more likely to have thoughts about suicide. Gay men and lesbian women report a similar level of psychological distress.[19]

44. Bisexual people are more likely to be diagnosed and treated for a mental disorder or anxiety and have higher levels of psychological distress than lesbian and gay people. Within this group, bisexual women are more likely to be diagnosed with a mental disorder and to self-harm, and bisexual men are more likely to think about suicide.[20]

45. Trans and gender diverse people have poorer mental health outcomes than lesbian, gay and bisexual people, and are nearly eleven times more likely to attempt suicide than the general population. 35% of transgender people aged 18 and over have attempted suicide in their lifetime, and 41% of transgender and gender diverse people aged 18 years and over reported thoughts of suicide or self-harm in the last two weeks.[21]

46. For people with an intersex variation, many report negative wellbeing due to medical interventions related to their intersex variation. In Australian research, 60% of intersex respondents reported that they had experienced medical intervention related to their intersex variation, and around half of this group experienced intervention before the age of 18. Close to 8% of people with an intersex variation have been diagnosed with PTSD, which is above the rate for the general population.[22] The effect of traumatic or unwanted surgery and being shamed or stigmatised can have life-long impacts.

47. For people with an intersex variation, their quality of life and wellbeing may be influenced by their sex and their particular intersex variations, for example in some cases, mental health may be influenced by specific clinical conditions. However, the main drivers of reduced mental health relate to non-clinical factors such as unnecessary medical interventions and other people's prejudices.[23]

---

[19] National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney (Annexure RA-2).
[20] National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney (Annexure RA-2).
[21] National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney (Annexure RA-2).
[22] National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney (Annexure RA-2).
[23] Victorian Department of Health and Human Services (2018) *Health and wellbeing of people with intersex variations: information and resource paper*. Initially prepared by T. Jones and W. Leonard; revised and edited J.

48. Intersecting factors such as age, race, culture, disability, gender, location or faith can also increase LGBTIQ people's experience of discrimination and social exclusion and can negatively impact on mental health and wellbeing.

49. In 2014, 66% of gender diverse and transgender young people in Australia had seen a health professional for their mental health in the last twelve months.[24] This year, Minus18 highlighted that 41% of gender diverse young people have reached out to a medical or mental health service provider who did not understand, respect or have previous experience with gender diverse people.[25]

50. Older people have seen significant social changes regarding sexuality, gender identity and intersex status, however, they often have experienced a number of personal challenges, including family rejection, persecution and criminalisation, grief and loss, particularly related to HIV and AIDS, and relationship challenges. A collaborative report between the National Ageing Research Institute, the Australian Research Centre for Sex, Health and Society, and the RMIT School of Mental Health also describes the lifelong impacts of 'the absence of celebratory discourses' for older people who have had less access to affirmation and community.[26]

51. Of the approximately 26.8% of LGBTIQ young people with a multicultural or multifaith background, 18% reported experiencing a conflict between their cultural background and their sexuality or gender.[27] The compounded experience of racism and faith-based discrimination, and homophobia, biphobia or transphobia results in poorer mental health and wellbeing outcomes among this group compared to other LGBTIQ people. Furthermore, LGBTIQ people from culturally and linguistically diverse backgrounds

---

Rostant on behalf of Department of Health and Human Services 2016–2018 Intersex Expert Advisory Group. Department of Health and Human Services: Melbourne.

[24] Smith, E., Jones, T., Ward, R., Dixon, J., Mitchell, A., & Hillier, L. (2014), From Blues to Rainbows: Mental health and wellbeing of gender diverse and transgender young people in Australia. The Australian Research Centre in Sex, Health, and Society, Melbourne.

[25] Clerke, E., Scott, M. (2019). Young & Queer Report: Youth Driven Ideas For A Better Victoria. Minus18, Melbourne.

[26] Joosten, M., Tinney, J., Barrett, Ca., Whyte, C., Dow, B. & Maude, P. (2015). Improving Mental Health for older LGBTI Australians. National Ageing Research Institute, the Australian Research Centre for Sex, Health and Society, and the RMIT School of Mental Health, Melbourne.

[27] National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney (Annexure RA-2).

experience racism and discrimination from within LGBTIQ services, venues and organisations.[28]

52. Disability is another factor that can shape the mental health and wellbeing outcomes of LGBTIQ people. 27% of people with an intersex variation aged 16 years and over report having one or more disabilities, and 36% of transgender people aged 18 or over report having a mental health issue that they described as a disability or chronic health condition.[29]

53. Experiences of disability compound discrimination based on sexuality, gender identity or intersex status. For example, LGBTIQ people with a disability may experience restrictions on their freedom of sexual expression, a lack of social support and connection to other LGBTIQ people and disability communities, as well as discrimination based on their disability from LGBTIQ people.[30]

54. Aboriginal and Torres Strait Islander LGBTIQ people experience poorer mental health outcomes than other LGBTIQ people and the general population. Experiences of racism and historical trauma, dispossession and disconnection compound with homophobia, biphobia and transphobia.[31]

<u>Question 7:</u> How can language, public discourse and media representations detrimentally impact the mental health of LGBTIQ+ people?

55. Language, public discourse and media representations can be respectful and affirming or can be stigmatising and shaming. At worst, LGBTIQ people are vilified through public discourse and media representations.

---

[28] Pallotta-Chiarolli , M. (2016) Supporting Same-Sex Attracted and Gender Diverse Young People of Multicultural and Multifaith Backgrounds (Executive Summary and Full Research Report).
[29] National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney (Annexure RA-2).
[30] GLHV. (2018). The everyday experiences of lesbian, gay, bisexual, transgender and intersex (LGBTI) people living with disability. GLHV, Melbourne.
[31] Australian Human Rights Commission. (2018). Brotherboys, sistergirls and LGBT Aboriginal and Torres Strait Islander peoples https://www.humanrights.gov.au/our-work/lgbti/brotherboys-sistergirls-and-lgbt-aboriginal-and-torres-strait-islander-peoples

56. LGBTIQ people engaging with contemporary news media as well as social media are aware that at the swipe of a page, we may read commentary suggesting that we are going to hell, are paedophiles, are deviant and so on.

57. There is growing debate about the impacts of hate speech, where hate speech is defined as 'speech that expresses hatred of a group of people'.[32]

Attached to this statement and marked 'RA-5' is a copy of 'End the Hate. Responding to prejudice motivated speech and violence against the LGBTI community.'

58. In the lead up to the ABS postal survey on whether legislation should be changed to allow same-sex couples to marry, there was an increase in hate speech and conduct.[33]

59. The public debate was highly stressful for many LGBTIQ people, and, in my opinion, the negative public commentary further emboldened people to be hateful and violent towards LGBTIQ people. This opinion is supported through national research.

60. Preliminary research by the Australia Institute and the National LGBTI Health Alliance, based on a study of close to 10,000 participants showed:

a. Almost 80% of LGBTIQ+ people and almost 60% allies said that they found the marriage equality debate considerably or extremely stressful;

b. LGBTIQ+ respondents experiencing depression, anxiety and stress increased by more than a third after the announcement of the vote, compared to the 6 months before the announcement;

c. LGBTIQ+ respondents said experiences of verbal and physical assaults in the 3 months following the announcement of the postal vote more than doubled, compared to the 6 months prior to the announcement.[34]

---

[32] Human Rights Law Centre. (2018). End the Hate. Responding to prejudice motivated speech and violence against the LGBTI community. HRLC, Melbourne (Annexure RA-5).
[33] Finance and Public Administration References Committee. (2018). Arrangements for the postal survey. Commonwealth of Australia, Canberra.
[34] Ecker, S. and Bennett, E. (2017). Preliminary results of the Coping with marriage equality debate survey. The Australia Institute and the National LGBTI Health Alliance, Sydney.

61. Advocates from both NSW and Victoria reported a 40% spike in demand from mental health services from people seeking support during and after the survey.[35]

62. There is also strong evidence that social rejection and intolerance have a major negative impact on the mental health of trans and gender diverse people.[36] Media coverage of trans and gender diverse Australians has a negative bias, which plays a pivotal role, both in shaping public understandings of trans and gender diverse people, as well as causing distress for trans and gender diverse people.

    Attached to this statement and marked 'RA-6' is a copy of 'Translating Transphobia. Portrayals of Transgender Australians in the Press, 2016-17.'

<u>Question 8:</u> Can I provide any examples of how LGBTIQ+ communities have adopted strategies of self-care and resilience to improve their own mental health and wellbeing?

63. In the face of discrimination and rejection from families and communities, LGBTIQ people have shown great resilience. The Australian Lesbian and Gay Archives[37] has a treasure trove of LGBTIQ history, showing how communities have come together for social connection, celebration and support, as well as advocacy and activism.

64. For example, Thorne Harbour Health was formed in 1983 (first as the Victorian AIDS Action Committee and then the Victorian AIDS Council) as a key driver of the Victorian community response to HIV/AIDS. The strength of this community response is a testament to the resilience and focus of LGBTIQ communities, and in turn it has shaped a broader focus on health and wellbeing for LGBTIQ people.

65. Another example of a community-led initiative is Switchboard, which was established in 1991 as the Gay and Lesbian Switchboard and provides peer-based support.

66. As well as organising community services and advocacy, LGBTIQ communities provide great social supports to LGBTIQ people. The Victorian Government recognises the importance of community events and festivals to foster pride and celebrate the diversity of LGBTIQ Victorians and supports this through the Pride Events and Festivals Fund.

---

[35] Finance and Public Administration References Committee (2018) Arrangements for the postal survey. Commonwealth of Australia, Canberra.
[36] Rainbow Rights Watch. (2018). Translating Transphobia. Portrayals of Transgender Australians in the Press, 2016-17 (Annexure RA-6).
[37] https://alga.org.au/

Funded events provide LGBTIQ people with the opportunity to connect and celebrate being themselves.

STIGMA

Question 9: What affect does the stigmatisation of mental illness and mental health issues have on individuals and communities?

67. For LGBTIQ people experiencing mental health issues and mental illness, connections to LGBTIQ communities can be positive, however, like the general population, mental health issues are not well understood.

68. One area which would benefit from further engagement and research is the role that alcohol and drugs can play for LGBTIQ people with mental health issues. I have heard many anecdotes about people who 'self-medicate' to cope, which in turn increases risk-taking.

69. Stigmatisation also leads to silence, whereby people do not feel that they can seek support from within their community.

Question 10: What role can the community play in minimising the stigmatisation of people living with mental illness or experiencing mental health issues?

70. There are opportunities at the whole-of-community level, as well as within LGBTIQ communities.

71. For the general community, one opportunity would be a greater focus on the impact of trauma on mental health, in particular trauma related to social exclusion, discrimination and violence. It seems that people do not understand the long-lasting adverse impacts of exclusion and discrimination.

72. Within LGBTIQ communities, a further opportunity would be greater communication about mental health, mental illness and available supports. Many LGBTIQ groups, formal and informal, use social media to share information and provide support. These networks could be used to share information that reduces stigma about mental illness and provide information about supports available for people who want help.

Question 11: In my experience, are there any strategies or programs that have worked to reduce stigma and what are my observations of who and how they are designed and delivered?

73. LGBTIQ organisations have a long history of providing support and connection for our communities. This can be in the form of social groups as well as support groups. Some of these now run as not-for-profit organisations, with paid staff as well as volunteers, while others are run solely by volunteers. Both types of organisations play a key role in promoting mental health and wellbeing for LGBTIQ people.

74. Some promote mental health through providing peer support. For example, Switchboard provides telephone and web-based peer support early intervention as part of the national QLife service. It provides confidential and free peer support and referral for LGBTIQ people and their allies, to talk about issues such as sexuality, gender, bodies, feelings and relationships. Switchboard also runs the Out and About program, which is a peer service that connects older, isolated LGBTIQ people with volunteer visitors.

75. drummond street services, one of Victoria's longest serving family support services, runs queerspace which was set up in 2009, by LGBTIQ communities for LGBTIQ communities. Services including counselling and professional development, and peer-based programs, for example for LGBTIQ people experiencing mental health issues, as well as for parents and families of LGBTIQ people.

76. Social groups and advocacy groups are also sources of connection and help people to develop a sense of self-worth and identity.

77. Typically volunteer and community groups do not attract high levels of funding, and it tends to be project-based for one to three years. This means that organisations often need to seek funding to sustain their programs and community connections.

78. A vital element for success is LGBTIQ community ownership of design as well as the delivery of supports or programs. This is the notion of 'by community, for community' and is important to ensure sensitive and effective design and delivery. It also supports LGBTIQ community engagement and fosters LGBTIQ community willingness to connect with the support or program.

ACCESS TO MENTAL SERVICES

Question 12: From my perspective, are members of the LGBTIQ+ community able to access welcoming and responsive mental health services across Victoria? In particular:

a) are mainstream mental health services (those services targeted towards the general population) suitable for and inclusive of LGPTIQ+ people; and

(b) are members of the LGBTIQ+ community aware of the range of services available specifically for LGBTIQ+ Victorians needing mental health support?

Discrimination as a barrier to engaging with mental health supports and services

79. LGBTIQ people still experience discrimination across a range of settings, including schools, the workplace, public spaces and broader services. As a result, we frequently make decisions about whether to disclose our sexuality, gender identity or intersex status. Anticipation or fear of discrimination actually stops us seeking help when we need it.

80. Recent research undertaken by ARCHS and Lifeline Research Foundation about LGBTI+ people and their use of crisis services[38] showed that over 71% of LGBTI+ participants chose against using a crisis support service during their most recent personal or mental health crisis. Participants in the study reported that a key reason for not using a crisis support service was the expectation or perception that they would experience discrimination, based on their sexuality, gender identity or another stigmatised or minority identity.

    Attached to this statement and marked 'RA-7' is a copy of 'Understanding LGBTI+ Lives in Crisis.'

81. The research found that another reason for not using a service was the fear of being "outed", that the disclosure of their identity could threaten their personal safety and/or their professional life. This is particularly a concern in regional and rural areas, and

[38] Waling, A., Lim, G., Dhalla, S., Lyons, A. and Bourne, A. (2019). Understanding LGBTI+ Lives in Crisis. Australian Research Centre in Sex, Health & Society and the Lifeline Research Foundation, Melbourne (Annexure RA-7).

participants reported worries about their confidentiality in attending a service or seeking counselling or other support.

82. Fear of discrimination prevents people from seeking help when they want or need it, yet people also experience discrimination when they seek help. This can take the form of:

a. Misgendering, where a person's gender identity is not respected, and the service or worker uses language that does not align with the person's gender identity or expression;

b. Heteronormativity, where it is assumed that everyone is – or should be – heterosexual and cisgender;

c. Discriminatory assumptions and derogatory terminology, for example making assumptions about sexual practices or preferences.

83. Discrimination can be direct or covert. Experiences of discrimination whilst using a service can mean that people disengage from the service, and no longer seek the support they need. It can also mean that people choose against disclosing important information, which limits the suitability or effectiveness of the supports they do receive.

84. A further negative experience for LGBTIQ people using mental health services can be 'having to educate the practitioner' and dealing with 'invasive and inappropriate curiosity' for example about bodies, relationships or sexual practices.[39]

Safety and inclusion in inpatient settings

85. Inpatient settings can pose particular problems for LGBTIQ people. In addition to experiencing discrimination from staff and services, LGBTIQ people can also experience abuse, harassment and even violence from other patients.[40]

86. For trans and gender diverse people, gender-specific mental health care and spaces can be problematic. More work is needed to ensure there are options that meet the varying

[39] Riggs, D. and Due, C. (2013). Gender Identity in Australia: the healthcare experiences of people whose gender identity differs from that expected of their natally assigned sex. Flinders University

[40] Benoit M. (2015). Reducing stigma and creating an LGBT affirmative environment on inpatient psychiatric units: process models, case studies, and interventions in professional psychology, University of St Thomas, Minnesota; National LGBTI Health Alliance. (2012). Pathways to inclusion. Frameworks to include LGBTI people in mental health and suicide prevention services and organisations. Scoping Paper. National LGBTI Health Alliance, Sydney.

needs of trans and gender diverse people. For example, a transwoman may prefer to be accommodated in a women-only space, and a gender diverse person may prefer a mixed-gender environment. In both instances, safety and privacy concerns are paramount.[41]

Recent history – persecution and pathologisation

87. One of the most profoundly negative experiences for a LGBTIQ person who seeks mental health support is when the clinician, service provider or support worker assumes that the person's mental health issues are the direct result of their sexuality, gender identity or intersex status.

88. While there have been great changes in society regarding attitudes towards LGBTIQ people, many LGBTIQ people, especially older people, have experienced legal persecution and medical pathologisation, in which our sexuality, gender identity or intersex status was deemed criminal or an illness to be 'cured'.

89. Up until the mid-1970s, homosexuality was classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders (the DSM), and consensual sex between men was a criminal offence in Victoria until 1981.

90. The DSM has made some progress on gender identity. It currently describes 'gender dysphoria', which has been updated from 'gender identity disorder' to reduce the stigma associated with the term 'disorder'. Just this year, the International Classification of Diseases (ICD) has been updated to remove gender incongruence out of the category of mental disorders.

91. Trans and gender diverse people face persistent challenges in navigating the health and mental health system. In part, this may be because people providing care and services were taught that gender incongruence is a mental illness.

92. The ICD has not, however, changed the classification relating to intersex status, and continues to use the term 'Disorder of Sex Development' (DSD) that has been opposed

[41] Mental Health Complaints Commissioner (2018) The Right to be Safe. Exploring sexual safety in acute mental health inpatient units: Sexual safety project report. Mental Health Complaints Commissioner, Melbourne.

as stigmatizing and harmful. This means that people with intersex variations are still engaging with health systems that consider them 'disordered'.

93. One practice that typifies out-dated and harmful beliefs about sexuality, gender identity and intersex status is so-called 'gay conversion therapy', which the Victorian Government has committed to outlawing.

94. Conversion practice is any practice or treatment that seeks to change, suppress or eliminate an individual's sexual orientation or gender identity, including efforts to eliminate sexual and/or romantic attractions or feelings toward individuals of the same gender, or efforts to change gender expressions.[42]

95. The effects of conversion practice include long-term psychological harm and distress, including acute distress and/or ongoing mental health issues such as severe anxiety and depression and feelings of guilt and shame[43] as well as self-harm and suicide.[44]

Attached to this statement and marked 'RA-8' is a copy of 'Preventing Harm, Promoting Justice: Responding to LGBT Conversion Therapy in Australia.'

Awareness of services available specifically for LGBTIQ Victorians needing mental health support

96. While there is some awareness of specialist services, people in rural and regional Victoria will have challenges with access because of distance. As I have said earlier, there are also concerns in smaller places about privacy when using a LGBTIQ service or support.

97. It can be challenging to promote services and programs that provide for support for LGBTIQ mental health. In 2010, the Victorian Government established Safe Schools to make sure that schools are safe for all students, including LGBTIQ students, and are free of discrimination. It was born out of the need identified by school communities, parents and teachers for greater support for LGBTIQ students, who are at higher risks of bullying and suicide, and to ensure that schools create safe and inclusive environments.

---

[42] Health Complaints Commissioner (2019). Report on the Inquiry into Conversion Therapy Executive Summary.
[43] Health Complaints Commissioner (2019). Report on the Inquiry into Conversion Therapy Executive Summary.
[44] Jones, T, Brown, A, Carnie, L, Fletcher, G, & Leonard, W. (2018). Preventing Harm, Promoting Justice: Responding to LGBT Conversion Therapy in Australia. GLHV@ARCSHS and the Human Rights Law Centre, Melbourne (Annexure RA-8).

A key part of the program is to provide professional development and training for secondary school teachers so that they are equipped to support LGBTIQ students[45]. All Victorian state high schools have now signed up to the program.

98. Recent research by Minus18 suggests that some LGBTIQ young people are unaware that Safe Schools is a continuing program and did not know whether their school was a Safe School.[46] This demonstrates that more can be done to promote programs and services already in place that support LGBTIQ mental health.

Question 13: What could be done to improve access to and the responsiveness of mental health services to LGBTIQ+ people?

99. It is important that providers across the mental health system become more LGBTIQ inclusive. Services and practitioners need to be better informed about the impact of discrimination, and work to demonstrate that they are welcoming, inclusive and non-judgemental.

100. This is from GPs and primary health providers, through private providers such as psychologists and psychiatrists, and to clinical treatment and rehabilitation mental health services and hospitals. Similarly, mental health promotion efforts should reach LGBTIQ people, both through inclusive and targeted designs.

101. Community health organisations and local governments increasingly deliver projects and programs with a focus on LGBTIQ mental health promotion and social connection, such as Cobaw Community Health's WayOut program and the City of Greater Geelong's GASP project, both of which support regional LGBTIQ young people.

102. In addition, there are several important services that provide specialist support for LGBTIQ people, such as drummond street services, including queerspace, and Thorne Harbour Health.

103. There is a growing number of good practice projects and services from which to learn. There are also system supports such as the Rainbow Tick accreditation system, which organisations can use to assess how LGBTIQ inclusive they are and identify areas for

[45] Department of Education and Training website (2019)
[46] Clerke, E., Scott, M. (2019). Young & Queer Report: Youth Driven Ideas For A Better Victoria. Minus18, Melbourne.

improvement. Recommendation 167 from the Royal Commission into Family Violence was that all funded family violence services achieve Rainbow Tick accreditation through a staged approach, of workforce training and LGBTI equity auditing followed by full accreditation. Lessons learnt through the implementation of this recommendation would be worth exploration in terms of applicability for mental health services.

Addressing hate speech

104. In the 2018 report 'End the Hate', the Human Rights Law Centre made three recommendations about avenues to address hate speech and conduct:

a. The first area is legislative reform to improve protections from hate speech and hate conduct, building on current legislation including the Sentencing Act 1991 and the Equal Opportunity Act 2010.

b. The second area is to improve research and data collection across agencies to better capture information about hate speech and hate conduct.

c. The final area is to strengthen and promote avenues to report crimes and make complaints, to encourage people who have experienced hate speech or hate conduct to report the incident/s.

105. I support efforts to prevent hate speech and conduct. I urge the Royal Commission to acknowledge that without addressing discrimination against LGBTIQ people, we will not improve the mental health status of LGBTIQ Victorians.

Conclusion

106. In conclusion, there are five domains for action to improve mental health outcomes for LGBTIQ people:

a. The first is to make a concerted effort to reduce discrimination and violence perpetrated against LGBTIQ people, including addressing hate speech, for example through legislation and education;

b. The second is to continue efforts to improve Victorian data collection regarding sexuality, gender identity and intersex status, as LGBTIQ people are let down by gaps in official data – this should also include advocacy at the national level;

c. The third is to ensure, through training and advice, that mental health services do not discriminate against LGBTIQ people and provide inclusive and respectful services and supports;

d. The fourth is to better promote mental health services and other supports that are inclusive and respectful so that people can feel confident to seek help if they want it;

e. The fifth is to bolster support for LGBTIQ community and volunteer organisations in promoting mental health as well as early intervention.

sign here ►

print name Ro Allen

date 2/7/19

Glossary

This summary of commonly used terms is taken from the LGBTIQ Inclusive Language Guide (https://www.vic.gov.au/inclusive-language-guide)

Sexuality

A **lesbian** woman is romantically and/or sexually attracted to other women.

A **gay** person is romantically and/or sexually attracted to people of the same sex and/or gender as themselves. This term is often used to describe men who are attracted to other men, but some women and gender diverse people may describe themselves as gay.

A **bisexual** person is romantically and/or sexually attracted to people of their own gender and other genders.

An **asexual** person does not experience sexual attraction, but may experience romantic attraction towards others.

A **pansexual** person is romantically and/or sexually attracted to people of all genders, binary or non-binary.

A **heterosexual** or 'straight' person is someone who is attracted to people of the opposite gender to themselves.

A person who is **non-binary** is someone who's gender is not exclusively female or male; while a person who is agender has no gender.

An **ally** is a person who considers themselves a friend and active supporter of the LGBTIQ community. This term can be used for non-LGBTIQ allies as well as those within the LGBTIQ community who support each other, e.g. a gay man who is an ally to the trans and gender diverse community.

Queer is often used as an umbrella term for diverse genders or sexualities. Some people use queer to describe their own gender and/or sexuality if other terms do not fit. For some people, especially older LGBTIQ people, 'queer' has negative connotations, because in the past it was used as a discriminatory term.

Questioning The 'Q' in LGBTIQ is used here as 'Queer and questioning". Rather than be locked in to a certainty, some people are still exploring or questioning their gender or sexual orientation. People may not wish to have one of the other labels applied to them yet, for a variety of reasons, but may still wish to be clear, for example, that they are non-binary or non-heterosexual. It is important these individuals feel welcome and included in the acronym and community spaces.

Gender

A **trans** (short for **transgender**) person is someone whose gender does not exclusively align with the one they were assigned at birth.

Trans can be used as an umbrella term, but not everyone uses it to describe themselves. For example, a man who was assigned female at birth might refer to himself as 'a trans man', 'a man with a trans history' or just 'a man'. It's important to use the terms someone uses to describe themselves.

Gender diverse generally refers to a range of genders expressed in different ways. There are many terms used by gender diverse people to describe themselves. Language in this space is dynamic, particularly among young people, who are more likely to describe themselves as non-binary.

Gender incongruence – is the preferred sexual health classification of transgender and gender diverse people by the World Health Organisation (WHO). WHO describes gender incongruence as 'characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex'. It replaces the stigmatising term 'gender dysphoria' which was used previously.

The terms **sistergirls** and **brotherboys** are general terms used in Aboriginal and Torres Strait Islander communities to describe transgender people and their relationships as a way of validating and strengthening their gender identities and relationships.

A **cis** (pronounced 'sis', short for **cisgender**) person is someone whose gender aligns with the sex they were assigned at birth – someone who isn't trans or gender diverse.

Transition or **affirmation** refers to the process where a trans or gender diverse person takes steps to socially and/or physically feel more aligned with their gender. There is a wide range of ways this process differs between people. Some people may change how they interact with others, and others may change their appearance or seek medical assistance to better express their gender.

The VPS has a standard model for the collection of gender information from staff:

What is your gender?

[ ] Woman

[ ] Man

[ ] Self-described (please specify): _____

Sex characteristics

An **intersex** person is born with atypical natural variations to physical or biological sex characteristics such as variations in chromosomes, hormones or anatomy. Intersex traits are a natural part of human bodily diversity. Not all intersex people use the term intersex.

References

Australian Bureau of Statistics. (2007). National Survey of Mental Health and Wellbeing. ABS, Canberra. https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/National%20Survey%20of%20Mental%20Health%20and%20Wellbeing%20Summary%20of%20Results.pdf

Australian Human Rights Commission. (2018). Brotherboys, sistergirls and LGBT Aboriginal and Torres Strait Islander peoples https://www.humanrights.gov.au/our-work/lgbti/brotherboys-sistergirls-and-lgbt-aboriginal-and-torres-strait-islander-peoples

Australian Lesbian and Gay Archives. https://alga.org.au/

Benoit M. (2015). Reducing stigma and creating an LGBT affirmative environment on inpatient psychiatric units: process models, case studies, and interventions in professional psychology. University of St Thomas, Minnesota. https://ir.stthomas.edu/caps_gradpsych_docdiss/17/

Clerke, E., Scott, M. (2019). Young & Queer Report: Youth Driven Ideas For A Better Victoria. Minus18, Melbourne. https://www.minus18.org.au/index.php/get-involved/campaigns/young-queer

Community Affairs References Group. (2010). The Hidden Toll: Suicide in Australia. Commonwealth of Australia, Canberra. https://www.aph.gov.au/~/media/wopapub/senate/committee/clac_ctte/completed_inquiries/2008_10/suicide/report/report_pdf.ashx

Ecker, S. and Bennett, E. (2017). Preliminary results of the Coping with marriage equality debate survey. The Australia Institute and the National LGBTI Health Alliance, Sydney. http://www.tai.org.au/sites/default/files/P447%20Briefing%20note_LGBTIQ%2B%20coping%20survey%20prelimary%20results.pdf

Finance and Public Administration References Committee. (2018). Arrangements for the postal survey. Commonwealth of Australia, Canberra. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/postalsurvey/~/media/Committees/fapa_ctte/postalsurvey/report.pdf

GLHV. (2018). The everyday experiences of lesbian, gay, bisexual, transgender and intersex (LGBTI) people living with disability. GLHV, Melbourne. https://www.glhv.org.au/sites/default/files/2018-07/GAFLA%20Report%20Final%20Version.pdf

Health Complaints Commissioner (2019). Report on the Inquiry into Conversion Therapy Executive Summary. https://www2.health.vic.gov.au/Api/downloadmedia/%7B22A41303-D7B0-4C08-B7BF-5A63070F5F94%7D

Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., & Mitchell, A. (2010). Writing themselves in 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people. LaTrobe University, Melbourne. https://www.glhv.org.au/sites/default/files/wti3_web_sml.pdf

Human Rights Law Centre. (2018). End the Hate. Responding to prejudice motivated speech and violence against the LGBTI community. HRLC, Melbourne. https://humanrightslawcentre.createsend1.com/t/i-l-nbujjk-l-y/

Jones, T, Brown, A, Carnie, L, Fletcher, G, & Leonard, W. (2018). Preventing Harm, Promoting Justice: Responding to LGBT Conversion Therapy in Australia. GLHV@ARCSHS and the Human Rights Law Centre, Melbourne. https://hrlc.squarespace.com/s/LGBT-conversion-therapy-in-Australia-v2.pdf

Joosten, M., Tinney, J., Barrett, Ca., Whyte, C., Dow, B. & Maude, P. (2015). Improving Mental Health for older LGBTI Australians. National Ageing Research Institute, the Australian Research Centre for Sex, Health and Society, and the RMIT School of Mental Health, Melbourne. https://www.beyondblue.org.au/docs/default-source/research-project-files/improving-mental-health-for-older-lgbti-australians-research-report.pdf?sfvrsn=c3897eea_2

Mental Health Complaints Commissioner (2018) The Right to be Safe. Exploring sexual safety in acute mental health inpatient units: Sexual safety project report. Mental Health Complaints Commissioner, Melbourne. https://www.mhcc.vic.gov.au/Api/downloadmedia/%7B76BF660A-3A27-4B20-A30C-448376D319C0%7D

National LGBTI Health Alliance. (2012). Pathways to inclusion. Frameworks to include LGBTI people in mental health and suicide prevention services and organisations. Scoping Paper. National LGBTI Health Alliance, Sydney. https://lgbtihealth.org.au/wp-content/uploads/2015/02/Pathways-to-Inclusion-Scoping-Paper-Final.pdf

National LGBTI Health Alliance. (2016). The Statistics at a glance: the mental health of lesbian, gay, bisexual, transgender and intersex people in Australia. National LGBTI Health Alliance, Sydney. https://lgbtihealth.org.au/statistics/

Pallotta-Chiarolli , M. (2016) Supporting Same-Sex Attracted and Gender Diverse Young People of Multicultural and Multifaith Backgrounds (Executive Summary and Full Research Report). http://www.agmc.org.au/wp-content/uploads/Supporting-Same-Sex-Attracted-and-Gender-Diverse-Young-People-of-Multicultural-Multifaith-Backgrounds-Research-Report.pdf

Rainbow Rights Watch. (2018). Translating Transphobia. Portrayals of Transgender Australians in the Press, 2016-17. https://www.acon.org.au/wp-content/uploads/2018/02/Translating-Transphobia-2016-2017.pdf

Riggs, D. and Due, C. (2013). Gender Identity in Australia: the healthcare experiences of people whose gender identity differs from that expected of their natally assigned sex. Flinders University, Adelaide. https://www.humanrights.gov.au/sites/default/files/21_Pub_Sub_Melody%20Moore_Transhealth_Flinders_University_Gender_Identity_Australia_Report.pdf

Rosenstreich, G. (2013). LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance, Sydney. https://www.beyondblue.org.au/docs/default-source/default-document-library/bw0258-lgbti-mental-health-and-suicide-2013-2nd-edition.pdf?sfvrsn=2

Smith, E., Jones, T., Ward, R., Dixon, J., Mitchell, A., & Hillier, L. (2014). From Blues to Rainbows: Mental health and wellbeing of gender diverse and transgender young people in Australia. The Australian Research Centre in Sex, Health, and Society, Melbourne. https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0268-from-blues-to-rainbows-report-final-report.pdf?sfvrsn=2

Sutherland, G; Milner, A; Dwyer, J; Bugeja, L; Woodward, A; Robinson, J; Pirkis, J. (2018). Implementation and evaluation of the Victorian Suicide Register. *Australian and New Zealand Journal of Public Health*, 42 (3), pp. 296 – 302. https://minerva-access.unimelb.edu.au/bitstream/handle/11343/194172/Sutherland_et_al-2017-Australian_and_New_Zealand_Journal_of_Public_Health.pdf?sequence=1&isAllowed=y

The Royal Australian and New Zealand College of Psychiatrists (2019) Recognising and addressing the mental health needs of the LGBTIQ+ population. Position Statement 83. https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/recognising-and-addressing-the-mental-health-needs

Victorian Department of Health and Human Services (2018) *Health and wellbeing of people with intersex variations: information and resource paper*. Initially prepared by T. Jones and W. Leonard; revised and edited J. Rostant on behalf of Department of Health and Human Services 2016–2018 Intersex Expert Advisory Group. Department of Health and Human Services: Melbourne. https://www2.health.vic.gov.au/Api/downloadmedia/%7BB6F44633-5E80-40EB-89DD-F4B348054E8A%7D

Waling, A., Lim, G., Dhalla, S., Lyons, A. and Bourne, A. (2019). Understanding LGBTI+ Lives in Crisis. Australian Research Centre in Sex, Health & Society and the Lifeline Research Foundation, Melbourne. https://www.lifeline.org.au/static/uploads/files/understanding-lgbti-lives-in-crisis-01-02-2019-wfvrtiijhbwm.pdf

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RA -1

This is the attachment marked 'RA-1' referred to in the witness statement of Ro Allen dated "2 July 2019" .

Australian Bureau of Statistics

2007

WW.4326.0.2007.1031
4326.0

NATIONAL SURVEY OF MENTAL HEALTH AND WELLBEING: SUMMARY OF RESULTS

AUSTRALIA

EMBARGO: 11.30AM (CANBERRA TIME) THURS 23 OCT 2008

CONTENTS

INQUIRIES

For further information about these and related statistics, contact the National Information and Referral Service on 1300 135 070.

NOTES

ABOUT THIS PUBLICATION

This publication presents a summary of results from the 2007 National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics (ABS) from August to December 2007. The survey collected information from approximately 8,800 Australians aged 16–85 years.

The survey provides information on the prevalence of selected lifetime and 12-month mental disorders by three major disorder groups: Anxiety disorders (eg Social Phobia), Affective disorders (eg Depression) and Substance Use disorders (eg Alcohol Harmful Use). It also provides information on the level of impairment, the health services used for mental health problems, physical conditions, social networks and caregiving, as well as demographic and socio-economic characteristics.

Mental health is one of Australia's National Health Priority Areas and funding for this survey was provided by the Australian Government Department of Health and Ageing. Information from the survey will contribute to research in the field of mental health and assist in the formulation of government policies and legislation.

INTERPRETATION OF RESULTS

The survey used the World Health Organization's (WHO) Composite International Diagnostic Interview (CIDI) for the diagnostic component of the survey. While the survey provides estimates on the prevalence of selected lifetime and 12-month mental disorders, the emphasis of this publication is on 12-month mental disorders.

RESPONSE RATES

As the response rate for this survey was lower than expected (60%), extensive non-response analyses were undertaken to assess the reliability of the survey estimates. As a result, adjustments were made to the weighting strategy. As non-response can vary across population characteristics, as well as across data items, users should exercise caution. See Reliability of Estimates in the Explanatory Notes.

COMPARISON WITH THE 1997 SURVEY

The survey was run in 1997 as the National Survey of Mental Health and Wellbeing of Adults. Due to differences in how the data were collected, data from 1997 are not presented in this publication. See Appendix 2 for further information.

ACKNOWLEDGMENTS

ABS publications draw extensively on information provided freely by individuals, businesses, governments and other organisations. Their continued cooperation is very much appreciated: without it, the wide range of statistics published by the ABS would not be available. Information received by the ABS is treated in strict confidence as required by the *Census and Statistics Act 1905*. The ABS would also like to acknowledge the extensive support and technical advice provided by Dr Tim Slade and Ms Amy Johnston from the University of New South Wales.

Ian Ewing
Acting Australian Statistician

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ANZSIC	Australian and New Zealand Standard Industrial Classification
AQoL	Assessment of Quality of Life
ASCED	Australian Standard Classification of Education
ASGC	Australian Standard Geographical Classification
BMI	body mass index
CAI	computer assisted interviewing
CD	collection district
CIDI	Composite International Diagnostic Interview
CURF	confidentialised unit record file
DoHA	Australian Government Department of Health and Ageing
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
GAD	Generalised Anxiety Disorder
GP	General Medical Practitioner
ICD-10	International Classification of Diseases 10th Revision
kg	kilogram
m	metre
NHMRC	National Health and Medical Research Council
NRFUS	non-response follow-up study
OCD	obsessive-compulsive disorder
PTSD	post-traumatic stress disorder
RSE	relative standard error
SACC	Standard Australian Classification of Countries
SE	standard error
SEIFA	Socio-Economic Indexes for Areas
SMHWB	National Survey of Mental Health and Wellbeing
WHO	World Health Organization
WHODAS	World Health Organization Disability Assessment Schedule
WMH	World Mental Health
WMH–CIDI 3.0	World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, Version 3.0.

INTRODUCTION

INTRODUCTION

Mental health is a state of emotional and social wellbeing. It influences how an individual copes with the normal stresses of life and whether he or she can achieve his or her potential. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably with one another and with their environment, in ways that promote subjective wellbeing and optimise opportunities for development and use of mental abilities (Australian Health Ministers, 2003).

The measurement of mental health is complex and is not simply the absence of mental illness. A *mental illness* is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities (Australian Health Ministers, 2003). Mental illness encompasses short and longer term conditions, including Anxiety disorders (eg Agoraphobia), Affective or mood disorders (eg Depression) and Substance Use disorders (eg Alcohol Dependence). Depending on the disorder and its severity, people may require specialist management, treatment with medication and/or intermittent use of health care services.

The 2007 National Survey of Mental Health and Wellbeing collected information on three major groups of mental disorders: Anxiety disorders; Affective disorders; and Substance Use disorders. This publication presents findings from the survey, with an emphasis on persons with a 12-month mental disorder, that is, persons with a lifetime mental disorder who experienced symptoms in the 12 months prior to the survey interview. The survey also collected information on the use of health services and medication for mental health problems, physical conditions, functioning and disability, social networks and caregiving, and a range of demographic and socio-economic characteristics.

BACKGROUND

Funding for the 2007 National Survey of Mental Health and Wellbeing (SMHWB) was provided by the Australian Government Department of Health and Ageing (DoHA). The survey was based on a widely-used international survey instrument, developed by the World Health Organization (WHO) for use by participants in the World Mental Health Survey Initiative. The Initiative is a global study aimed at monitoring mental and addictive disorders. It aims to collect accurate information about the prevalence of mental, substance use, and behavioural, disorders. It measures the severity of these disorders and helps to determine the burden on families, carers and the community. It also assesses who is treated, who remains untreated and the barriers to treatment. The survey has been run in 32 countries, representing all regions of the world.

Most of the survey was based on the international survey modules; however, some modules, such as Health Service Utilisation, were tailored to fit the Australian context. The adapted modules were designed in consultation with subject matter experts from government and the research community. Where possible, adapted modules used existing ABS questions.

A Survey Reference Group, comprising experts and key stakeholders in the field of mental health, provided the ABS with advice on survey content, including the most appropriate topics for collection, and associated concepts and definitions. They also provided advice on issues that arose during field tests and the most suitable survey outputs. Group members included representatives from government departments, universities, health research organisations, carers organisations and consumer groups.

INTRODUCTION *continued*

OVERVIEW

The National Survey of Mental Health and Wellbeing (SMHWB) was conducted from August to December 2007 with a representative sample of people aged 16–85 years who lived in private dwellings across Australia. Broadly, it collected information about:

- lifetime and 12-month prevalence of selected mental disorders;
- level of impairment for these disorders;
- physical conditions;
- health services used for mental health problems, such as consultations with health practitioners or visits to hospital;
- social networks and caregiving; and
- demographic and socio-economic characteristics.

A summary of the findings from the survey are presented in this publication through text, diagrams and tables. As this publication is a Summary of Results, not all of the information collected in the survey can be presented. For people who wish to undertake more detailed analysis of the survey data, special tabulations are available on request. Two confidentialised unit record files (CURFs) are planned for release in early 2009. See Products and Services in the Explanatory Notes.

MEASURING MENTAL HEALTH

Measuring mental health in the community through household surveys is a complex task as mental disorders are usually determined through detailed clinical assessment. To estimate the prevalence of specific mental disorders, the 2007 National Survey of Mental Health and Wellbeing used the World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH–CIDI 3.0). The WMH–CIDI 3.0 was chosen because it:

- provides a fully structured diagnostic interview;
- can be administered by lay interviewers;
- is widely used in epidemiological surveys;
- is supported by the World Health Organization (WHO); and
- provides comparability with similar surveys conducted worldwide.

The WMH–CIDI 3.0 provides an assessment of mental disorders based on the definitions and criteria of two classification systems: the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV); and the WHO International Classification of Diseases, Tenth Revision (ICD–10). Each classification system lists sets of criteria that are necessary for diagnosis. The criteria specify the nature and number of symptoms required; the level of distress or impairment required; and the exclusion of cases where symptoms can be directly attributed to general medical conditions, such as a physical injury, or to substances, such as alcohol. Data in this publication are presented using the ICD–10 classification system. More information on the WMH–CIDI 3.0 diagnostic assessment criteria according to the ICD–10 is provided in Appendix 1.

INTRODUCTION *continued*

COMPARISON WITH THE 1997 SURVEY

In 1997 the ABS conducted the first National Survey of Mental Health and Wellbeing of Adults. The survey provided information on the prevalence of selected 12-month mental disorders, the level of disability associated with those disorders, health services used, and perceived need for help with a mental health problem, for Australians aged 18 years and over. The survey was an initiative of, and was funded by, the then Commonwealth Department of Health and Family Services, as part of the National Mental Health Strategy. A key aim of the 1997 survey was to provide prevalence estimates for mental disorders in a 12 month time-frame. Therefore, diagnostic criteria were assessed solely on respondents' experiences in the 12 months prior to the survey interview.

In comparison, the 2007 National Survey of Mental Health and Wellbeing was designed to provide lifetime prevalence estimates for mental disorders. Respondents aged 16–85 years were asked about experiences throughout their lifetime. In the 2007 survey 12-month diagnoses were based on lifetime diagnosis and the presence of symptoms of that disorder in the 12 months prior to the survey interview. The full diagnostic criteria were not assessed within the 12 month time-frame. Users should exercise caution when comparing data from the two surveys. More information on comparability is provided in the Explanatory Notes. A list of the broad differences between the two surveys is also provided in Appendix 2 and further information will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008.

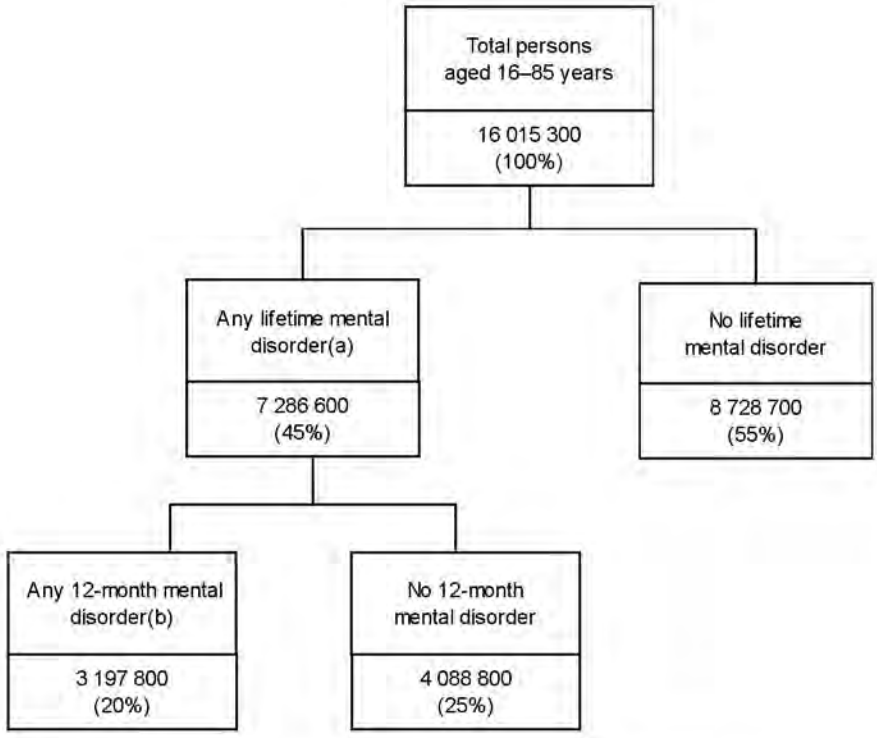
SUMMARY OF FINDINGS

PREVALENCE OF MENTAL DISORDERS

The 2007 National Survey of Mental Health and Wellbeing (SMHWB) was designed to provide lifetime prevalence estimates for mental disorders. Respondents were asked about experiences throughout their lifetime. In this survey, 12-month diagnoses were derived based on lifetime diagnosis and the presence of symptoms of that disorder in the 12 months prior to the survey interview. Assessment of mental disorders presented in this publication are based on the definitions and criteria of the World Health Organization's (WHO) International Classification of Diseases, Tenth Revision (ICD–10). Prevalence rates are presented with hierarchy rules applied (ie a person will not meet the criteria for particular disorders because the symptoms are believed to be accounted for by the presence of another disorder). Information on hierarchy rules is provided in the Explanatory Notes and Appendix 1.

In this publication, Tables 1 and 2 provide an overview of the prevalence of mental disorders, with Table 1 focussing on people who had lifetime mental disorders and Table 2 focussing on the subset of people who had 12-month mental disorders.

Of the 16 million Australians aged 16–85 years, almost half (45% or 7.3 million) had a lifetime mental disorder, ie a mental disorder at some point in their life. One in five (20% or 3.2 million) Australians had a 12-month mental disorder. There were also 4.1 million people who had experienced a lifetime mental disorder but did not have symptoms in the 12 months prior to the survey interview.

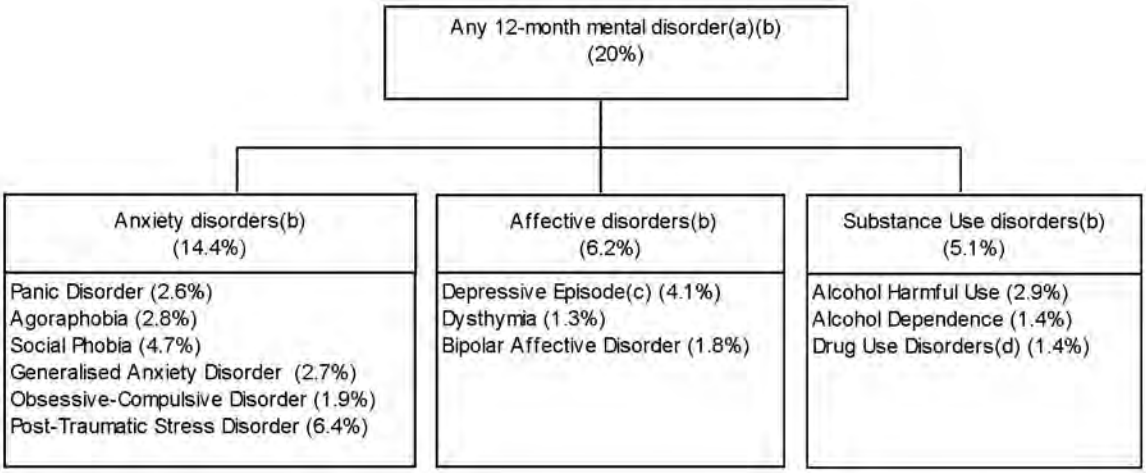


(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy).
(b) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

SUMMARY OF FINDINGS *continued*

PREVALENCE OF 12-MONTH MENTAL DISORDERS

Prevalence of mental disorders is the proportion of people in a given population who met the criteria for diagnosis of a mental disorder at a point in time. The diagram below shows the 12-month prevalence rates for each of the major disorder groups (Anxiety, Affective and Substance Use) and prevalence rates for each of the mental disorders within each group.

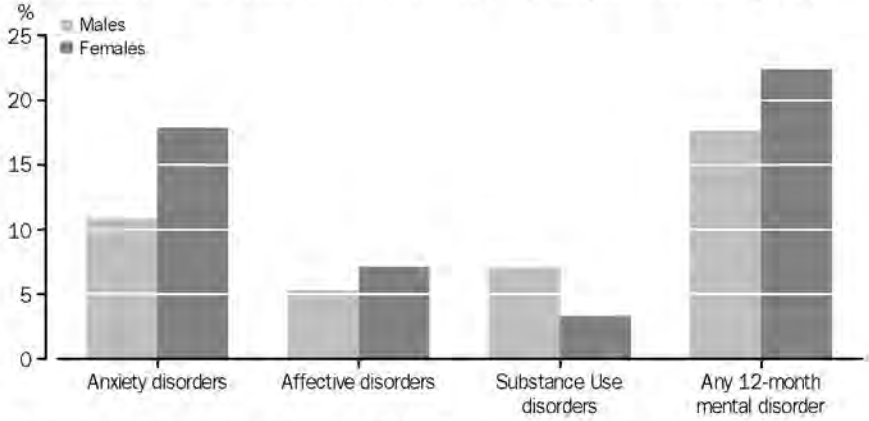


(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.
(b) A person may have had more than one mental disorder. The components when added may therefore not add to the total shown.
(c) Includes Severe Depressive Episode, Moderate Depressive Episode, and Mild Depressive Episode.
(d) Includes Harmful Use and Dependence.

There were 3.2 million people who had a 12-month mental disorder. In total, 14.4% (2.3 million) of Australians aged 16–85 years had a 12-month Anxiety disorder, 6.2% (995,900) had a 12-month Affective disorder and 5.1% (819,800) had a 12-month Substance Use disorder.

Women experienced higher rates of 12-month mental disorders than men (22% compared with 18%). Women experienced higher rates than men of Anxiety (18% and 11% respectively) and Affective disorders (7.1% and 5.3% respectively). However, men had twice the rate of Substance Use disorders (7.0% compared with 3.3% for women).

1. 12-MONTH MENTAL DISORDERS(a), by Major disorder group



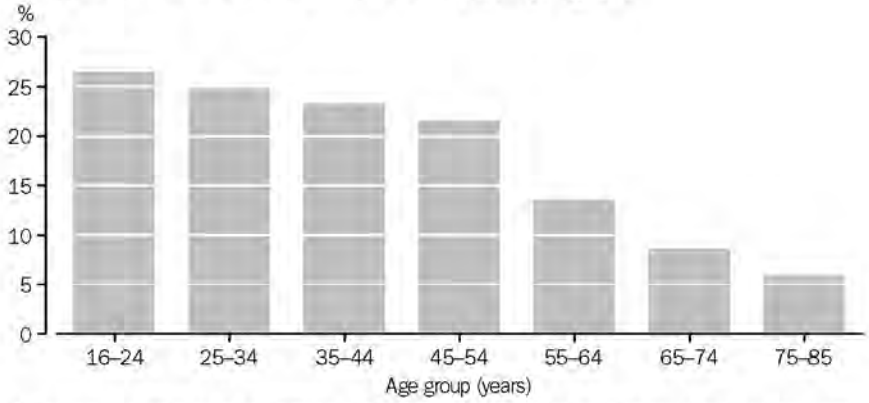
(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.

SUMMARY OF FINDINGS *continued*

PREVALENCE OF 12-MONTH MENTAL DISORDERS continued

The prevalence of 12-month mental disorders varies across age groups, with people in younger age groups experiencing higher rates of disorder. More than a quarter (26%) of people aged 16–24 years and a similar proportion (25%) of people aged 25–34 years had a 12-month mental disorder compared with 5.9% of those aged 75–85 years old.

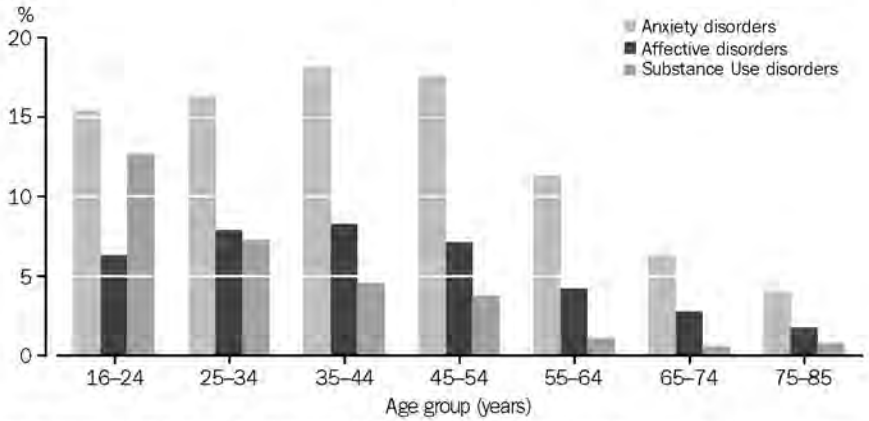
2. 12-MONTH MENTAL DISORDERS(a), by Age(b)



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.
(b) Persons who had a 12-month mental disorder as a proportion of all persons in that same age group.

Among all age groups 12-month Anxiety disorders had the highest prevalence, with the highest rate in the 35–44 years age group (18%). People in younger age groups had higher prevalence of 12-month Substance Use disorders (ie the harmful use and/or dependence on alcohol and/or drugs). Of the 2.5 million people aged 16–24 years, 13% (323,500) had a 12-month Substance Use disorder.

3. 12-MONTH MENTAL DISORDERS(a), by Major disorder group and age



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.

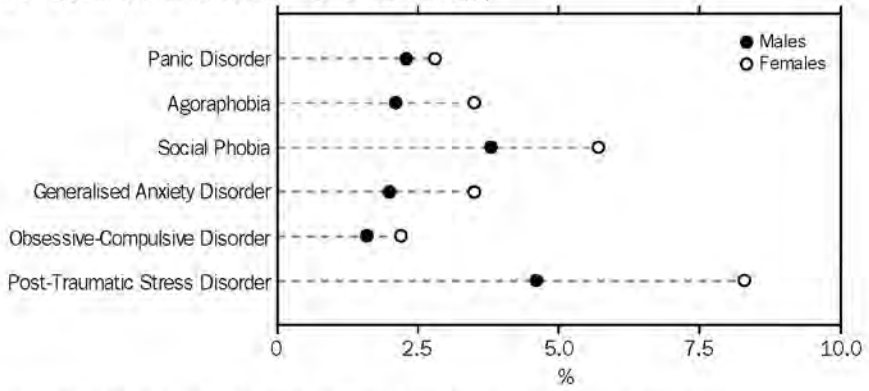
Women aged 16–24 years had nearly twice the prevalence of 12-month Affective disorders compared with men in the same age group (8.4% and 4.3% respectively). Men aged 25–34 years had more than three times the prevalence of 12-month Substance Use disorders compared with women in the same age group (11.3% and 3.3% respectively). Women aged 25–34 years experienced almost twice the prevalence of 12-month Anxiety disorders, compared with men (21% and 12% respectively).

12-MONTH MENTAL DISORDERS

12-MONTH ANXIETY DISORDERS

Anxiety disorders generally involve feelings of tension, distress or nervousness. A person may avoid, or endure with dread, situations which cause these types of feelings. Anxiety disorders comprise: Panic Disorder, Agoraphobia, Social Phobia, Generalised Anxiety Disorder (GAD), Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD). Of people aged 16–85 years, 14.4% (2.3 million) had a 12-month Anxiety disorder. PTSD and Social Phobia were the most prevalent Anxiety disorders (6.4% and 4.7% respectively). Women experienced higher rates of PTSD than men (8.3% compared with 4.6% respectively) and also Social Phobia (5.7% compared with 3.8%).

4. 12-MONTH ANXIETY DISORDERS(a)

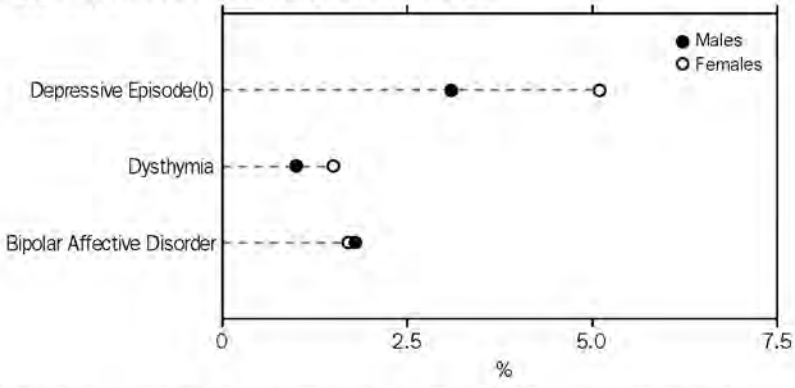


(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one Anxiety disorder.

12-MONTH AFFECTIVE DISORDERS

Affective disorders involve mood disturbance, or change in affect. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations. Affective disorders comprise: Depressive Episode, Dysthymia and Bipolar Affective Disorder. Of people aged 16–85 years, 6.2% (995,900) had a 12-month Affective disorder. Depressive Episode was the most prevalent Affective disorder (4.1%). Women experienced a higher rate of Depressive Episode than men (5.1% compared with 3.1%).

5. 12-MONTH AFFECTIVE DISORDERS(a)



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one Affective disorder.
(b) Includes Severe Depressive Episode, Moderate Depressive Episode, and Mild Depressive Episode.

12-MONTH MENTAL DISORDERS continued

12-MONTH SUBSTANCE USE DISORDERS

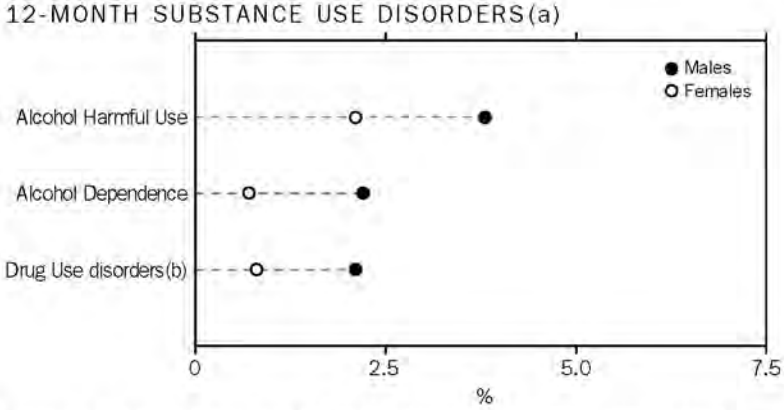
Substance Use disorders involve the harmful use and/or dependence on alcohol and/or drugs and comprise: Alcohol Harmful Use, Alcohol Dependence and Drug Use disorders. Harmful Use is the pattern of use of alcohol or drugs that is responsible for (or substantially contributes to) physical or psychological harm, including impaired judgement or dysfunctional behaviour. Dependence is a maladaptive pattern of use in which the use of alcohol or drugs takes on a much higher priority for a person than other behaviours that once had greater value. The central characteristic of Dependence is the strong, sometimes overpowering, desire to take the substance despite significant substance-related problems.

Drug Use includes the use of illicit substances and the misuse of prescribed medicines. Four drug categories were included in this survey:

- sedatives, eg serepax, sleeping pills, valium
- stimulants, eg amphetamines, speed
- cannabinoids eg marijuana
- opioids, eg heroin, methadone, opium.

Of people aged 16–85 years, 5.1% (819,800) had a 12-month Substance Use disorder. Alcohol Harmful Use was the most prevalent Substance Use disorder (2.9%). Men experienced higher rates of 12-month Substance Use disorders than women (7.0% and 3.3% respectively). They also had nearly twice the rate of Alcohol Harmful Use (3.8% of men and 2.1% of women).

6. 12-MONTH SUBSTANCE USE DISORDERS(a)



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one Substance Use disorder.
(b) Includes Harmful Use and Dependence.

POPULATION CHARACTERISTICS

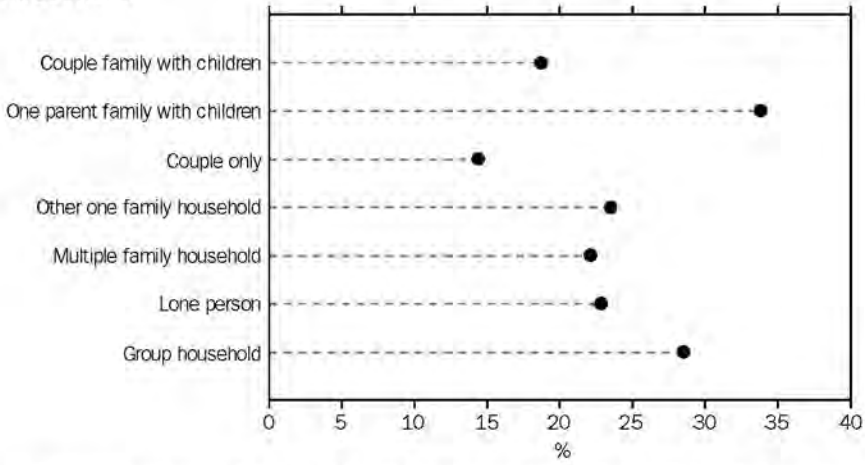
Mental health and mental illnesses are determined by multiple and interacting social, psychological, and biological factors, just as they generally are in health and illness (WHO, 2005). Mental health may be impacted by individual or societal factors, including economic disadvantage, poor housing, lack of social support and the level of access to, and use of, health services. A person's socio-economic circumstances (eg employment), may impact on their likelihood of developing a mental disorder. Studies have shown that people of lower socio-economic status have a higher prevalence of mental disorders, particularly Depression, and certain Anxiety disorders (Fryers et al, 2005). Mental illness may also impact on a person's employment, housing, social support, etc. Tables 4 and 5 explore the prevalence of 12-month mental disorders by selected household and population characteristics, including: family composition of household; household income; labour force status; level of highest non-school qualification; country of birth; and marital status.

LIVING ARRANGEMENTS

Living arrangements give some indication of the level of social support that a person is able to access. People in some living arrangements are more likely to have a mental disorder than others. However, it should be noted that some observed differences may be due to the relationship between living arrangements and age. Of the 745,100 people aged 16–85 years living in a one parent family with children, more than a third (34%) had a 12-month mental disorder. In comparison, 14% of the 4.4 million people living in a couple only households had a 12-month mental disorder.

People living in a one parent family with children had a higher prevalence of Anxiety disorders (26%) than other types of households, while people living in group households were more likely to have a Substance Use disorder (13%).

7. 12-MONTH MENTAL DISORDERS(a), by Family composition of household



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.

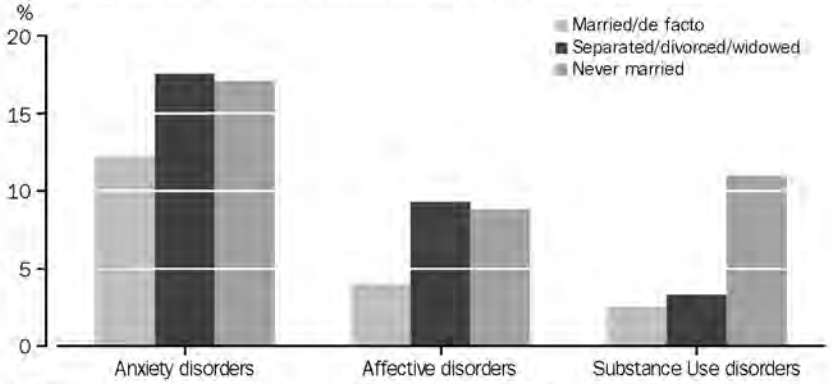
SUMMARY OF FINDINGS *continued*

POPULATION CHARACTERISTICS continued

LIVING ARRANGEMENTS *continued*

Marital status has also been shown to be related to a person's physical and mental health. People who had never been married experienced almost twice the prevalence of 12-month mental disorders compared with people who were married or living in a de facto relationship (28% and 15% respectively). However, this may be partly explained by the number of young people who have never been married, and their higher prevalence of 12-month Substance Use disorders. The prevalence of Substance Use disorders for people who had never been married was more than four times as high as the rate for people who were married or living in a de facto relationship (11.1% compared with 2.5% respectively).

8. 12-MONTH MENTAL DISORDERS(a), by Marital status



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.

LABOUR FORCE STATUS

Education, employment and income are closely related socio-economic characteristics. People with higher educational attainment are more likely to be employed, and of employed people, are more likely to be in a higher skilled occupation (ABS, 2007). Economically disadvantaged people, such as those who are unemployed, are more vulnerable to mental illnesses, as they are more likely to experience insecurity, hopelessness, rapid social change, and risks to their physical health (WHO, 2005). People who have mental illness may also be more likely to fall into economic disadvantage.

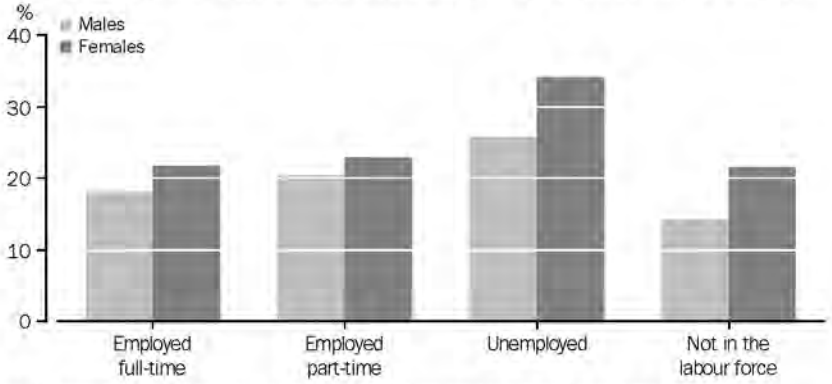
A person's ability to sustain themselves and to be a productive member of society, may impact on their mental health and wellbeing. Being unemployed may increase the likelihood of developing mental disorders (Fryers et al, 2005).

POPULATION CHARACTERISTICS continued

LABOUR FORCE STATUS *continued*

Of the 413,600 unemployed people, 29% had a 12-month mental disorder. In comparison, 20% of the 10.4 million people who were employed had a 12-month mental disorder. Unemployed people experienced almost twice the prevalence of Substance Use disorders than employed people (11.1% and 6.0% respectively) and almost three times the prevalence of Affective disorders (15.9% and 5.7% respectively). More than a third of unemployed women (34%) and more than a quarter of unemployed men (26%) had a 12-month mental disorder. Men who were not in the labour force had the lowest prevalence of 12-month mental disorders (14%).

9. 12-MONTH MENTAL DISORDERS(a), by Labour force status



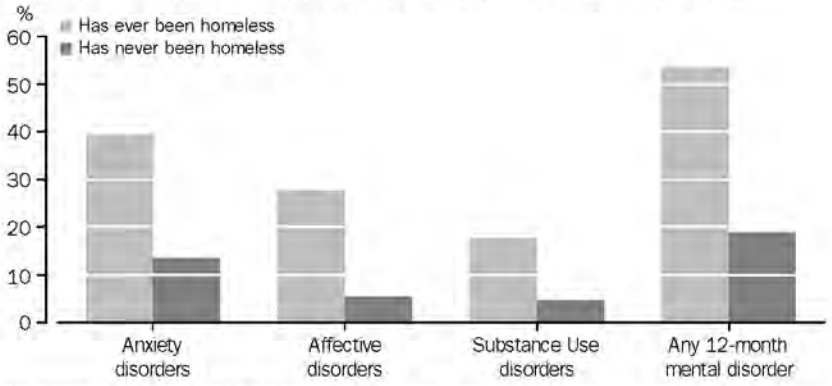
(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.

LIFE EXPERIENCES

People may be more or less likely to develop a mental disorder, depending on their life experiences. This survey collected information on a selection of life experiences, including homelessness and incarceration.

Of the 484,400 people who reported ever being homeless, more than half (54%) had a 12-month mental disorder, which is almost three times the prevalence of people who reported they had never been homeless (19%). Of the people who reported ever being homeless, 39% had a 12-month Anxiety disorder, 28% had a 12-month Affective disorder and 18% had a 12-month Substance Use disorder.

10. 12-MONTH MENTAL DISORDERS(a), by Homelessness



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.

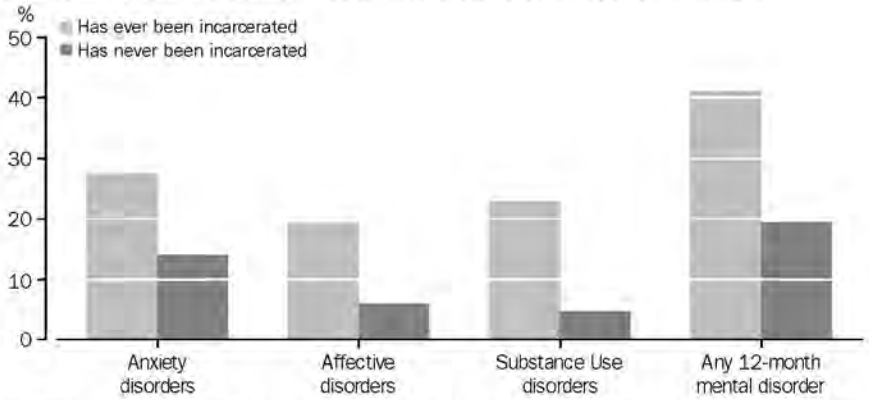
SUMMARY OF FINDINGS *continued*

POPULATION CHARACTERISTICS continued

LIFE EXPERIENCES *continued*

Of the 385,100 people who reported they had ever been incarcerated, 41% had a 12-month mental disorder, which is more than twice the prevalence of people who reported they had never been incarcerated (19%). People who reported they had ever been incarcerated experienced almost five times the prevalence of 12-month Substance Use disorders (23% compared with 4.7%), more than three times the prevalence of 12-month Affective disorders (19% compared with 5.9%), and almost twice the prevalence of 12-month Anxiety disorders (28% compared with 14.1%).

11. 12-MONTH MENTAL DISORDERS(a), by Incarceration(b)



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.
(b) Time spent in gaol, prison or a correctional facility.

CONTACT WITH FAMILY AND FRIENDS

Interaction with other people is vital to human development. Social relationships and networks can act as protective factors against the onset or recurrence of mental illness and enhance recovery from mental disorders (WHO, 2005). Tables 6 and 7 provide information on the social networks that people have access to and the frequency of contact with their family and friends.

The prevalence of 12-month mental disorders was very similar for people who did and did not have contact with their family. Of the 15.9 million people who had contact with their family, one in five (20%) had a 12-month mental disorder. Of the 121,800 people who had no contact with their family or no family, just under a quarter (23%) had a 12-month mental disorder. However, the prevalence of 12-month mental disorders for people who did and did not have contact with their friends was quite different. Of the 15.7 million people who had contact with their friends, one in five (20%) had a 12-month mental disorder, but for the 352,500 who had no contact with friends or no friends, 38% had a 12-month mental disorder.

SUMMARY OF FINDINGS *continued*

POPULATION CHARACTERISTICS continued

CONTACT WITH FAMILY AND FRIENDS *continued*

Of the people who had contact with their family, those who had family members to rely on or family members to confide in were less likely to have a 12-month mental disorder. One in three people with no family members to rely on (33%) or confide in (33%) had a 12-month mental disorder, compared with around one in six people with three or more family members to rely on (17%) or confide in (15%).

Of the people who had contact with their friends, those who had friends to rely on or friends to confide in were also less likely to have a 12-month mental disorder. Around a quarter (25% and 22% respectively) of the people with no friends to rely on or confide in had a 12-month mental disorder, compared with 18% each for the people with three or more friends to rely on or confide in.

SELECTED PHYSICAL AND MENTAL HEALTH CHARACTERISTICS

SELECTED HEALTH RISK FACTORS

Certain health risk factors have an association with mental health problems or mental illness. A number of lifestyle or behavioural factors have been identified as positively and/or negatively impacting on health. These include: level of exercise (physical activity); overweight and obesity; tobacco use (smoking); alcohol consumption; and misuse of drugs (including the use of illicit drugs and/or the misuse of prescribed medicines). Table 8 provides information about each of these selected health risk factors.

Health risks may also be indicated through information about other health and related characteristics, such as the presence of a long-term, or chronic condition. Table 9 provides information on physical conditions, level of psychological distress, suicidal behaviour, disability status, and number of days out of role.

SMOKER STATUS

Smoking leads to a wide range of health problems, including cancer and cardiovascular disease. The relationship between smoking and mental illness is complex, as mental illness is also a risk factor for smoking (Access Economics, 2007).

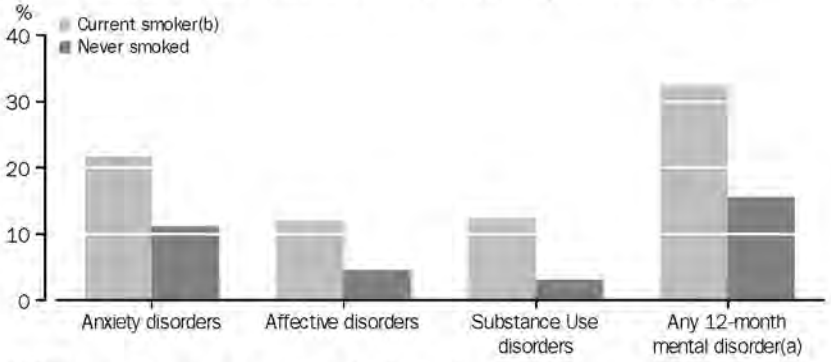
Of the 3.6 million people who identified as current smokers, almost a third (32%) had a 12-month mental disorder. Current smokers had twice the prevalence of 12-month mental disorders compared with people who had never smoked. Of the 8.1 million people who had never smoked, 16% had a 12-month mental disorder.

SELECTED PHYSICAL AND MENTAL HEALTH CHARACTERISTICS continued

SMOKER STATUS *continued*

Current smokers also experienced four times the prevalence of 12-month Substance Use disorders (12%), nearly three times the prevalence of 12-month Affective disorders (12%) and twice the prevalence of 12-month Anxiety disorders (22%) compared with people who had never smoked (3.1%, 4.5%, and 11.1% respectively).

12. 12-MONTH MENTAL DISORDERS(a), by Smoker status



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have more than one mental disorder.
(b) Daily and other smoker.

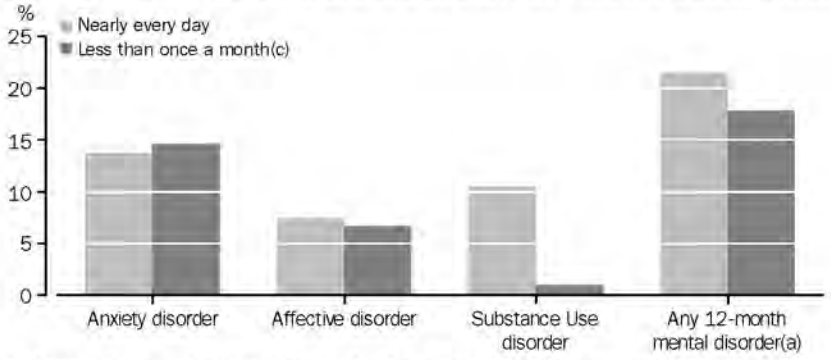
ALCOHOL CONSUMPTION

Excessive alcohol consumption is a health risk factor that contributes to morbidity and mortality. Alcohol consumption may also interact with mental health in various ways, including:

- people who are diagnosed as having an Alcohol Dependence are more likely to suffer from other mental health problems; and
- people with mental health problems are at particular risk of experiencing problems relating to alcohol (Department of Veteran's Affairs, 2004).

Of the 2.8 million people who reported that they drank nearly every day, more than one in five (21%) had a 12-month mental disorder. Slightly less (18%) of the 6 million people who reported that they drank less than once a month had a 12-month mental disorder.

13. 12-MONTH MENTAL DISORDERS(a), by Alcohol consumption(b)



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.
(b) Frequency in the 12 months prior to interview. See Alcohol consumption in the Glossary.
(c) Includes persons who did not drink in the 12 months prior to interview and those who have never had a drink.

SUMMARY OF FINDINGS *continued*

SELECTED PHYSICAL AND MENTAL HEALTH CHARACTERISTICS continued

ALCOHOL CONSUMPTION *continued*

While there were only slight differences in the overall prevalence rates for these two groups, there were significant differences in the prevalence of 12-month Substance Use disorders. People who reported that they drank nearly every day had more than 10 times the prevalence of 12-month Substance Use disorders compared with people who reported that they drank less than once a month (10.5% and 1.0% respectively).

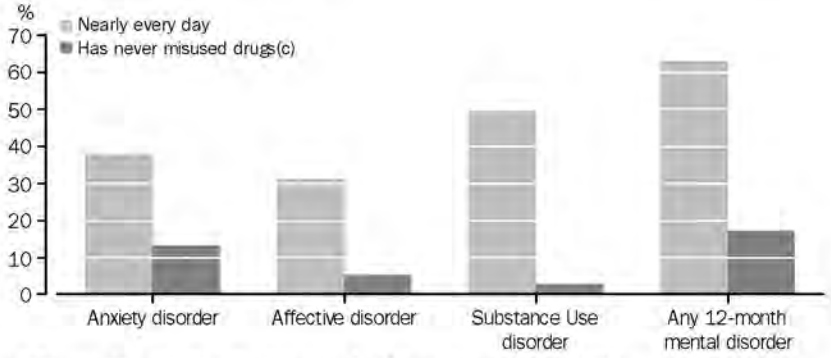
MISUSE OF DRUGS

In this survey, the misuse of drugs refers to the use of illicit substances and/or the misuse of prescribed medicines. People must have misused the same drug more than five times in their lifetime before being asked about their use of drugs in the 12 months prior to the survey interview.

Personal and social problems from drug misuse may be substantial and can interfere with personal relationships, employment and psychological health. The misuse of drugs may exacerbate the symptoms of mental illness. For example, Opioid Dependence is often accompanied by high rates of mental disorder, particularly Depression, Social Phobia and other Anxiety disorders. The existence of a mental disorder may also exacerbate drug misuse. For example, people with Anxiety disorders experience high rates of alcohol and drug problems (NCETA, 2004).

Of the 183,900 people who misused drugs nearly every day in the 12 months prior to the survey interview, almost two-thirds (63%) had a 12-month mental disorder. Almost half (49%) of the people who misused drugs nearly every day had a 12-month Substance Use disorder, 38% had a 12-month Anxiety disorder, and 31% had a 12-month Affective disorder.

14. 12-MONTH MENTAL DISORDERS(a), by Misuse of drugs(b)



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.
(b) In the 12 months prior to interview. See Misuse of drugs in the Glossary.
(c) Includes persons who have never used drugs and persons who may have used the same drug less than 5 times in their lifetime.

SUMMARY OF FINDINGS *continued*

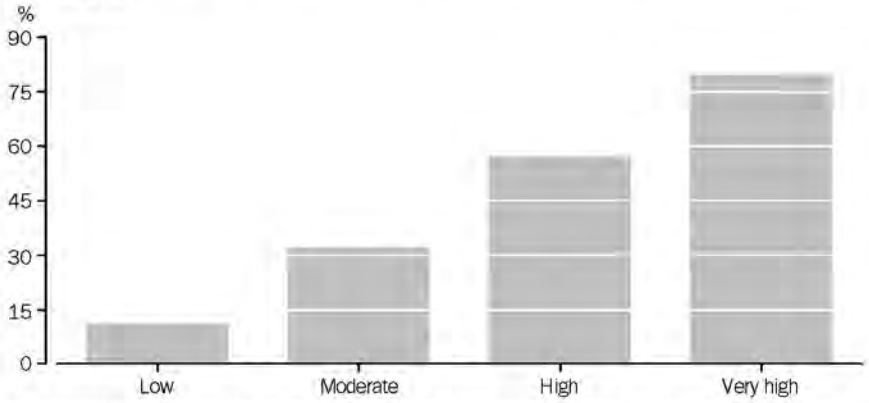
SELECTED PHYSICAL AND MENTAL HEALTH CHARACTERISTICS continued

LEVEL OF PSYCHOLOGICAL DISTRESS (K10)

The Kessler Psychological Distress Scale (K10) is a widely used indicator, which gives a simple measure of psychological distress. The K10 is based on 10 questions about a person's emotional state during the 30 days prior to the survey interview. Research has found a strong association between high scores on the K10 and the diagnosis of Anxiety and Affective disorders through the current WMH–CIDI (version 3.0). There is also a lesser, but still significant association between the K10 and other mental disorder categories, or the presence of any current mental disorder (Andrews & Slade, 2001).

Of the 409,300 people who had a 'very high' K10 score, 80% had a 12-month mental disorder. More than half (57%) of the 1.1 million people who had a 'high' K10 score also had a 12-month mental disorder. In comparison, there were 11.4 million people who had a 'low' K10 score, of whom, 11% had a 12-month mental disorder.

15. 12-MONTH MENTAL DISORDERS(a), by Level of psychological distress(b)



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.
(b) In the 30 days prior to interview. See Psychological distress in the Glossary.

SUICIDAL BEHAVIOUR

Suicide is a major public health issue. In this survey, people were asked about suicidal behaviour in their lifetime and in the 12 months prior to the survey interview (refer to Table 9). Of the 368,100 people who reported suicidal ideation in the 12 months prior to the survey interview (that is they had serious thoughts about committing suicide), almost three-quarters (72%) had a 12-month mental disorder.

SUMMARY OF FINDINGS *continued*

SELECTED PHYSICAL AND MENTAL HEALTH CHARACTERISTICS continued

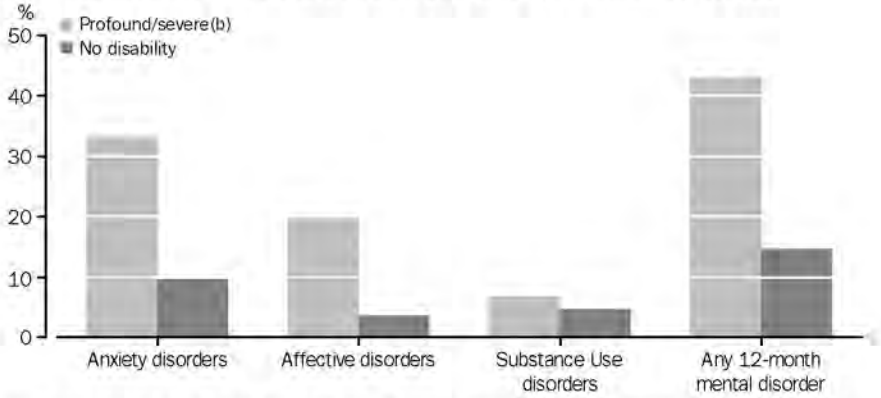
DISABILITY STATUS

Disability can be described in a number of ways, including: an impairment in body structure or function; a limitation in activities (eg mobility and communication); or a restriction in participation (eg social interaction and work). These different aspects of disability can exist in varying degrees and combinations (AIHW, 2008). Disability status recognises the difficulties that a person may have experienced because of a long-term physical or mental health condition and the limitations, impairments or restrictions to their everyday activities. A long-term health condition, or chronic condition, is a health condition or disorder that has lasted, or is expected to last for six months or more.

This survey assesses the nature and severity of specific activity limitations or restrictions to 'core activities', such as self-care, mobility and communication, and in schooling or employment, for people who reported they have a chronic condition. Disability status is calculated based on responses to questions from the standard ABS Short Disability Module. Responses are combined to create a scale measure which ranges from 'mild' to 'profound' core-activity limitation and also assesses whether there is a schooling and/or employment restriction. A profound or severe core-activity limitation means that the respondent always or sometimes needed personal assistance or supervision with their daily activities.

Of the 481,700 people who had a profound or severe core-activity limitation, 43% had a 12-month mental disorder. People who had a profound or severe core-activity limitation had almost three times the prevalence of 12-month Anxiety disorders (33%) and five times the prevalence (20%) of 12-month Affective disorders compared with people who had no disability or no specific limitations or restrictions (11.6% and 4.2% respectively).

16. 12-MONTH MENTAL DISORDERS(a), by Disability status



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have more than one mental disorder.
(b) Core-activity limitation. See Disability status in the Glossary.

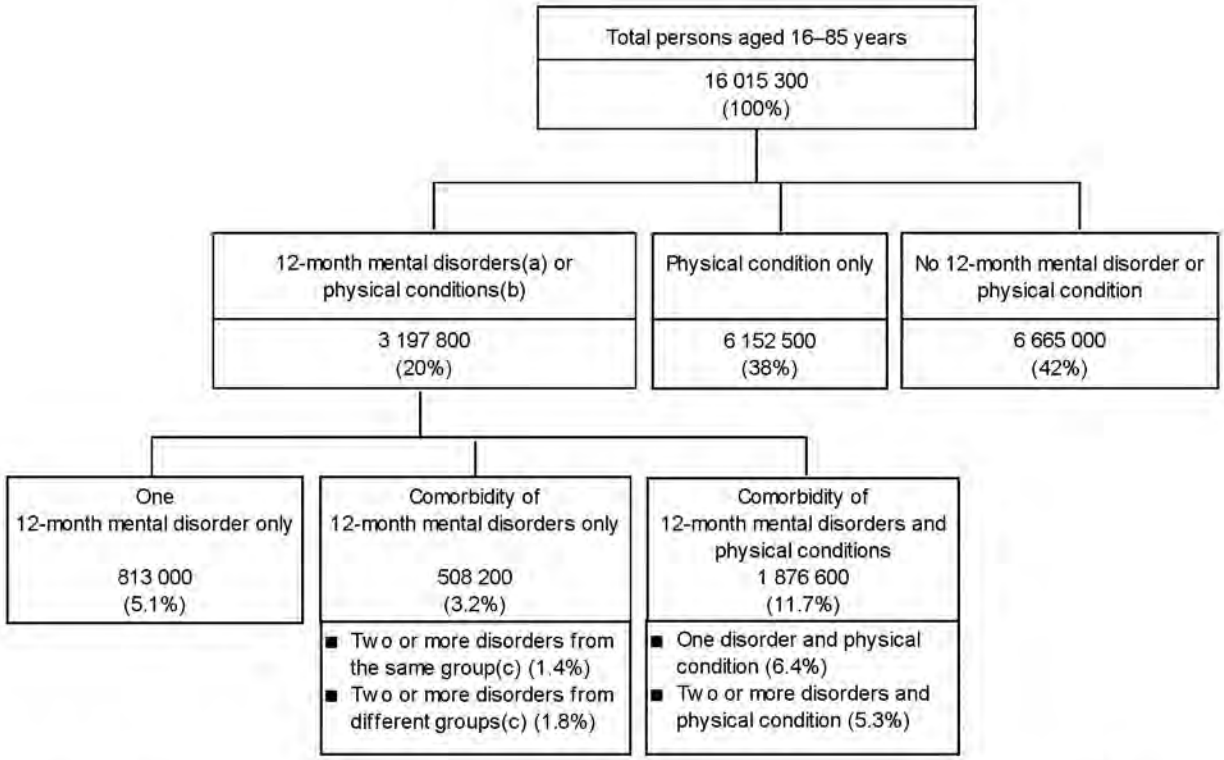
SUMMARY OF FINDINGS *continued*

COMORBIDITY

Comorbidity is the co-occurrence of more than one disease and/or disorder in an individual. Mental disorders may co-occur for a variety of reasons, and Substance Use disorders frequently co-occur (CDHAC, 2001). A person with co-occurring diseases or disorders is likely to experience more severe and chronic medical, social and emotional problems than if they had a single disease or disorder. People with comorbid conditions are also more vulnerable to alcohol and drug relapses, and relapse of mental health problems. Higher numbers of disorders are associated with greater impairment, higher risk of suicidal behaviour and greater use of health services.

In this publication, information is presented on both the comorbidity of mental disorder groups and physical conditions (Table 10), and the co-occurrence of more than one mental disorder with physical conditions (Table 11). As people with comorbid disorders generally require higher levels of support than people with only one disorder, Table 13 presents the number of 12-month mental disorders by services used for mental health problems.

All comorbidity tables in this publication are presented without the WMH–CIDI 3.0 hierarchy rules applied. Presenting the 12-month mental disorders without hierarchy provides a more complete picture of the combinations of symptoms and disorders experienced by individuals. For more information on hierarchy rules see the Explanatory Notes and Appendix 1.



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) and had symptoms in the 12 months prior to interview.
(b) A physical condition that a person had or received treatment for in the 12 months prior to interview. See Physical condition in the Glossary.
(c) These categories are mutually exclusive.

SUMMARY OF FINDINGS *continued*

COMORBIDITY continued

COMORBIDITY OF MENTAL DISORDERS AND PHYSICAL CONDITIONS

Of the 16 million Australians aged 16–85 years, almost three in five (58%) had a 12-month mental disorder or physical condition: 8.2% (1.3 million) had mental disorders only and 11.7% (1.9 million) had both a mental disorder and a physical condition. The most common comorbidity was a combination of 12-month Anxiety disorders and physical conditions (6.0%).

COMORBIDITY OF MENTAL DISORDERS

There were 1.4 million (8.5%) people who had two or more 12-month mental disorders. Of Australians aged 16–85 years, 3.4% (548,100) had disorders from the same group (eg two Anxiety disorders) and 5.1% (812,300) had disorders from different groups (eg one Anxiety disorder and one Affective disorder).

SERVICES USED FOR MENTAL HEALTH PROBLEMS

Information on services used for mental health problems supports the development of policies and programs to assist people with mental disorders. Monitoring mental health and mental illness within populations, both currently and over time, also provides information on the level and type of interventions that may be needed.

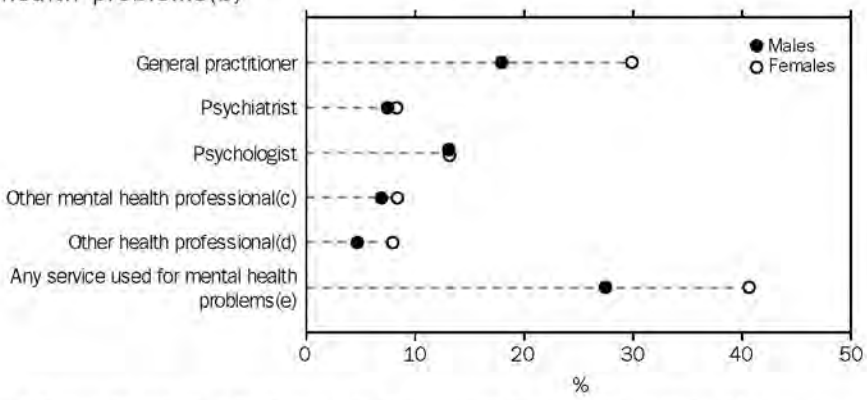
This survey collected information on services used by respondents for mental health problems in their lifetime and in the 12 months prior to the survey interview. The types of services used varied and included: professional treatment of physical and emotional problems, such as visits to a general practitioner or psychologist; hospital admissions; and self-management strategies, such as using the Internet or going to a self-help group. Tables 12 and 13 provide information on professional consultations for mental health problems, focussing on the 12 months prior to the survey interview.

Of Australians aged 16–85 years, 12% (1.9 million) accessed services for mental health problems in the 12 months prior to the survey interview. Of these, three in five (59%) people had a 12-month mental disorder, and one in five either met the criteria for lifetime diagnosis of a mental disorder but did not have symptoms in the 12 months prior to the survey interview (20%) or had no lifetime mental disorder (21%). People who were not diagnosed with a lifetime disorder may have consulted a health professional for a mental disorder that was not included in this survey or for some other type of mental health problem.

SERVICES USED FOR MENTAL HEALTH PROBLEMS continued

Of the 3.2 million people with a 12-month mental disorder, more than a third (35%) accessed services for mental health problems. Women with a 12-month mental disorder accessed services for mental health problems more than men (41% compared with 28%). Almost one in three (30%) women with a 12-month mental disorder visited a general practitioner, compared with just over one in six (18%) men. Women were also more likely to visit some other type of health professional, such as a complementary or alternative therapist, compared with men (8.0% and 4.7% respectively).

17. 12-MONTH MENTAL DISORDERS(a), by Services used for mental health problems(b)



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have more than one mental disorder.
(b) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.
(c) Includes mental health nurse and other professionals providing specialist mental health services.
(d) Includes medical specialist, other general specialist, complementary and alternative therapist.
(e) A person may have used more than one service for mental health. The components when added may therefore not add to the total shown. Also includes hospital admissions.

SERVICE USE AND COMORBIDITY

People with comorbid disorders had greater use of health services. Table 13 in this publication presents the number of 12-month mental disorders without hierarchy and services used for mental health problems. People with one disorder only were less likely to use services for their mental health than those with two or more disorders (23% and 52% respectively). Of the 1.8 million people with one disorder only, those with a 12-month Affective disorder were much more likely to use health services, than those with an Anxiety or Substance Use disorder. Of the people who had a 12-month Affective disorder only, 45% used services for their mental health, with most of these (80%) seeing a General Medical Practitioner (GP).

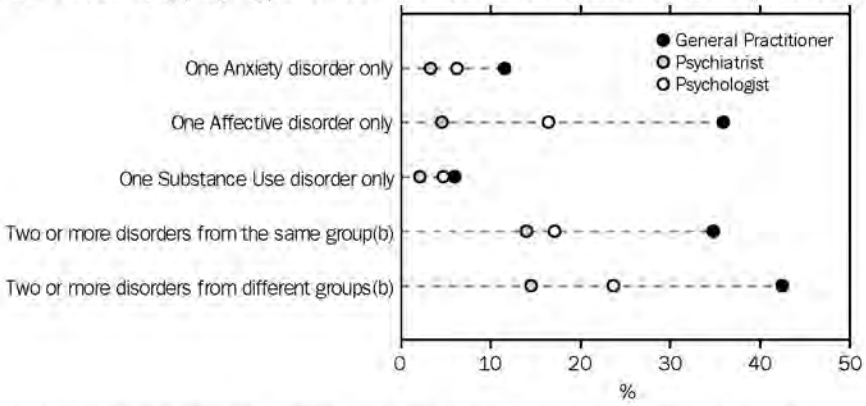
SUMMARY OF FINDINGS *continued*

SERVICES USED FOR MENTAL HEALTH PROBLEMS continued

SERVICE USE AND COMORBIDITY *continued*

People with two or more mental disorders (1.4 million) had a rate of service use more than twice that of people with one disorder only (52% and 23% respectively). People with two or more disorders from different groups had a higher rate of service use than people with two or more disorders from the same group (57% and 43% respectively). Again, people were more likely to see a GP than other types of health professional: 43% of people with two or more disorders from different groups and 35% of people with two or more disorders from the same group saw a GP. Almost a quarter (24%) of people with two or more disorders from different groups saw a Psychologist for their mental health.

18. NUMBER OF 12-MONTH MENTAL DISORDERS WITHOUT HIERARCHY(a), by Type of service used for mental health problems



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) and had symptoms in the 12 months prior to interview.
(b) These categories are mutually exclusive.

PERCEIVED NEED FOR HELP

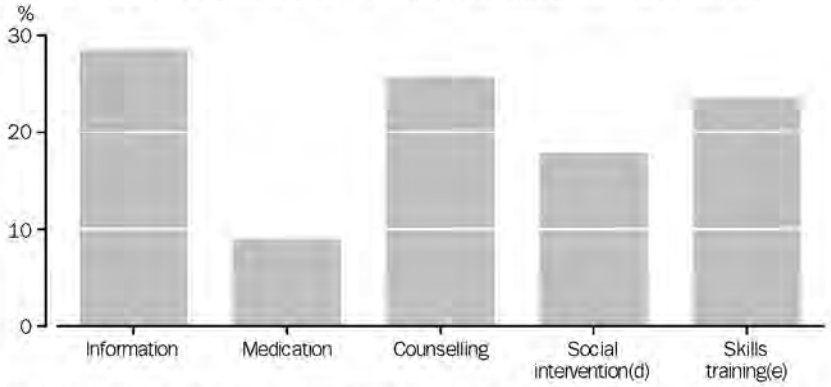
Whether people had a perceived need for help was assessed in relation to: information, medication, counselling, social intervention, and skills training. Table 14 presents information on perceived needs for people who used services for mental health problems, and whether or not they had a 12-month mental disorder. Table 15 focuses on people who had a 12-month mental disorder who did not use services for mental health problems.

PERCEIVED NEED FOR HELP continued

PERCEIVED NEED FOR HELP FOR PEOPLE WHO USED SERVICES

Of people with a 12-month mental disorder who used services, just over a quarter (26%) did not have their need for counselling met or only had their need partially met. A slightly higher proportion, 29% did not have their need for information met or only had their need partially met.

12-MONTH MENTAL DISORDERS(a), by Persons who used services for mental health problems(b)—Perceived need not fully met(c)

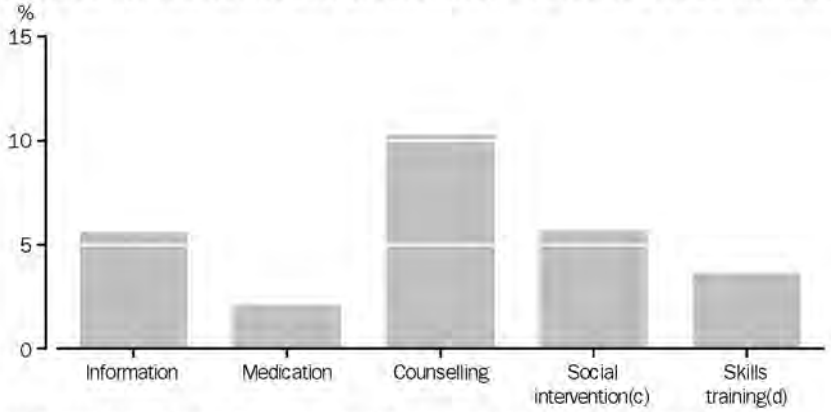


(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have more than one mental disorder.
(b) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.
(c) Need partially met and need not met.
(d) Includes help to sort out practical issues, such as money or housing, or help to meet people for support or company.
(e) Includes help to improve ability to work, to care for self, or to use time effectively.

PERCEIVED NEED FOR HELP FOR PEOPLE WHO DID NOT USE SERVICES

There were 2.1 million people with a 12-month mental disorder who did not use services for mental health problems. Of those who did not use services for mental health problems, 10% perceived that their need for counselling was not met.

12-MONTH MENTAL DISORDERS(a), by Persons who did not use services for mental health problems(b)—Perceived need not met



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have more than one mental disorder.
(b) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.
(c) Includes help to sort out practical issues, such as money or housing, or help to meet people for support or company.
(d) Includes help to improve ability to work, to care for self, or to use time effectively.

LIST OF TABLES

1 LIFETIME MENTAL DISORDERS(a)

	Males		Females		Persons	
	'000	%	'000	%	'000	%
Lifetime mental disorders(a)						
Anxiety disorders						
Panic Disorder	364.3	4.6	467.8	5.8	832.2	5.2
Agoraphobia	328.5	4.1	633.7	7.9	962.2	6.0
Social Phobia	669.8	8.4	1 034.8	12.8	1 704.6	10.6
Generalised Anxiety Disorder	348.1	4.4	592.7	7.3	940.8	5.9
Obsessive-Compulsive Disorder	180.4	2.3	260.6	3.2	441.1	2.8
Post-Traumatic Stress Disorder	681.8	8.6	1 277.5	15.8	1 959.2	12.2
Any Anxiety disorder(b)	1 624.2	20.4	2 580.8	32.0	4 205.0	26.3
Affective disorders						
Depressive Episode(c)	697.0	8.8	1 168.1	14.5	1 865.1	11.6
Dysthymia	115.8	1.5	195.1	2.4	310.8	1.9
Bipolar Affective Disorder	238.3	3.0	219.9	2.7	458.2	2.9
Any Affective disorder(b)	972.1	12.2	1 433.3	17.8	2 405.3	15.0
Substance Use disorders						
Alcohol Harmful Use	2 237.8	28.1	788.8	9.8	3 026.6	18.9
Alcohol Dependence	413.5	5.2	194.7	2.4	608.2	3.8
Drug Use disorders(d)	814.5	10.2	390.7	4.8	1 205.2	7.5
Any Substance Use disorder(b)	2 816.7	35.4	1 143.5	14.2	3 960.3	24.7
Any lifetime mental disorder(a)(b)	3 822.0	48.1	3 464.6	43.0	7 286.6	45.5
No lifetime mental disorder(e)	4 127.8	51.9	4 600.9	57.0	8 728.7	54.5
Total persons aged 16–85 years	*7 949.8*	*100.0*	*8 065.5*	*100.0*	*16 015.3*	*100.0*

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy). See paragraphs 30–31 of Explanatory Notes.

(b) A person may have more than one lifetime mental disorder. The components when added may therefore not add to the total shown.

(c) Includes Severe Depressive Episode, Moderate Depressive Episode, and Mild Depressive Episode.

(d) Includes Harmful Use and Dependence.

(e) Persons who did not meet criteria for diagnosis of a lifetime mental disorder. See paragraphs 30–31 of Explanatory Notes.

2 12-MONTH MENTAL DISORDERS (a)

	Males		Females		Persons	
	'000	%	'000	%	'000	%
Any 12-month mental disorder(a)						
Anxiety disorders						
Panic Disorder	180.5	2.3	229.8	2.8	410.3	2.6
Agoraphobia	170.5	2.1	279.9	3.5	450.4	2.8
Social Phobia	298.9	3.8	461.0	5.7	759.9	4.7
Generalised Anxiety Disorder	155.2	2.0	280.9	3.5	436.1	2.7
Obsessive-Compulsive Disorder	130.6	1.6	175.0	2.2	305.6	1.9
Post-Traumatic Stress Disorder	366.3	4.6	665.7	8.3	1 031.9	6.4
Any Anxiety disorder(b)	860.7	10.8	1 442.3	17.9	2 303.0	14.4
Affective disorders						
Depressive Episode(c)	245.0	3.1	407.4	5.1	652.4	4.1
Dysthymia	79.7	1.0	124.0	1.5	203.8	1.3
Bipolar Affective Disorder	145.3	1.8	140.3	1.7	285.6	1.8
Any Affective disorder(b)	420.1	5.3	575.8	7.1	995.9	6.2
Substance Use disorders						
Alcohol Harmful Use	300.8	3.8	169.3	2.1	470.1	2.9
Alcohol Dependence	174.9	2.2	55.3	0.7	230.2	1.4
Drug Use disorders(d)	165.7	2.1	65.7	0.8	231.4	1.4
Any Substance Use disorder(b)	556.4	7.0	263.5	3.3	819.8	5.1
Any 12-month mental disorder(a)(b)	1 400.1	17.6	1 797.7	22.3	3 197.8	20.0
No 12-month mental disorder(e)	6 549.7	82.4	6 267.8	77.7	12 817.5	80.0
Total persons aged 16–85 years	*7 949.8*	*100.0*	*8 065.5*	*100.0*	*16 015.3*	*100.0*

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Includes Severe Depressive Episode, Moderate Depressive Episode, and Mild Depressive Episode.

(d) Includes Harmful Use and Dependence.

(e) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

3 12-MONTH MENTAL DISORDERS(a), by Age group (years)

	Anxiety disorders		Affective disorders		Substance Use disorders		Any 12-month mental disorder(a)(b)		No 12-month mental disorder(c)		Total
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
MALES											
16–24	120.3	9.3	56.3	4.3	201.0	15.5	296.3	22.8	1 003.0	77.2	1 299.3
25–34	162.8	11.5	99.0	7.0	159.9	11.3	321.5	22.8	1 091.0	77.2	1 412.6
35–44	228.9	14.9	128.3	8.4	100.1	6.5	319.0	20.8	1 215.5	79.2	1 534.5
45–54	195.5	13.9	88.8	6.3	*62.0	*4.4	262.1	18.6	1 143.4	81.4	1 405.4
55–64	103.0	8.9	*30.1	*2.6	*18.1	*1.6	126.5	10.9	1 032.3	89.1	1 158.8
65–74	39.1	5.6	np	np	np	np	53.8	7.7	645.4	92.3	699.2
75–85	*11.0	*2.5	np	np	np	np	*20.9	*4.8	419.1	95.2	440.0
Total males aged 16–85 years	*860.7*	*10.8*	*420.1*	*5.3*	*556.4*	*7.0*	*1 400.1*	*17.6*	*6 549.7*	*82.4*	*7 949.8*
FEMALES											
16–24	270.9	21.7	105.0	8.4	122.5	9.8	374.8	30.1	871.3	69.9	1 246.1
25–34	297.0	21.2	121.9	8.7	46.5	3.3	376.8	26.9	1 022.4	73.1	1 399.2
35–44	326.2	21.2	126.9	8.3	*39.6	*2.6	397.5	25.9	1 138.3	74.1	1 535.8
45–54	308.7	21.2	113.3	7.8	*46.4	*3.2	351.6	24.2	1 101.6	75.8	1 453.2
55–64	160.2	13.8	68.4	5.9	**7.4	**0.6	190.2	16.3	974.8	83.7	1 165.0
65–74	51.7	7.0	np	np	np	np	70.0	9.5	665.1	90.5	735.1
75–85	*27.6	*5.2	np	np	np	np	*36.8	*6.9	494.4	93.1	531.2
Total females aged 16–85 years	*1 442.3*	*17.9*	*575.8*	*7.1*	*263.5*	*3.3*	*1 797.7*	*22.3*	*6 267.8*	*77.7*	*8 065.5*
PERSONS											
16–24	391.3	15.4	161.4	6.3	323.5	12.7	671.1	26.4	1 874.3	73.6	2 545.4
25–34	459.7	16.3	220.9	7.9	206.4	7.3	698.4	24.8	2 113.4	75.2	2 811.8
35–44	555.1	18.1	255.2	8.3	139.7	4.6	716.4	23.3	2 353.8	76.7	3 070.3
45–54	504.2	17.6	202.1	7.1	108.4	3.8	613.7	21.5	2 245.0	78.5	2 858.6
55–64	263.3	11.3	98.4	4.2	*25.5	*1.1	316.7	13.6	2 007.1	86.4	2 323.8
65–74	90.8	6.3	40.4	2.8	*8.6	*0.6	123.8	8.6	1 310.5	91.4	1 434.3
75–85	38.6	4.0	*17.5	*1.8	*7.7	*0.8	57.7	5.9	913.5	94.1	971.2
Total persons aged 16–85 years	*2 303.0*	*14.4*	*995.9*	*6.2*	*819.8*	*5.1*	*3 197.8*	*20.0*	*12 817.5*	*80.0*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

np not available for publication but included in totals where applicable, unless otherwise indicated

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A person may have had more than one mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

4 12-MONTH MENTAL DISORDERS(a), by Selected household characteristics

	Anxiety disorders		Affective disorders		Substance Use disorders		Any 12-month mental disorder(a)(b)		No 12-month mental disorder(c)		Total
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
Household income(d)											
1st quintile	464.9	17.3	248.7	9.3	120.6	4.5	633.5	23.6	2 051.2	76.4	2 684.6
5th quintile	345.0	12.7	113.0	4.1	135.0	5.0	488.1	17.9	2 236.0	82.1	2 724.2
Index of disadvantage(e)											
1st quintile	419.5	15.8	199.1	7.5	149.1	5.6	570.7	21.5	2 081.3	78.5	2 652.0
5th quintile	398.2	10.9	154.2	4.2	147.9	4.0	582.6	15.9	3 082.2	84.1	3 664.8
Family composition of household											
One family households											
Couple family with children	751.2	14.0	229.8	4.3	241.3	4.5	1 000.7	18.7	4 354.8	81.3	5 355.4
One parent family with children	190.7	25.6	71.1	9.5	67.9	9.1	251.9	33.8	493.2	66.2	745.1
Couple only	484.5	11.1	190.4	4.4	119.8	2.7	631.4	14.4	3 740.5	85.6	4 371.9
Other one family households	352.8	15.2	181.1	7.8	172.5	7.4	545.6	23.5	1 774.1	76.5	2 319.7
Multiple family households	*73.8	*15.9	*53.4	*11.5	**13.1	**2.8	102.6	22.1	360.6	77.9	463.1
Non-family households											
Lone person household	336.6	16.0	195.6	9.3	119.3	5.7	479.6	22.8	1 628.4	77.2	2 107.9
Group household	113.4	17.4	74.6	11.4	85.9	13.2	186.2	28.5	466.0	71.5	652.2
Area of usual residence											
State capital city	1 519.3	14.7	697.2	6.7	569.2	5.5	2 117.8	20.5	8 232.9	79.5	10 350.7
Balance of state/territory	783.8	13.8	298.7	5.3	250.7	4.4	1 080.0	19.1	4 584.6	80.9	5 664.7
Section of state											
Major urban	1 553.6	14.6	686.4	6.5	586.0	5.5	2 160.0	20.4	8 452.9	79.6	10 613.0
Other urban	454.8	13.3	207.6	6.1	164.8	4.8	658.1	19.2	2 762.7	80.8	3 420.8
Balance of state(f)	294.6	14.9	101.9	5.1	69.1	3.5	379.7	19.2	1 601.8	80.8	1 981.6
Total persons aged 16–85 years	*2 303.0*	*14.4*	*995.9*	*6.2*	*819.8*	*5.1*	*3 197.8*	*20.0*	*12 817.5*	*80.0*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) See Household income in the Glossary.

(e) See Index of disadvantage in the Glossary.

(f) Bounded locality and Rural balance. See Section of state in the Glossary.

5 12-MONTH MENTAL DISORDERS(a), by Selected population characteristics

	Anxiety disorders		Affective disorders		Substance Use disorders		Any 12-month mental disorder(a)(b)		No 12-month mental disorder(c)		Total
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
Level of highest non-school qualification(d)											
Bachelor degree or above	389.0	12.2	190.6	6.0	114.6	3.6	541.8	16.9	2 656.6	83.1	3 198.4
Advanced diploma/Diploma	210.3	15.4	122.3	8.9	*61.9	*4.5	298.9	21.9	1 068.9	78.1	1 367.8
Certificate(e)	554.6	13.6	238.9	5.9	268.1	6.6	819.3	20.2	3 245.7	79.8	4 064.9
No non-school qualification(f)	1 149.0	15.6	444.1	6.0	375.3	5.1	1 537.8	20.8	5 846.4	79.2	7 384.2
Labour force status											
Employed	1 485.4	14.2	595.6	5.7	624.1	6.0	2 117.1	20.3	8 330.6	79.7	10 447.8
Full-time	930.5	13.4	379.5	5.5	418.5	6.0	1 336.4	19.3	5 585.1	80.7	6 921.5
Part-time	554.9	15.7	216.1	6.1	205.6	5.8	780.7	22.1	2 745.5	77.9	3 526.3
Unemployed	72.2	17.5	65.7	15.9	46.1	11.1	121.4	29.4	292.1	70.6	413.6
Not in the labour force	745.4	14.5	334.7	6.5	149.7	2.9	959.3	18.6	4 194.7	81.4	5 154.0
Occupation											
Managers	194.7	13.6	79.9	5.6	*65.7	*4.6	266.7	18.7	1 161.8	81.3	1 428.5
Professionals	308.6	14.6	113.2	5.3	59.6	2.8	394.3	18.6	1 725.1	81.4	2 119.3
Technicians and Trades Workers	163.2	11.1	84.7	5.8	149.0	10.1	309.7	21.1	1 160.1	78.9	1 469.8
Community and Personal Service Workers	181.6	18.8	58.9	6.1	61.3	6.3	217.5	22.5	748.5	77.5	965.9
Clerical and Administrative Workers	255.7	15.9	105.7	6.6	74.9	4.7	352.4	22.0	1 250.7	78.0	1 603.2
Sales Workers	169.3	16.6	*31.7	*3.1	91.2	9.0	211.8	20.8	806.7	79.2	1 018.5
Machinery Operators and Drivers	*79.4	*12.8	*26.0	*4.2	*35.7	*5.7	118.7	19.1	503.5	80.9	622.2
Labourers	119.7	10.6	*91.9	*8.1	86.7	7.7	233.0	20.6	899.5	79.4	1 132.5
Total employed persons(g)	1 485.4	14.2	595.6	5.7	624.1	6.0	2 117.1	20.3	8 330.6	79.7	10 447.8
Main source of personal income(h)											
Employee cash income	1 277.9	14.4	487.5	5.5	562.6	6.3	1 824.2	20.5	7 071.0	79.5	8 895.1
Unincorporated business cash income	109.6	11.9	42.0	4.6	*28.7	*3.1	148.9	16.2	770.0	83.8	918.9
Government cash pensions and allowances	624.7	17.4	338.2	9.4	156.3	4.3	831.8	23.1	2 766.6	76.9	3 598.4
Other cash income(i)	177.7	10.8	*67.4	*4.1	*39.2	*2.4	242.5	14.8	1 400.6	85.2	1 643.1

* estimate has a relative standard error of 25% to 50% and should be used with caution

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) andhad symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) Non-school qualification refers to educational attainments other than those of pre-primary, primary or secondary education. For more information refer to the 'Australian Standard Classification of Education (ASCED) (cat. no. 1272.0)'.

(e) Includes 'Certificate I or II', 'Certificate III or IV', and 'Certificate not further defined'.

(f) Includes 'Level not determined'.

(g) Includes 'Inadequately described'. Occupation is classified by the Australian and New Zealand Standard Classification of Occupations (ANZSCO). See Occupation in the Glossary.

(h) See Main source of personal income in the Glossary.

(i) Includes income from property, superannuation/annuities, transfers from private organisations or other households, and other non-specified sources.

5 12-MONTH MENTAL DISORDERS(a), by Selected population characteristics *continued*

	Anxiety disorders		Affective disorders		Substance Use disorders		Any 12-month mental disorder(a)(b)		No 12-month mental disorder(c)		Total
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
Country of birth(d)											
Born in Australia	1 798.5	15.4	772.7	6.6	700.2	6.0	2 541.9	21.8	9 129.5	78.2	11 671.4
Born overseas	504.5	11.6	223.2	5.1	119.6	2.8	655.9	15.1	3 688.0	84.9	4 344.0
Arrived before 1986	305.3	13.4	124.5	5.4	*37.0	*1.6	360.6	15.8	1 924.7	84.2	2 285.4
Arrived 1986–1995	86.5	11.3	34.0	4.4	*43.3	*5.7	134.1	17.5	630.7	82.5	764.8
Arrived 1996–2007	112.7	8.7	64.7	5.0	*39.3	*3.0	161.2	12.5	1 132.6	87.5	1 293.8
Marital status											
Married/De facto	1 111.6	12.2	361.9	4.0	227.4	2.5	1 393.0	15.2	7 743.2	84.8	9 136.1
Separated/Divorced/Widowed	384.3	17.8	211.0	9.8	68.6	3.2	487.1	22.5	1 673.6	77.5	2 160.6
Never married	807.1	17.1	423.0	9.0	523.9	11.1	1 317.8	27.9	3 400.8	72.1	4 718.6
Sexual orientation											
Heterosexual	2 210.5	14.1	939.7	6.0	793.4	5.0	3 075.2	19.6	12 640.8	80.4	15 716.0
Homosexual/Bisexual	92.5	31.5	56.2	19.2	*25.3	*8.6	121.5	41.4	171.8	58.6	293.3
Homelessness											
Has ever been homeless	190.7	39.4	134.0	27.7	85.3	17.6	259.6	53.6	224.8	46.4	484.4
Has never been homeless	2 112.3	13.6	861.9	5.5	734.5	4.7	2 938.3	18.9	12 592.7	81.1	15 530.9
Incarceration											
Has ever been incarcerated(e)	106.0	27.5	74.2	19.3	87.8	22.8	158.4	41.1	226.7	58.9	385.1
Has never been incarcerated	2 197.1	14.1	921.7	5.9	732.1	4.7	3 039.5	19.4	12 590.8	80.6	15 630.2
Service in the Australian defence forces											
Has ever served(f)	101.1	12.1	*49.7	*5.9	*25.6	*3.1	137.9	16.5	699.0	83.5	837.0
Has never served	2 201.9	14.5	946.3	6.2	794.3	5.2	3 059.9	20.2	12 118.5	79.8	15 178.4
Total persons aged 16–85 years	*2 303.0*	*14.4*	*995.9*	*6.2*	*819.8*	*5.1*	*3 197.8*	*20.0*	*12 817.5*	*80.0*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) andhad symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) Country of birth is classified by the Standard Australian Classification of Countries (SACC). See Country of birth in the Glossary.

(e) Time spent in gaol, prison or correctional facility.

(f) Includes persons who had overseas qualifying service, serving and ex-serving Australian Defence Force members.

6 12-MONTH MENTAL DISORDERS(a), by Contact with family or friends

	Anxiety disorders		Affective disorders		Substance Use disorders		Any 12-month mental disorder(a)(b)		No 12-month mental disorder(c)		Total
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
No contact with or no family	*21.5	*17.6	*17.0	*14.0	**4.1	**3.3	*27.7	*22.8	94.1	77.2	121.8
Contact with family members(d)	2 281.5	14.4	978.9	6.2	815.8	5.1	3 170.1	19.9	12 723.5	80.1	15 893.6
Number of family members to rely on											
0 family members to rely on	216.4	25.6	145.6	17.2	*65.1	7.7	282.7	33.4	563.6	66.6	846.2
1–2 family members to rely on	870.3	18.2	363.9	7.6	276.9	5.8	1 162.9	24.3	3 619.7	75.7	4 782.5
3 or more family members to rely on	1 194.8	11.6	469.4	4.6	473.8	4.6	1 724.6	16.8	8 535.6	83.2	10 260.2
Family members to confide in											
0 family members to confide in	296.0	26.4	186.8	16.7	91.5	8.2	372.7	33.2	749.0	66.8	1 121.7
1–2 family members to confide in	1 213.1	17.2	505.2	7.2	394.4	5.6	1 642.5	23.3	5 419.3	76.7	7 061.8
3 or more family members to confide in	772.4	10.0	286.9	3.7	329.8	4.3	1 154.9	15.0	6 552.7	85.0	7 707.6
No contact with or no friends	111.7	31.7	*71.3	*20.2	**24.5	**6.9	135.4	38.4	217.1	61.6	352.5
Contact with friends(d)	2 191.3	14.0	924.6	5.9	795.4	5.1	3 062.4	19.6	12 600.4	80.4	15 662.8
Number of friends to rely on											
0 friends to rely on	306.1	19.0	166.3	10.3	88.0	5.5	395.0	24.6	1 212.1	75.4	1 607.1
1–2 friends to rely on	882.9	15.4	380.9	6.7	260.9	4.6	1 191.8	20.8	4 524.6	79.2	5 716.4
3 or more friends to rely on	1 002.3	12.0	377.5	4.5	446.5	5.4	1 475.6	17.7	6 859.7	82.3	8 335.3
Number of friends to confide in											
0 friends to confide in	298.1	16.7	168.4	9.4	87.6	4.9	396.7	22.2	1 389.0	77.8	1 785.7
1–2 friends to confide in	1 049.7	15.1	391.4	5.6	310.1	4.5	1 402.3	20.2	5 542.7	79.8	6 945.0
3 or more friends to confide in	842.4	12.2	364.8	5.3	397.7	5.7	1 262.2	18.2	5 658.9	81.8	6 921.1
Total persons aged 16–85 years(d)	*2 303.0*	*14.4*	*995.9*	*6.2*	*819.8*	*5.1*	*3 197.8*	*20.0*	*12 817.5*	*80.0*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) Includes 'not stated' how many family/friends a person can rely on/confide in.

7 12-MONTH MENTAL DISORDERS(a), by Frequency of contact with family or friends

	Anxiety disorders		*Affective disorders*		*Substance Use disorders*		*Any 12-month mental disorder(a)(b)*		*No 12-month mental disorder(c)*		*Total*
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
Frequency of contact with family members											
Nearly every day	1 405.3	13.6	545.2	5.3	536.6	5.2	1 978.0	19.2	8 334.2	80.8	10 312.3
At least once a week	622.6	14.8	283.0	6.7	197.3	4.7	841.0	20.0	3 361.3	80.0	4 202.4
At least once a month	182.9	19.6	*97.5	*10.5	58.5	6.3	236.1	25.3	695.5	74.7	931.6
Less than once a month	70.8	15.8	*53.2	*11.9	*23.5	*5.3	114.9	25.7	332.4	74.3	447.3
No contact or no family	*21.5	*17.6	*17.0	*14.0	**4.1	**3.3	*27.7	*22.8	94.1	77.2	121.8
Frequency of contact with friends											
Nearly every day	920.3	13.5	340.9	5.0	443.1	6.5	1 369.4	20.0	5 463.4	80.0	6 832.8
At least once a week	856.3	12.5	371.1	5.4	269.5	3.9	1 188.1	17.3	5 665.7	82.7	6 853.9
At least once a month	253.0	18.1	139.2	9.9	*48.3	*3.4	316.4	22.6	1 083.6	77.4	1 400.0
Less than once a month	161.7	28.1	*73.4	12.7	*34.5	*6.0	188.4	32.7	387.7	67.3	576.1
No contact or no friends	111.7	31.7	*71.3	*20.2	**24.5	**6.9	135.4	38.4	217.1	61.6	352.5
Total persons aged 16–85 years	*2 303.0*	*14.4*	995.9	*6.2*	*819.8*	*5.1*	*3 197.8*	*20.0*	*12 817.5*	*80.0*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

8 12-MONTH MENTAL DISORDERS(a), by Selected health risk characteristics(b)

	Anxiety disorders		Affective disorders		Substance Use disorders		Any 12-month mental disorder(a)(c)		No 12-month mental disorder(d)		Total
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
MALES											
Level of exercise(e)											
Sedentary(f)	203.6	13.6	81.7	5.5	89.4	6.0	290.4	19.4	1 203.8	80.6	1 494.2
Low	409.5	11.0	186.2	5.0	216.2	5.8	620.6	16.6	3 115.7	83.4	3 736.3
Moderate/High	247.7	9.1	152.2	5.6	250.8	9.2	489.1	18.0	2 226.2	82.0	2 715.3
Body Mass Index(g)											
Underweight/Normal(h)	327.0	11.2	184.5	6.3	272.1	9.3	588.4	20.2	2 323.5	79.8	2 911.9
Overweight	333.1	9.7	135.4	4.0	221.3	6.5	509.5	14.9	2 915.3	85.1	3 424.8
Obese	191.1	12.7	98.0	6.5	50.2	3.3	277.7	18.5	1 226.6	81.5	1 504.3
Smoker status											
Current smoker(i)	302.0	15.2	208.5	10.5	296.1	14.9	552.9	27.8	1 438.2	72.2	1 991.1
Ex-smoker	268.0	11.4	80.4	3.4	79.0	3.4	352.3	15.0	1 993.1	85.0	2 345.4
Never smoked	290.7	8.0	131.3	3.6	181.3	5.0	494.9	13.7	3 118.4	86.3	3 613.3
Alcohol consumption(j)											
Nearly every day	213.6	11.6	*123.2	6.7	219.8	12.0	373.1	20.3	1 461.7	79.7	1 834.8
3–4 days per week	163.9	12.7	*61.0	*4.7	101.2	7.9	262.5	20.4	1 023.0	79.6	1 285.5
1–2 days per week	193.9	10.8	70.7	3.9	170.4	9.5	350.1	19.4	1 450.1	80.6	1 800.2
1–3 days per month	84.1	9.6	*50.8	*5.8	*35.7	*4.1	129.5	14.9	742.1	85.1	871.6
Less than once a month(k)	205.2	9.5	114.3	5.3	*29.4	*1.4	284.9	13.2	1 872.8	86.8	2 157.7
Misuse of drugs(l)											
Nearly every day	*43.9	35.3	*36.9	*29.7	59.4	47.8	76.7	61.8	47.5	38.2	124.2
3–4 days a week	*42.3	*37.6	**7.9	**7.1	*53.7	47.8	*75.2	66.9	*37.2	*33.1	112.4
1–2 days a week	*20.8	*20.6	*17.6	*17.4	*38.5	38.2	50.9	50.5	50.0	49.5	100.8
1–3 days a month	36.7	27.1	*17.2	*12.7	*43.8	32.4	65.3	48.3	69.9	51.7	135.3
Less than once a month	50.4	12.3	*53.2	*13.0	109.5	26.7	161.5	39.3	249.0	60.7	410.5
Have never misused drugs(m)	666.6	9.4	287.3	4.1	251.5	3.6	970.4	13.7	6 096.2	86.3	7 066.6
Total males aged 16–85 years	*860.7*	*10.8*	*420.1*	*5.3*	*556.4*	*7.0*	*1 400.1*	*17.6*	*6 549.7*	*82.4*	*7 949.8*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) Health risk factors present in the 12 months prior to interview. See Health risk factors in the Glossary.

(c) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(d) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(e) In the week prior to interview. Includes persons whose level of exercise was not stated. See Level of exercise in the Glossary.

(f) Includes persons who did no exercise.

(g) Total includes 'not stated'.

(h) There were insufficient respondents assessed as 'underweight' for them to be included as a separate category in this table.

(i) Daily and other smoker.

(j) Frequency of consumption in the 12 months prior to interview. Only persons who had at least 12 standard drinks in a year were asked about their consumption.

(k) Includes persons who did not drink in the 12 months prior to interview and those who have never had a drink.

(l) Misuse of drugs in the 12 months prior to interview. Refers to the use of illicit drugs and/or the misuse of prescription drugs. People must have misused the same drug more than 5 times in their lifetime. Only persons who had misused the same drug more than 5 times in their lifetime were asked about their consumption. See Misuse of drugs in the Glossary.

(m) Includes persons who did not misuse drugs in the 12 months prior to interview, those who have never misused drugs, or those who have misused the same drug 5 times or less in their lifetime.

8 12-MONTH MENTAL DISORDERS(a), by Selected health risk characteristics(b) *continued*

	Anxiety disorders		*Affective disorders*		*Substance Use disorders*		*Any 12-month mental disorder(a)(c)*		*No 12-month mental disorder(d)*		*Total*
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
FEMALES											
Level of exercise(e)											
Sedentary(f)	255.3	17.2	134.5	9.1	*35.0	*2.4	333.7	22.5	1 150.8	77.5	1 484.5
Low	852.1	17.3	292.8	5.9	164.2	3.3	1 049.5	21.3	3 872.2	78.7	4 921.7
Moderate/High	334.9	20.2	148.5	9.0	64.3	3.9	414.6	25.1	1 239.8	74.9	1 654.3
Body Mass Index(g)											
Underweight/Normal(h)	704.8	17.1	272.7	6.6	183.5	4.4	905.7	22.0	3 218.9	78.0	4 124.6
Overweight	351.9	17.4	156.1	7.7	49.1	2.4	440.5	21.7	1 587.3	78.3	2 027.7
Obese	359.5	20.9	129.1	7.5	*23.1	*1.3	406.7	23.7	1 311.2	76.3	1 717.9
Smoker status											
Current smoker(i)	468.2	29.7	223.3	14.2	143.6	9.1	603.7	38.3	971.9	61.7	1 575.7
Ex-smoker	357.3	18.2	119.3	6.1	*47.6	*2.4	420.4	21.4	1 541.4	78.6	1 961.7
Never smoked	616.9	13.6	233.2	5.1	72.2	1.6	773.6	17.1	3 754.5	82.9	4 528.1
Alcohol consumption(j)											
Nearly every day	165.8	17.6	82.1	8.7	73.3	7.8	222.9	23.6	721.2	76.4	944.1
3–4 days per week	123.1	14.9	38.6	4.7	*50.9	*6.2	176.9	21.4	648.0	78.6	824.9
1–2 days per week	270.3	19.0	97.7	6.9	81.8	5.8	360.6	25.4	1 059.6	74.6	1 420.2
1–3 days per month	213.8	20.4	73.4	7.0	*24.6	*2.3	259.2	24.7	789.0	75.3	1 048.2
Less than once a month(k)	669.3	17.5	283.8	7.4	*32.8	*0.9	778.2	20.3	3 050.0	79.7	3 828.2
Misuse of drugs(l)											
Nearly every day	*25.8	43.2	*20.1	*33.6	*31.5	52.8	39.1	65.4	*20.7	*34.6	59.7
3–4 days a week	*10.0	*36.1	*6.0	*21.6	*16.2	58.5	*19.9	71.8	*7.8	*28.2	*27.8
1–2 days a week	*22.2	*43.2	**20.4	*39.7	*18.0	*35.1	*30.2	58.8	*21.2	*41.2	51.4
1–3 days a month	36.4	50.1	*18.0	*24.7	*21.3	*29.4	51.3	70.7	*21.3	29.3	72.6
Less than once a month	87.6	33.3	*34.3	13.0	*37.0	14.1	121.0	45.9	142.4	54.1	263.4
Has never misused drugs(m)	1 260.4	16.6	477.1	6.3	139.3	1.8	1 536.2	20.2	6 054.5	79.8	7 590.7
Total females aged 16–85 years	*1 442.3*	*17.9*	*575.8*	*7.1*	*263.5*	*3.3*	*1 797.7*	*22.3*	*6 267.8*	*77.7*	*8 065.5*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) Health risk factors present in the 12 months prior to interview. See Health risk factors in the Glossary.

(c) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(d) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(e) In the week prior to interview. Includes persons whose level of exercise was not stated. See Level of exercise in the Glossary.

(f) Includes persons who did no exercise.

(g) Total includes 'not stated'.

(h) There were insufficient respondents assessed as 'underweight' for them to be included as a separate category in this table.

(i) Daily and other smoker.

(j) Frequency of consumption in the 12 months prior to interview. Only persons who had at least 12 standard drinks in a year were asked about their consumption.

(k) Includes persons who did not drink in the 12 months prior to interview and those who have never had a drink.

(l) Misuse of drugs in the 12 months prior to interview. Refers to the use of illicit drugs and/or the misuse of prescription drugs. People must have misused the same drug more than 5 times in their lifetime. Only persons who had misused the same drug more than 5 times in their lifetime were asked about their consumption. See Misuse of drugs in the Glossary.

(m) Includes persons who did not misuse drugs in the 12 months prior to interview, those who have never misused drugs, or those who have misused the same drug 5 times or less in their lifetime.

8 12-MONTH MENTAL DISORDERS(a), by Selected health risk characteristics(b) *continued*

	Anxiety disorders		*Affective disorders*		*Substance Use disorders*		*Any 12-month mental disorder(a)(c)*		*No 12-month mental disorder(d)*		*Total*
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
PERSONS											
Level of exercise(e)											
Sedentary(f)	458.9	15.4	216.3	7.3	124.3	4.2	624.1	21.0	2 354.5	79.0	2 978.7
Low	1 261.6	14.6	479.0	5.5	380.4	4.4	1 670.1	19.3	6 987.9	80.7	8 658.0
Moderate/High	582.6	13.3	300.7	6.9	315.1	7.2	903.7	20.7	3 466.0	79.3	4 369.6
Body Mass Index(g)											
Underweight/Normal(h)	1 031.8	14.7	457.3	6.5	455.6	6.5	1 494.1	21.2	5 542.4	78.8	7 036.5
Overweight	685.0	12.6	291.5	5.3	270.5	5.0	950.0	17.4	4 502.6	82.6	5 452.6
Obese	550.6	17.1	227.1	7.0	73.3	2.3	684.4	21.2	2 537.8	78.8	3 222.2
Smoker status											
Current smoker(i)	770.1	21.6	431.8	12.1	439.7	12.3	1 156.6	32.4	2 410.1	67.6	3 566.8
Ex-smoker	625.3	14.5	199.6	4.6	126.6	2.9	772.7	17.9	3 534.5	82.1	4 307.2
Never smoked	907.6	11.1	364.5	4.5	253.5	3.1	1 268.5	15.6	6 872.9	84.4	8 141.4
Alcohol consumption(j)											
Nearly every day	379.5	13.7	205.4	7.4	293.1	10.5	596.0	21.4	2 182.9	78.6	2 778.8
3–4 days per week	287.0	13.6	99.7	4.7	152.1	7.2	439.4	20.8	1 670.9	79.2	2 110.4
1–2 days per week	464.2	14.4	168.5	5.2	252.2	7.8	710.7	22.1	2 509.8	77.9	3 220.4
1–3 days per month	297.9	15.5	124.3	6.5	60.3	3.1	388.7	20.2	1 531.2	79.8	1 919.8
Less than once a month(k)	874.5	14.6	398.1	6.7	62.1	1.0	1 063.1	17.8	4 922.8	82.2	5 985.9
Misuse of drugs(l)											
Nearly every day	69.7	37.9	56.9	30.9	90.9	49.4	115.8	63.0	68.1	37.0	183.9
3–4 days a week	*52.3	*37.3	*14.0	*10.0	69.9	49.9	95.1	67.9	*45.0	*32.1	140.2
1–2 days a week	*43.0	28.2	*38.0	*24.9	56.5	37.1	81.1	53.3	71.1	46.7	152.2
1–3 days a month	73.1	35.1	35.2	16.9	65.1	31.3	116.7	56.1	91.2	43.9	207.8
Less than once a month	138.0	20.5	87.5	13.0	146.5	21.7	282.5	41.9	391.4	58.1	673.9
Has never misused drugs(m)	1 927.0	13.1	764.4	5.2	390.8	2.7	2 506.7	17.1	12 150.6	82.9	14 657.3
Total persons aged 16–85 years	*2 303.0*	*14.4*	995.9	6.2	*819.8*	*5.1*	*3 197.8*	*20.0*	*12 817.5*	*80.0*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) Health risk factors present in the 12 months prior to interview. See Health risk factors in the Glossary.

(c) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(d) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(e) In the week prior to interview. Includes persons whose level of exercise was not stated. See Level of exercise in the Glossary.

(f) Includes persons who did no exercise.

(g) Total includes 'not stated'.

(h) There were insufficient respondents assessed as 'underweight' for them to be included as a separate category in this table.

(i) Daily and other smoker.

(j) Frequency of consumption in the 12 months prior to interview. Only persons who had at least 12 standard drinks in a year were asked about their consumption.

(k) Includes persons who did not drink in the 12 months prior to interview and those who have never had a drink.

(l) Misuse of drugs in the 12 months prior to interview. Refers to the use of illicit drugs and/or the misuse of prescription drugs. People must have misused the same drug more than 5 times in their lifetime. Only persons who had misused the same drug more than 5 times in their lifetime were asked about their consumption. See Misuse of drugs in the Glossary.

(m) Includes persons who did not misuse drugs in the 12 months prior to interview, those who have never misused drugs, or those who have misused the same drug 5 times or less in their lifetime.

9 12-MONTH MENTAL DISORDERS(a), by Selected physical and mental health characteristics

	Anxiety disorders		Affective disorders		Substance Use disorders		Any 12-month mental disorder(a)(b)		No 12-month mental disorder(c)		Total
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
MALES											
Physical condition(d)											
With physical condition	456.1	12.7	247.1	6.9	254.0	7.1	704.7	19.7	2 874.6	80.3	3 579.3
Without physical condition	404.6	9.3	173.0	4.0	302.3	6.9	695.4	15.9	3 675.1	84.1	4 370.6
Level of psychological distress(e)											
Low	317.6	5.3	86.2	1.4	283.4	4.8	611.6	10.3	5 349.4	89.7	5 961.1
Moderate	268.3	19.0	122.2	8.6	145.6	10.3	427.1	30.2	987.0	69.8	1 414.1
High	182.7	43.9	118.8	28.6	93.2	22.4	243.6	58.6	172.1	41.4	415.7
Very high	92.1	58.2	93.0	58.8	*34.2	*21.6	117.8	74.5	*40.3	25.5	158.1
Suicidal behaviour(f)											
Ideation(g)	*70.9	48.3	*63.0	42.9	*51.1	34.8	97.2	66.3	49.5	33.7	146.7
Plans	*17.4	51.8	*18.9	56.3	*14.6	*43.5	*24.5	73.0	*9.0	*27.0	33.5
Attempts	*13.8	*61.1	*13.0	*57.6	**12.0	*53.1	np	np	np	np	*22.6
No suicidal behaviours(h)	788.8	10.1	352.2	4.5	504.8	6.5	1 297.4	16.6	6 500.2	83.4	7 797.6
Disability status(i)											
Profound/Severe	*52.6	*27.3	*39.8	*20.7	*21.9	*11.4	*71.4	37.1	121.0	62.9	192.5
Moderate/Mild	101.6	20.8	*33.3	*6.8	*32.6	*6.7	134.4	27.5	354.3	72.5	488.7
Schooling/Employment restriction only	138.7	31.1	89.9	20.2	*45.6	*10.2	187.4	42.1	258.1	57.9	445.5
No disability/No specific limitations or restrictions	567.8	8.3	257.2	3.8	456.3	6.7	1 006.9	14.8	5 816.3	85.2	6 823.1
Days out of role(j)											
0 days	439.9	7.5	195.1	3.3	362.4	6.2	829.7	14.2	5 006.0	85.8	5 835.7
1 to 7 days	239.7	15.9	108.4	7.2	106.6	7.1	340.7	22.6	1 167.9	77.4	1 508.6
More than 7 days	179.7	30.2	116.6	19.6	87.4	14.7	228.3	38.4	365.8	61.6	594.1
Total males aged 16–85 years	*860.7*	*10.8*	*420.1*	*5.3*	*556.4*	*7.0*	*1 400.1*	*17.6*	*6 549.7*	*82.4*	*7 949.8*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

np not available for publication but included in totals where applicable, unless otherwise indicated

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A persons may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for a diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) A physical condition that a person had or received treatment for in the 12 months prior to interview. See Physical condition in the Glossary.

(e) As measured by the Kessler Psychological Distress Scale (K10), from which a score of 10 to 50 is produced. Total includes 'not stated'. See Psychological distress in the Glossary.

(f) Suicidal behaviour in the 12 months prior to interview. A person may have suicidal ideations, plans or attempts, therefore the components when added may not add to the total shown.

(g) Refers to the presence of serious thoughts about committing suicide.

(h) Includes 'not stated'.

(i) See Disability status in the Glossary.

(j) Persons who were unable to carry out or had to cut down on their usual activities in the 30 days prior to interview. Total includes 'not stated'. See Days out of role in the Glossary.

9 12-MONTH MENTAL DISORDERS(a), by Selected physical and mental health characteristics *continued*

	Anxiety disorders		*Affective disorders*		*Substance Use disorders*		*Any 12-month mental disorder(a)(b)*		*No 12-month mental disorder(c)*		*Total*
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
FEMALES											
Physical condition(d)											
With physical condition	966.2	21.7	394.8	8.9	149.6	3.4	1 171.9	26.3	3 277.9	73.7	4 449.8
Without physical condition	476.1	13.2	181.0	5.0	113.9	3.1	625.8	17.3	2 989.9	82.7	3 615.7
Level of psychological distress(e)											
Low	495.4	9.1	105.8	2.0	114.9	2.1	633.3	11.7	4 786.8	88.3	5 420.1
Moderate	456.0	26.6	163.1	9.5	73.0	4.3	573.4	33.5	1 138.4	66.5	1 711.8
High	308.2	45.2	179.2	26.3	50.2	7.4	383.3	56.2	298.5	43.8	681.8
Very high	182.8	72.8	127.7	50.8	*25.4	*10.1	207.8	82.7	*43.4	*17.3	251.1
Suicidal behaviour(f)											
Ideation(g)	133.1	60.1	104.0	47.0	37.8	17.1	166.6	75.3	54.7	24.7	221.3
Plans	*37.2	64.8	*41.2	71.7	*14.2	*24.8	46.0	80.1	*11.4	*19.9	57.5
Attempts	*33.7	78.9	*29.8	69.9	*13.2	*31.0	np	np	np	np	42.7
No suicidal behaviours(h)	1 304.2	16.6	470.7	6.0	225.6	2.9	1 626.1	20.7	6 210.4	79.3	7 836.5
Disability status(i)											
Profound/Severe	107.3	37.1	56.8	19.6	**11.1	**3.8	135.4	46.8	153.8	53.2	289.3
Moderate/Mild	164.0	28.0	96.1	16.4	*14.9	*2.5	211.2	36.0	375.0	64.0	586.2
Schooling/Employment restriction only	160.9	36.0	107.5	24.0	*41.2	*9.2	200.1	44.7	247.2	55.3	447.4
No disability/No specific limitations or restrictions	1 010.2	15.0	315.3	4.7	196.3	2.9	1 251.0	18.6	5 491.7	81.4	6 742.7
Days out of role(j)											
0 days	645.1	12.0	215.5	4.0	125.2	2.3	819.1	15.3	4 548.7	84.7	5 367.8
1 to 7 days	519.2	26.5	182.8	9.3	102.3	5.2	647.7	33.1	1 308.8	66.9	1 956.5
More than 7 days	278.0	37.7	177.4	24.0	*36.0	*4.9	330.9	44.8	407.4	55.2	738.2
Total females aged 16–85 years	*1 442.3*	*17.9*	*575.8*	*7.1*	*263.5*	*3.3*	*1 797.7*	*22.3*	*6 267.8*	*77.7*	*8 065.5*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

np not available for publication but included in totals where applicable, unless otherwise indicated

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A persons may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for a diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) A physical condition that a person had or received treatment for in the 12 months prior to interview. See Physical condition in the Glossary.

(e) As measured by the Kessler Psychological Distress Scale (K10), from which a score of 10 to 50 is produced. Total includes 'not stated'. See Psychological distress in the Glossary.

(f) Suicidal behaviour in the 12 months prior to interview. A person may have suicidal ideations, plans or attempts, therefore the components when added may not add to the total shown.

(g) Refers to the presence of serious thoughts about committing suicide.

(h) Includes 'not stated'.

(i) See Disability status in the Glossary.

(j) Persons who were unable to carry out or had to cut down on their usual activities in the 30 days prior to interview. Total includes 'not stated'. See Days out of role in the Glossary.

9 12-MONTH MENTAL DISORDERS(a), by Selected physical and mental health characteristics *continued*

	Anxiety disorders		*Affective disorders*		*Substance Use disorders*		*Any 12-month mental disorder(a)(b)*		*No 12-month mental disorder(c)*		*Total*
	'000	%	'000	%	'000	%	'000	%	'000	%	'000
PERSONS											
Physical condition(d)											
With physical condition	1 422.4	17.7	641.9	8.0	403.6	5.0	1 876.6	23.4	6 152.5	76.6	8 029.1
Without physical condition	880.7	11.0	354.0	4.4	416.2	5.2	1 321.2	16.5	6 665.0	83.5	7 986.2
Level of psychological distress(e)											
Low	813.0	7.1	192.0	1.7	398.3	3.5	1 245.0	10.9	10 136.2	89.1	11 381.2
Moderate	724.3	23.2	285.2	9.1	218.6	7.0	1 000.4	32.0	2 125.5	68.0	3 125.9
High	490.8	44.7	298.0	27.2	143.3	13.1	626.8	57.1	470.6	42.9	1 097.5
Very high	274.9	67.2	220.7	53.9	*59.6	*14.6	325.6	79.6	83.7	20.4	409.3
Suicidal behaviour(f)											
Ideation(g)	204.0	55.4	167.0	45.4	88.9	24.2	263.8	71.7	104.2	28.3	368.1
Plans	54.6	60.0	60.1	66.0	*28.8	31.7	70.5	77.5	*20.5	*22.5	91.0
Attempts	47.5	72.7	*42.9	65.7	*25.2	*38.6	61.5	94.2	**3.8	**5.8	65.3
No suicidal behaviours(h)	2 093.0	13.4	822.9	5.3	730.4	4.7	2 923.5	18.7	12 710.6	81.3	15 634.1
Disability status(i)											
Profound/Severe	159.9	33.2	96.5	20.0	*33.0	*6.8	206.9	42.9	274.9	57.1	481.7
Moderate/Mild	265.6	24.7	129.4	12.0	*47.5	*4.4	345.6	32.1	729.3	67.9	1 074.9
Schooling/Employment restriction only	299.6	33.6	197.4	22.1	86.8	9.7	387.5	43.4	505.3	56.6	892.9
No disability/No specific limitations or restrictions	1 578.0	11.6	572.5	4.2	652.6	4.8	2 257.9	16.6	11 307.9	83.4	13 565.8
Days out of role(j)											
0 days	1 085.1	9.7	410.7	3.7	487.6	4.4	1 648.9	14.7	9 554.7	85.3	11 203.6
1 to 7 days	758.9	21.9	291.2	8.4	208.9	6.0	988.5	28.5	2 476.7	71.5	3 465.2
More than 7 days	457.7	34.4	294.0	22.1	123.4	9.3	559.1	42.0	773.2	58.0	1 332.3
Total persons aged 16–85 years	*2 303.0*	*14.4*	*995.9*	*6.2*	*819.8*	*5.1*	*3 197.8*	*20.0*	*12 817.5*	*80.0*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A persons may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for a diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) A physical condition that a person had or received treatment for in the 12 months prior to interview. See Physical condition in the Glossary.

(e) As measured by the Kessler Psychological Distress Scale (K10), from which a score of 10 to 50 is produced. Total includes 'not stated'. See Psychological distress in the Glossary.

(f) Suicidal behaviour in the 12 months prior to interview. A person may have suicidal ideations, plans or attempts, therefore the components when added may not add to the total shown.

(g) Refers to the presence of serious thoughts about committing suicide.

(h) Includes 'not stated'.

(i) See Disability status in the Glossary.

(j) Persons who were unable to carry out or had to cut down on their usual activities in the 30 days prior to interview. Total includes 'not stated'. See Days out of role in the Glossary.

10 COMORBIDITY OF 12-MONTH MENTAL DISORDERS WITHOUT HIERARCHY(a), AND PHYSICAL CONDITIONS(b)

	Males		Females		Persons	
	'000	%	'000	%	'000	%
Mental disorders only						
Anxiety only	252.0	3.2	345.5	4.3	597.4	3.7
Affective only	*62.4	*0.8	68.4	0.8	130.8	0.8
Substance Use only	219.8	2.8	81.3	1.0	301.1	1.9
Anxiety and Affective only	*78.7	*1.0	98.1	1.2	176.8	1.1
Anxiety and Substance Use only	50.7	0.6	*16.7	*0.2	67.4	0.4
Affective and Substance Use only	**8.7	**0.1	—	—	**8.7	**0.1
Anxiety, Affective and Substance Use only	*23.2	*0.3	*15.8	*0.2	*39.0	*0.2
Total mental disorders only	695.4	8.7	625.8	7.8	1 321.2	8.2
Physical only	2 874.6	36.2	3 277.9	40.6	6 152.5	38.4
Mental disorders and physical conditions						
Anxiety and Physical only	284.1	3.6	673.3	8.3	957.5	6.0
Affective and Physical only	87.5	1.1	131.7	1.6	219.2	1.4
Substance Use and Physical only	122.2	1.5	57.3	0.7	179.6	1.1
Anxiety, Affective and Physical only	79.0	1.0	217.3	2.7	296.3	1.9
Anxiety, Substance Use and Physical only	*49.6	*0.6	*46.4	*0.6	96.0	0.6
Affective, Substance Use and Physical only	*38.8	*0.5	*16.6	*0.2	*55.5	*0.3
Anxiety, Affective, Substance Use and Physical	*43.4	*0.5	*29.2	*0.4	72.6	0.5
Total mental disorders and physical conditions	704.7	8.9	1 171.9	14.5	1 876.6	11.7
No mental disorder or physical condition	3 675.1	46.2	2 989.9	37.1	6 665.0	41.6
Total persons aged 16–85 years	*7 949.8*	*100.0*	*8 065.5*	*100.0*	*16 015.3*	*100.0*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

— nil or rounded to zero (including null cells)

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A physical condition that a person had or received treatment for in the 12 months prior to interview. See Physical condition in the Glossary.

11 COMORBIDITY OF 12-MONTH MENTAL DISORDERS WITHOUT HIERARCHY(a), AND PHYSICAL CONDITIONS(b)—by Age group (years)

	16–24		25–34		35–44		45–54		55–64	
	'000	%	'000	%	'000	%	'000	%	'000	%
Mental disorders only										
One disorder	267.4	10.5	223.0	7.9	155.6	5.1	118.5	4.1	35.2	1.5
Two or more disorders	161.9	6.4	122.6	4.4	118.9	3.9	*79.4	*2.8	*17.0	*0.7
Two or more disorders from the same group(c)	72.6	2.9	*66.9	*2.4	*38.1	*1.2	**29.0	**1.0	np	np
Two or more disorders from different groups(c)	89.4	3.5	55.7	2.0	80.8	2.6	*50.5	*1.8	np	np
Total mental disorders only	429.3	16.9	345.6	12.3	274.6	8.9	198.0	6.9	52.1	2.2
Physical conditions only	398.9	15.7	686.0	24.4	889.5	29.0	1 153.8	40.4	1 328.3	57.2
Mental disorders and physical conditions										
One disorder and physical conditions	126.7	5.0	162.2	5.8	260.1	8.5	231.3	8.1	125.2	5.4
Two or more disorders and physical conditions	115.1	4.5	190.5	6.8	181.8	5.9	184.4	6.5	139.3	6.0
Total mental disorders and physical conditions	241.8	9.5	352.8	12.5	441.9	14.4	415.7	14.5	264.6	11.4
No 12-month mental disorder or physical condition(d)	1 475.4	58.0	1 427.5	50.8	1 464.3	47.7	1 091.1	38.2	678.8	29.2
Total persons aged 16–85 years	*2 545.4*	*100.0*	*2 811.8*	*100.0*	*3 070.3*	*100.0*	*2 858.6*	*100.0*	*2 323.8*	*100.0*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

np not available for publication but included in totals where applicable, unless otherwise indicated

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A physical condition that a person had or received treatment for in the 12 months prior to interview. See Physical condition in the Glossary.

(c) These categories are mutually exclusive.

(d) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

11 COMORBIDITY OF 12-MONTH MENTAL DISORDERS WITHOUT HIERARCHY(a), AND PHYSICAL CONDITIONS(b)—by Age group (years) *continued*

	65–85		Total
	'000	%	'000
Mental disorders only			
One disorder	*13.3	*0.6	813.0
Two or more disorders	*8.3	*0.3	508.2
Two or more disorders from the same group(c)	np	np	216.3
Two or more disorders from different groups(c)	np	np	292.0
Total mental disorders only	*21.6	*0.9	1 321.2
Physical conditions only	1 696.0	70.5	6 152.5
Mental disorders and physical conditions			
One disorder and physical conditions	118.9	4.9	1 024.4
Two or more disorders and physical conditions	41.0	1.7	852.2
Total mental disorders and physical conditions	159.9	6.6	1 876.6
No 12-month mental disorder or physical condition(d)	528.0	21.9	6 665.0
Total persons aged 16–85 years	*2 405.5*	*100.0*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

np not available for publication but included in totals where applicable, unless otherwise indicated

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A physical condition that a person had or received treatment for in the 12 months prior to interview. See Physical condition in the Glossary.

(c) These categories are mutually exclusive.

(d) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

12 MENTAL DISORDERS, by Services used for mental health problems(a)

	Lifetime mental disorder with 12-month symptoms(b)		*Lifetime mental disorder with no 12-month symptoms(c)*		*No lifetime mental disorder(d)*		*Total*	
	'000	%	'000	%	'000	%	'000	%
MALES								
Services used for mental health problems(a)								
General Practitioner	252.3	18.0	114.5	4.7	*98.6	*2.4	465.3	5.9
Psychiatrist	*104.4	7.5	*26.8	*1.1	*24.3	*0.6	155.5	2.0
Psychologist	182.9	13.1	43.4	1.8	*24.6	*0.6	250.8	3.2
Other mental health professional(e)	96.5	6.9	**13.3	**0.5	**16.2	**0.4	126.0	1.6
Other health professional(f)	*66.5	*4.7	*34.5	*1.4	*21.4	*0.5	122.4	1.5
Services used for mental health problems(g)	385.4	27.5	170.5	7.0	144.1	3.5	699.9	8.8
No services used for mental health problems(h)	1 014.8	72.5	2 251.4	93.0	3 983.7	96.5	7 249.9	91.2
Total males aged 16–85 years	*1 400.1*	*100.0*	*2 421.9*	*100.0*	*4 127.8*	*100.0*	*7 949.8*	*100.0*
FEMALES								
Services used for mental health problems(a)								
General Practitioner	537.8	29.9	137.2	8.2	149.2	3.2	824.2	10.2
Psychiatrist	149.5	8.3	*32.2	*1.9	*30.0	*0.7	211.7	2.6
Psychologist	238.0	13.2	31.8	1.9	44.9	1.0	314.7	3.9
Other mental health professional(e)	150.7	8.4	48.5	2.9	*30.9	*0.7	230.0	2.9
Other health professional(f)	143.8	8.0	*53.1	*3.2	65.7	1.4	262.7	3.3
Services used for mental health problems(g)	731.0	40.7	205.3	12.3	264.5	5.7	1 200.9	14.9
No services used for mental health problems(h)	1 066.7	59.3	1 461.6	87.7	4 336.3	94.3	6 864.6	85.1
Total females aged 16–85 years	*1 797.7*	*100.0*	*1 666.9*	*100.0*	*4 600.9*	*100.0*	*8 065.5*	*100.0*
PERSONS								
Services used for rmental health problems(a)								
General Practitioner	790.0	24.7	251.7	6.2	247.8	2.8	1 289.5	8.1
Psychiatrist	253.9	7.9	59.0	1.4	54.3	0.6	367.2	2.3
Psychologist	420.9	13.2	75.2	1.8	69.5	0.8	565.6	3.5
Other mental health professional(e)	247.2	7.7	61.8	1.5	*47.1	*0.5	356.1	2.2
Other health professional(f)	210.3	6.6	87.6	2.1	87.1	1.0	385.0	2.4
Services used for mental health problems(g)	1 116.4	34.9	375.8	9.2	408.6	4.7	1 900.8	11.9
No services used for mental health problems(h)	2 081.5	65.1	3 713.0	90.8	8 320.1	95.3	14 114.5	88.1
Total persons aged 16–85 years	*3 197.8*	*100.0*	*4 088.8*	*100.0*	*8 728.7*	*100.0*	*16 015.3*	*100.0*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.

(b) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(c) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) Persons who did not meet criteria for diagnosis of a lifetime mental disorder. See paragraphs 30–31 of Explanatory Notes.

(e) Other mental health professional includes: mental health nurse and other professional providing specialist mental health services.

(f) Other health professional includes: medical specialist, other professional providing general services and complementary and alternative therapist.

(g) A person may have used more than one service for mental health. The components when added may therefore not add to the total shown. Also includes hospital admissions.

(h) Includes 'not stated'.

13 NUMBER OF 12-MONTH MENTAL DISORDERS WITHOUT HIERARCHY(a), by Persons who used services for mental health problems(b)

	General Practitioner	*Psychiatrist*	*Psychologist*	*Other(c)*	*Total who used services for mental health problems(d)*	*No services used for mental health problems(e)*	*Total persons*
	%	%	%	%	%	%	'000
One disorder							
Anxiety disorder	11.5	*3.3	6.2	6.8	21.2	78.8	1 203.7
Affective disorder	35.9	*4.5	16.4	*12.2	44.8	55.2	261.4
Substance Use disorder	*6.0	**2.1	**4.7	*4.3	*11.1	88.9	372.3
Total	13.8	*3.2	7.3	7.1	22.5	77.5	1 837.4
Two or more disorders							
Two or more disorders from the same group(f)	34.8	*14.0	17.1	14.2	43.4	56.6	548.1
Two or more disorders from different groups(f)	42.5	14.5	23.7	23.9	57.2	42.8	812.3
Total	39.4	14.3	21.0	19.9	51.7	48.3	1 360.4
Any 12-month mental disorder(a)	24.7	7.9	13.2	12.5	34.9	65.1	3 197.8
No 12-month mental disorder(g)	3.9	0.9	1.1	2.1	6.1	93.9	12 817.5
Total persons aged 16–85 years	*8.1*	*2.3*	*3.5*	*4.2*	*11.9*	*88.1*	*16 015.3*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.

(c) Other includes consultations with: mental health nurse, social worker, counsellor, medical specialist, and complementary and alternative therapist.

(d) A person may have used more than one service for mental health. Therefore, the components when added may not equal the total shown. Also includes hospital admissions.

(e) Includes 'not stated'.

(f) These categories are mutually exclusive.

(g) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (without hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

14 MENTAL DISORDERS, by Persons who used services for mental health problems(a)—Perceived need for help

	Any 12-month mental disorder(b)		*No 12-month mental disorder(c)*		*Total*	
	'000	%	'000	%	'000	%
MALES						
Information						
No need	105.2	27.3	193.1	61.4	298.3	42.6
Need fully met	151.2	39.2	85.9	27.3	237.1	33.9
Need partially met	*64.3	16.7	*19.2	*6.1	83.5	11.9
Need not met	*64.7	16.8	*16.3	*5.2	81.0	11.6
Medication						
No need	132.2	34.3	*144.8	46.0	276.9	39.6
Need fully met	219.3	56.9	149.8	47.6	369.0	52.7
Need partially met	np	np	np	np	*36.3	*5.2
Need not met	np	np	np	np	*13.7	*2.0
Counselling						
No need	*54.5	14.1	154.5	49.1	209.0	29.9
Need fully met	231.2	60.0	111.8	35.5	343.0	49.0
Need partially met	*69.0	*17.9	*33.7	*10.7	102.7	14.7
Need not met	*30.6	*7.9	*13.8	*4.4	44.4	6.3
Social intervention(d)						
No need	219.3	56.9	274.2	87.2	493.5	70.5
Need fully met	*58.7	*15.2	*12.8	*4.1	71.5	10.2
Need partially met	*20.0	*5.2	**9.7	**3.1	*29.7	*4.2
Need not met	*87.4	22.7	*17.1	*5.4	*104.5	14.9
Skills training(e)						
No need	240.9	62.5	246.7	78.4	487.6	69.7
Need fully met	68.4	17.7	*42.0	*13.4	110.4	15.8
Need partially met	*19.5	*5.1	**7.6	**2.4	*27.1	*3.9
Need not met	*55.5	*14.4	*17.4	*5.5	*72.9	*10.4
Total males aged 16–85 years(f)	*385.4*	*100.0*	*314.6*	*100.0*	699.9	*100.0*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

np not available for publication but included in totals where applicable, unless otherwise indicated

(a) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.

(b) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) Includes help to sort out practical issues, such as housing or money problems, or help to meet people for support or company.

(e) Includes help to improve ability to work, to care for self, or to use time effectively.

(f) Total includes 'not stated'.

14 MENTAL DISORDERS, by Persons who used services for mental health problems(a)—Perceived need for help *continued*

	Any 12-month mental disorder(b)		*No 12-month mental disorder(c)*		*Total*	
	'000	%	'000	%	'000	%
FEMALES						
Information						
No need	276.4	37.8	268.9	57.2	545.3	45.4
Need fully met	263.9	36.1	127.7	27.2	391.6	32.6
Need partially met	90.7	12.4	*29.1	*6.2	119.7	10.0
Need not met	98.9	13.5	42.2	9.0	141.1	11.7
Medication						
No need	227.3	31.1	204.5	43.5	431.8	36.0
Need fully met	434.1	59.4	234.4	49.9	668.5	55.7
Need partially met	np	np	np	np	81.3	6.8
Need not met	np	np	np	np	*17.7	*1.5
Counselling						
No need	159.2	21.8	116.8	24.9	276.0	23.0
Need fully met	384.6	52.6	272.9	58.1	657.5	54.8
Need partially met	113.2	15.5	41.9	8.9	155.1	12.9
Need not met	74.0	10.1	*38.4	8.2	112.4	9.4
Social intervention(d)						
No need	513.0	70.2	371.0	79.0	884.0	73.6
Need fully met	61.2	8.4	*35.8	*7.6	97.1	8.1
Need partially met	23.3	3.2	**15.1	**3.2	*38.5	*3.2
Need not met	132.7	18.1	47.9	10.2	180.5	15.0
Skills training(e)						
No need	516.0	70.6	367.3	78.2	883.4	73.6
Need fully met	89.0	12.2	*57.0	*12.1	146.0	12.2
Need partially met	*43.9	*6.0	*7.4	*1.6	*51.2	*4.3
Need not met	81.2	11.1	*37.4	*8.0	118.6	9.9
Total females aged 16–85 years(f)	*731.0*	*100.0*	*469.9*	*100.0*	*1 200.9*	*100.0*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

np not available for publication but included in totals where applicable, unless otherwise indicated

(a) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.

(b) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) Includes help to sort out practical issues, such as housing or money problems, or help to meet people for support or company.

(e) Includes help to improve ability to work, to care for self, or to use time effectively.

(f) Total includes 'not stated'.

14 MENTAL DISORDERS, by Persons who used services for mental health problems(a)—Perceived need for help *continued*

	Any 12-month mental disorder(b)		*No 12-month mental disorder(c)*		*Total*	
	'000	%	'000	%	'000	%
PERSONS						
Information						
No need	381.6	34.2	462.0	58.9	843.6	44.4
Need fully met	415.1	37.2	213.6	27.2	628.7	33.1
Need partially met	155.0	13.9	*48.3	*6.2	203.2	10.7
Need not met	163.6	14.7	58.5	7.5	222.1	11.7
Medication						
No need	359.5	32.2	349.2	44.5	708.7	37.3
Need fully met	653.4	58.5	384.2	49.0	1 037.5	54.6
Need partially met	81.5	7.3	*36.1	4.6	117.6	6.2
Need not met	*18.6	*1.7	*12.8	*1.6	*31.4	*1.7
Counselling						
No need	213.7	19.1	271.3	34.6	485.0	25.5
Need fully met	615.8	55.2	384.6	49.0	1 000.5	52.6
Need partially met	182.2	16.3	75.6	9.6	257.8	13.6
Need not met	104.6	9.4	52.1	6.6	156.8	8.2
Social intervention(d)						
No need	732.2	65.6	645.3	82.3	1 377.5	72.5
Need fully met	120.0	10.7	*48.6	*6.2	168.5	8.9
Need partially met	43.3	3.9	**24.8	**3.2	*68.1	*3.6
Need not met	220.1	19.7	65.0	8.3	285.0	15.0
Skills training(e)						
No need	756.9	67.8	614.1	78.3	1 371.0	72.1
Need fully met	157.4	14.1	*99.0	12.6	256.4	13.5
Need partially met	*63.4	*5.7	*15.0	*1.9	78.4	4.1
Need not met	136.7	12.2	54.8	7.0	191.5	10.1
Total persons aged 16–85 years(f)	*1 116.4*	*100.0*	*784.4*	*100.0*	*1 900.8*	*100.0*

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.

(b) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(c) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(d) Includes help to sort out practical issues, such as housing or money problems, or help to meet people for support or company.

(e) Includes help to improve ability to work, to care for self, or to use time effectively.

(f) Total includes 'not stated'.

15 12-MONTH MENTAL DISORDERS(a), by Persons who did not use services for mental health problems(b)—Perceived need for help

	Males		Females		Persons	
	'000	%	'000	%	'000	%
Information						
No need	967.5	95.3	997.2	93.5	1 964.7	94.4
Need not met	*47.2	*4.7	*69.5	*6.5	116.7	5.6
Medication						
No need	984.6	97.0	1 053.2	98.7	2 037.8	97.9
Need not met	*30.1	*3.0	*13.5	*1.3	43.6	2.1
Counselling						
No need	939.9	92.6	928.0	87.0	1 867.9	89.7
Need not met	74.9	7.4	138.7	13.0	213.6	10.3
Social intervention(c)						
No need	951.2	93.7	1 011.1	94.8	1 962.3	94.3
Need not met	*63.6	*6.3	55.6	5.2	119.2	5.7
Skills training(d)						
No need	972.2	95.8	1 034.0	96.9	2 006.1	96.4
Need not met	*42.6	*4.2	*32.7	*3.1	75.3	3.6
Total persons aged 16–85 years	*1 014.8*	*100.0*	*1 066.7*	*100.0*	*2 081.5*	*100.0*

* estimate has a relative standard error of 25% to 50% and should be used with caution

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) In the 12 months prior to interview. See Services used for mental health problems in the Glossary.

(c) Includes help to sort out practical issues, such as housing or money problems, or help to meet people for support or company.

(d) Includes help to improve ability to work, to care for self, or to use time effectively.

EXPLANATORY NOTES

INTRODUCTION

1 This publication presents a summary of results from the National Survey of Mental Health and Wellbeing (SMHWB), which was conducted throughout Australia from August to December 2007. This is the second mental health and wellbeing survey, with the previous survey conducted in 1997. Funding for this survey was provided by the Australian Government Department of Health and Ageing (DoHA).

2 The survey was based on a widely-used international survey instrument, developed by the World Health Organization (WHO) for use by participants in the World Mental Health Survey Initiative. The Initiative is a global study aimed at monitoring mental and addictive disorders. It aims to collect accurate information about the prevalence of mental, substance use and behavioural disorders. It measures the severity of these disorders and helps to determine the burden on families, carers and the community. It also assesses who is treated, who remains untreated and the barriers to treatment. The survey has been run in 32 countries, representing all regions of the world.

3 The survey used the World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH–CIDI 3.0). While most of the survey was based on the international survey modules, some modules, such as Health Service Utilisation, have been tailored to fit the Australian context. The adapted modules have been designed in consultation with subject matter experts from academic institutions and staff from the Mental Health Reform Branch of DoHA. Where possible, adapted modules used existing ABS questions. Extensive testing was conducted by the ABS to ensure that the survey would collect objective and high quality data.

4 Due to the high level of sensitivity of the survey's content, this survey was conducted on a voluntary basis.

5 The 2007 SMHWB collected information about:

- lifetime and 12-month prevalence of selected mental disorders;
- level of impairment for these disorders;
- physical conditions;
- health services used for mental health problems, such as consultations with health practitioners or visits to hospital;
- social networks and caregiving; and
- demographic and socio-economic characteristics.

6 A full list of the data items from the 2007 SMHWB will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008. The Users' Guide will also assist with evaluation and interpretation of the survey results.

SCOPE AND COVERAGE OF THE SURVEY

7 The scope of the survey is people aged 16–85 years, who were usual residents of private dwellings in Australia, excluding very remote areas. Private dwellings are houses, flats, home units and any other structures used as private places of residence at the time of the survey. People usually resident in non-private dwellings, such as hotels, motels, hostels, hospitals, nursing homes, and short-stay caravan parks were not in scope. Usual residents are those who usually live in a particular dwelling and regard it as their own or main home.

SCOPE AND COVERAGE OF THE SURVEY *continued*

8 Scope inclusions:

- Members of the Australian permanent defence forces; and
- Overseas visitors who have been working or studying in Australia for the 12 months or more prior to the survey interview, or intended to do so.

9 Scope exclusions:

- Non-Australian diplomats, non-Australian diplomatic staff and non-Australian members of their household;
- Members of non-Australian defence forces stationed in Australia and their dependents; and
- Overseas visitors (except for those mentioned in paragraph 8).

10 Proxy and foreign language interviews were not conducted. Therefore, people who were unable to answer for themselves were not included in the survey coverage but are represented in statistical outputs through inclusion in population benchmarks used for weighting.

11 The projected Australian adult resident population aged 16 years and over, as at 31 October 2007 (excluding people living in non-private dwellings and very remote areas of Australia), was 16,213,900, of which, 16,015,300 were aged 16–85 years.

12 Population benchmarks are projections of the most recently released quarterly Estimated Resident Population (ERP) data, in this case, 30 June 2007. For information on the methodology used to produce the ERP see Australian Demographic Statistics Quarterly *(cat. no. 3101.0)*. To create the population benchmarks for the 2007 SMHWB, the most recently released quarterly ERP estimates were projected forward two quarters past the period for which they were required. The projection was based on the historical pattern of each population component - births, deaths, interstate migration and overseas migration. By projecting two quarters past that needed for the current population benchmarks, demographic changes are smoothed in, thereby making them less noticeable in the population benchmarks.

SAMPLE DESIGN

13 The 2007 SMHWB was designed to provide reliable estimates at the national level. The survey was not designed to provide state/territory level data, however, some data may be available (on request) for the states with larger populations, eg New South Wales. Users should exercise caution when using estimates at this level due to high sampling errors. RSEs for all estimates in this publication are available free-of-charge on the ABS website <www.abs.gov.au>, released in spreadsheet format as an attachment to this publication. As a guide, the population and RSE estimates for Table 2 have also been included in the Technical Note.

14 Dwellings included in the survey in each state and territory were selected at random using a stratified, multistage area sample. This sample included only private dwellings from the geographic areas covered by the survey. Sample was allocated to states and territories roughly in proportion to their respective population size. The expected number of fully-responding households was 11,000.

15 To improve the reliability of estimates for younger (16–24 years) and older (65–85 years) persons, these age groups were given a higher chance of selection in the household person selection process. That is, if you were a household member within the younger or older age group, you were more likely to be selected for interview than other household members.

16 There were 17,352 private dwellings initially selected for the survey. This sample was expected to deliver the desired fully-responding sample, based on an expected response rate of 75% and sample loss. The sample was reduced to 14,805 dwellings due to the loss of households with no residents in scope for the survey and where dwellings proved to be vacant, under construction or derelict.

EXPLANATORY NOTES *continued*

SAMPLE DESIGN *continued*

17 Of the eligible dwellings selected, there were 8,841 fully-responding households, representing a 60% response rate at the national level. Interviews took, on average, around 90 minutes to complete.

18 Some survey respondents provided most of the required information, but were unable or unwilling to provide a response to certain data items. The records for these persons were retained in the sample and the missing values were recorded as 'don't know' or 'not stated'. No attempt was made to deduce or impute for these missing values.

19 Due to the lower than expected response rate, the ABS undertook extensive non-response analyses as part of the validation and estimation process. A Non-Response Follow-Up Study (NRFUS) was conducted from January to February 2008. The aim of the NRFUS was to provide a qualitative assessment of the likelihood of non-response bias associated with the 2007 SMHWB estimates.

20 The Non-Response Follow-Up Study (NRFUS) consisted of a sample of non-respondents from the 2007 SMHWB in Sydney and Perth and was based on reduced survey content. It had a response rate of 39%, yielding information on 151 non-respondents. Further information on the non-response analyses is provided in paragraphs 63–72.

DATA COLLECTION

21 A group of ABS officers were trained in the use of the Composite International Diagnostic Interview (CIDI) by staff from the CIDI Training and Reference Center, University of Michigan. These officers then provided training to experienced ABS interviewers, as part of a comprehensive four-day training program, which also included sensitivity training and field procedures.

22 Trained ABS interviewers conducted personal interviews at selected private dwellings from August to December 2007. Interviews were conducted using a Computer-Assisted Interviewing (CAI) questionnaire. CAI involves the use of a notebook computer to record, store, manipulate and transmit the data collected during interviews.

23 One person in the household, aged 18 years or over, was selected to provide basic information, such as age and sex, for all household members. This person, or an elected household spokesperson, also answered some financial and housing items, such as income and tenure, on behalf of other household members.

24 Once basic details had been recorded for all in-scope household members, one person aged 16–85 years was randomly selected to complete a personal interview. Younger and older persons were given a higher chance of selection. See paragraph 15 and paragraph 50 for more information.

SURVEY CONTENT

25 Broadly, the 2007 SMHWB collected information on: selected mental disorders; the use of health services and medication for mental health problems; physical conditions; disability; social networks and caregiving; demographic; and socio-economic characteristics.

26 A Survey Reference Group, comprising experts and key stakeholders in the field of mental health, provided the ABS with advice on the survey content, including the most appropriate topics for collection, and associated concepts and definitions. They also provided advice on issues that arose during field tests and the most suitable survey outputs. Group members included representatives from government departments, universities, health research organisations, carers organisations and consumer groups.

SELECTED MENTAL DISORDERS

27 The 2007 SMHWB collected information on selected mental disorders, which were considered to have the highest rates of prevalence in the population and that were able to be identified in an interviewer based household survey. These mental disorders were:

- *Anxiety disorders*
  - Panic Disorder
  - Agoraphobia
  - Social Phobia
  - Generalised Anxiety Disorder (GAD)
  - Obsessive-Compulsive Disorder (OCD)
  - Post-Traumatic Stress Disorder (PTSD)
- *Affective (mood) disorders*
  - Depressive Episode
  - Dysthymia
  - Bipolar Affective Disorder
- *Substance Use disorders*
  - Alcohol Harmful Use
  - Alcohol Dependence
  - Drug Use Disorders

COMPOSITE INTERNATIONAL DIAGNOSTIC INTERVIEW (CIDI)

28 Measuring mental health in the community through household surveys is complex, as mental disorders are usually determined through detailed clinical assessment. To estimate the prevalence of specific mental disorders, the 2007 National Survey of Mental Health and Wellbeing used the World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH–CIDI 3.0). The WMH–CIDI 3.0 was chosen because it:

- provides a fully structured diagnostic interview;
- can be administered by lay interviewers;
- is widely used in epidemiological surveys;
- is supported by the World Health Organization (WHO); and
- provides comparability with similar surveys conducted worldwide.

29 The WMH–CIDI 3.0 provides an assessment of mental disorders based on the definitions and criteria of two classification systems: the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (DSM–IV); and the WHO INTERNATIONAL CLASSIFICATION OF DISEASES, TENTH REVISION (ICD–10). Each classification system lists sets of criteria that are necessary for diagnosis. The criteria specify the nature and number of symptoms required; the level of distress or impairment required; and the exclusion of cases where symptoms can be directly attributed to general medical conditions, such as a physical injury, or to substances, such as alcohol.

30 The 2007 SMHWB was designed to provide lifetime prevalence estimates for mental disorders. Respondents were asked about experiences throughout their lifetime. In this survey, 12-month diagnoses were derived based on lifetime diagnosis and the presence of symptoms of that disorder in the 12 months prior to the survey interview. The full diagnostic criteria were not assessed within the 12 month time-frame. This differs from the 1997 survey where diagnostic criteria were assessed solely on respondents' experiences in the 12 months prior to the survey interview. More information on the comparison between the 1997 and 2007 surveys is provided in Appendix 2.

31 Diagnostic algorithms are specified in accordance with the DSM–IV and ICD–10 classification systems. As not all modules contained in the WMH–CIDI 3.0 were operationalised for the 2007 SMHWB, it was necessary to tailor the diagnostic algorithms to fit the Australian context. Data in this publication are presented using the ICD–10 classification system. Prevalence rates are presented with hierarchy rules applied, for more information see paragraphs 34–37. More information on the WMH–CIDI 3.0 diagnostic assessment criteria according to the ICD–10 is provided in Appendix 1.

EXPLANATORY NOTES *continued*

COMPOSITE INTERNATIONAL DIAGNOSTIC INTERVIEW (CIDI) continued

32 A screener was introduced to the WMH–CIDI 3.0 to try to alleviate the effects of learned responses, such as providing a particular response to avoid further questions. The module included a series of introductory questions about the respondent's general health, followed by diagnostic screening questions for the primary disorders assessed in the survey, eg Depressive Episode. This screening method has been shown to increase the accuracy of diagnostic assessments, by reducing the effects of learned responses due to respondent fatigue. Other non-core disorders, such as Obsessive-Compulsive Disorder (OCD), were screened at the beginning of the individual module.

33 The WMH–CIDI 3.0 was also used to collect information on:

- the onset of symptoms and mental disorders;
- the courses of mental disorders, that is, the varying degrees to which the symptoms of mental disorders present themselves, including: episodic (eg depression), clusters of attacks (eg panic disorder), and fairly persistent dispositions (eg phobias);
- the impact of mental disorders on home management, work life, relationships and social life; and
- treatment seeking and access to helpful treatment.

HIERARCHY RULES

34 The classification system for some of the ICD–10 disorders contain diagnostic exclusion rules so that a person, despite having symptoms that meet diagnostic criteria, will not meet criteria for particular disorders because the symptoms are believed to be accounted for by the presence of another disorder. In these cases, one disorder takes precedence over another. These exclusion rules are built into the diagnostic algorithms.

35 The developers of WMH–CIDI 3.0 established two versions of the diagnoses in the algorithms for a number of the mental disorders: a 'with hierarchy' version and a 'without hierarchy' version. The 'with hierarchy' version specifies the full diagnostic criteria consistent with the ICD–10 classification system (ie the exclusion criteria are enforced). The 'without hierarchy' version applies all diagnostic criteria except the criteria specifying the hierarchical relationship with other disorders. More information on the WMH–CIDI 3.0 diagnostic assessment criteria according to the ICD–10 is provided in Appendix 1.

36 One example of a disorder specified with and without hierarchy is Alcohol Harmful Use. ICD–10 states that in order for diagnostic criteria for Harmful Use to be met, criteria cannot be met for Dependence on the same substance during the same time period. Therefore, the 'with hierarchy' version of Alcohol Harmful Use will exclude cases where Alcohol Dependence has been established for the same time period. The 'without hierarchy' version includes all cases of Alcohol Harmful Use regardless of coexisting Alcohol Dependence. Note that a person can meet criteria for Alcohol Dependence and the hierarchical version of Alcohol Harmful Use if there is no overlap in time between the two disorders.

37 Throughout this publication, the ICD–10 prevalence rates are presented with the hierarchy rules applied, except for the comorbidity data, which are presented without hierarchy. The ICD–10 disorders specified with and without hierarchy in this publication are: Generalised Anxiety Disorder; Hypomania; Mild, Moderate and Severe Depressive Episode; Dysthymia; and the Harmful Use of Alcohol, Cannabis, Sedatives, Stimulants and Opioids.

COMORBIDITY

38 Comorbidity is the co-occurrence of more than one disease and/or disorder in an individual. Mental disorders may co-occur for a variety of reasons, and Substance Use disorders frequently co-occur (CDHAC, 2001). A person with co-occurring diseases or disorders is likely to experience more severe and chronic medical, social and emotional problems than if they had a single disease or disorder. People with comorbid conditions are also more vulnerable to alcohol and drug relapses, and relapse of mental health problems. Higher numbers of disorders are also associated with greater impairment, higher risk of suicidal behaviour and greater use of health services.

39 In this publication, information is presented on both the comorbidity of mental disorder groups and physical conditions (Table 10), and the co-occurrence of more than one mental disorder with physical conditions (Table 11). As people with comorbid disorders generally require higher levels of support than people with only one disorder, Table 13 presents the number of 12-month mental disorders by services used for mental health problems.

40 All comorbidity tables in this publication are presented without the WMH–CIDI 3.0 hierarchy rules applied to provide a more complete picture of the combinations of symptoms and disorders experienced by individuals. For more information on hierarchy rules see paragraphs 34–37 and Appendix 1.

CHRONIC CONDITIONS

41 Questions regarding chronic conditions have been adapted from a module in the WMH–CIDI 3.0, to enable some cross-country comparisons of physical conditions. The resulting module comprised: a checklist of the National Health Priority Area physical conditions, such as asthma, heart condition and diabetes and the presence of a restricted set of physical conditions *only* if they had lasted for six months or more (for a complete list refer to Physical conditions in the Glossary). The module also included: questions on whether the conditions occurred in the 12 months prior to the survey interview and the age of onset of these conditions; a standard set of ABS questions on role impairment (ABS disability module); and questions to determine hypochondriasis/somatisation.

42 Respondents were asked a series of questions relating to health risk factors, specifically those related to lifestyle behaviours. The 2007 SMHWB collected information on smoking, level of exercise, and self-reported height and weight measurements to calculate a Body Mass Index (BMI). This was the first time that questions on physical activity and body mass were included in the SMHWB.

THE KESSLER PSYCHOLOGICAL DISTRESS SCALE (K10)

43 The Kessler Psychological Distress Scale (K10) is a widely used screening instrument, which gives a simple measure of psychological distress. It is not a diagnostic tool, but is an indicator of psychological distress. The K10 is based on a person's emotional state during the 30 days prior to the survey interview. Respondents were asked a series of 10 questions and for each item, they provided a five-level response scale, based on the amount of time they reported experiencing the particular problem. The response scale of '1 to 5' corresponds to a scale that ranges from 'none of the time' to 'all of the time'. Scores for the 10 questions are put together, with a minimum possible score of 10 and a maximum possible score of 50. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress.

FUNCTIONING

44 A series of measures were used to determine the extent to which health problems affected the respondent's life and activities during the 30 days prior to the survey. This module included questions from the World Health Organization's Disability Assessment Schedule (WHODAS) and the (Australian) Assessment of Quality of Life (AQoL) instrument. Two questions on 30–day functioning ('Days out of role'), from the 1997 SMHWB were also included in this module.

HEALTH SERVICE UTILISATION

45 Respondents were asked about their health service utilisation for mental health problems and/or physical conditions. Health service utilisation covered admissions to hospital and consultations with a range of health professionals. Respondents were also asked about the number and length of admissions to hospital; the number of consultations with health professionals for mental health problems; and the method of payment for consultations.

46 Further information on the survey modules will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008.

DATA PROCESSING

47 A combination of clerical and computer-based systems were used to process data from the 2007 SMHWB. The content of the data file was checked to identify unusual values which may have significantly altered estimates and also to assess illogical relationships not previously identified by edits. Where necessary, the ABS sought the advice of subject matter experts from academic institutions in order to determine the appropriate treatment.

48 The survey contained a number of open-ended questions, for which there were no predetermined responses. These responses were office coded. Some of the open-ended questions formed part of the assessment to determine whether a respondent met the criteria for diagnosis of a mental health disorder. These open-ended questions were designed to probe causes of a particular episode or symptom. Responses were then used to eliminate cases where there was a clear physical cause. As part of the processing procedures set out for the WMH–CIDI 3.0, responses provided to the open-ended questions are required to be interpreted by a suitably qualified person. The technical assistance for coding of the open-ended diagnostic-related questions for the 2007 SMHWB was provided by the University of New South Wales. Further information on data processing will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008.

WEIGHTING, BENCHMARKING AND ESTIMATION

WEIGHTING

49 Weighting is the process of adjusting results from a sample survey to infer results for the total in-scope population. To do this, a 'weight' is allocated to each sample unit corresponding to the level at which population statistics are produced, eg household and person level. The weight can be considered an indication of how many population units are represented by the sample unit. For the 2007 SMHWB, separate person and household weights were developed.

SELECTION WEIGHTS

50 The first step in calculating weights for each person or household is to assign an initial weight, which is equal to the inverse of the probability of being selected in the survey. For the 2007 SMHWB, due to the length of the interview, only one in-scope person was selected per household. Thus the initial person weight was derived from the initial household weight according to the total number of in-scope persons in the household and the differential probability of selection by age used to obtain more younger (16–24 years) and older (65–85 years) persons in the sample.

WEIGHTING continued

51 Apart from the 8,841 fully-responding households, basic information was obtained from the survey's household form for an additional 1,476 households and their occupants. This information was provided by a household member aged 18 years or over. In the case of these 1,476 households, the selected person did not complete the main questionnaire (eg they were unavailable or refused to participate). The information provided by these additional 1,476 households was analysed to determine if an adjustment to initial selection weights could be made as a means of correcting for non-response. However, no explicit adjustment was made to the weighting due to the negligible impact on survey estimates.

BENCHMARKING

52 The person and household weights were separately calibrated to independent estimates of the population of interest, referred to as 'benchmarks'. Weights calibrated against population benchmarks ensure that the survey estimates conform to the independently estimated distributions of the population rather than to the distribution within the sample itself. Calibration to population benchmarks helps to compensate for over- or under-enumeration of particular categories which may occur due to either the random nature of sampling or non-response. This process can reduce the sampling error of estimates and may reduce the level of non-response bias.

53 A standard approach in ABS household surveys is to calibrate to population benchmarks by state, part of state, age and sex. In terms of the effectiveness of 'correcting' for potential non-response bias, it is assumed that the characteristics being measured by the survey for the responding population are similar to the non-responding population within weighting classes, as determined by the benchmarking strategy. Where this assumption does not hold, biased estimates may result.

54 Given the relatively low response rate for the 2007 SMHWB, extensive analysis was done to ascertain whether further benchmark variables, in addition to geography, age, and sex, should be incorporated into the weighting strategy. Analysis showed that the standard weighting approach did not adequately compensate for differential undercoverage in the 2007 SMHWB sample for variables such as educational attainment, household composition, and labour force status, when compared to other ABS surveys and the *2006 Census of Population and Housing*. As these variables were considered to have possible association with mental health characteristics, additional benchmarks were incorporated into the weighting strategy.

55 Initial person weights were simultaneously calibrated to the following population benchmarks:

- state by part of state by age by sex; and
- state by household composition; and
- state by educational attainment; and
- state by labour force status.

56 The state by part of state by age and sex benchmarks were obtained from demographic projections of the resident population, aged 16–85 years who were living in private dwellings, excluding very remote areas of Australia, at 31 October 2007. The projected resident population was based on the *2006 Census of Population and Housing* using 30 June 2007 as the latest available Estimated Resident Population base. Therefore, the SMHWB estimates do not (and are not intended to) match estimates for the total Australian resident population (which include persons and households living in non-private dwellings, such as hotels and boarding houses, and in very remote parts of Australia) obtained from other sources.

EXPLANATORY NOTES *continued*

BENCHMARKING continued

57 The remaining benchmarks were obtained from other ABS survey data. These benchmarks are considered 'pseudo-benchmarks' as they are not demographic counts and they have a non-negligible level of sample error associated with them. The *2007 Survey of Education and Work* (persons aged 16–64 years) was used to provide a pseudo-benchmark for educational attainment. The monthly *Labour Force Survey* (September to December 2007) provided the pseudo-benchmark for labour force status, as well as the resident population living in households by household composition. The pseudo-benchmarks were aligned to the projected resident population aged 16–85 years, who were living in private dwellings in each state and territory, excluding very remote areas of Australia, at 31 October 2007. The pseudo-benchmark of household composition was also aligned to the projected household composition population counts of households. The sample error associated with these pseudo-benchmarks was incorporated into the standard error estimation.

58 Household weights were derived by separately calibrating initial household selection weights to the projected household composition population counts of households containing persons aged 16–85 years, who were living in private dwellings in each state and territory, excluding very remote areas of Australia, at 31 October 2007.

ESTIMATION

59 Estimates of counts of persons are obtained by summing person weights of persons with the characteristic of interest. Similarly, household estimates are produced using household level weights. The majority of estimates contained in this publication are based on benchmarked person weights.

60 Further information on weighting, benchmarking and estimation will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008.

RELIABILITY OF ESTIMATES

61 All sample surveys are subject to error which can be broadly categorised as either sampling error or non-sampling error. Sampling error occurs because only a small proportion of the total population is used to produce estimates that represent the whole population. Sampling error can be reliably measured as it is calculated based on the scientific methods used to design surveys. Non-sampling error may occur in any data collection, whether it is based on a sample or a full count (eg Census). Non-sampling error may occur at any stage throughout the survey process. For example, persons selected for the survey may not respond (non-response); survey questions may not be clearly understood by the respondent; responses may be incorrectly recorded by interviewers; or there may be errors in coding or processing survey data.

SAMPLING ERROR

62 Sampling error is the expected random difference that could occur between the published estimates, derived from using a sample of persons, and the value that would have been produced if all persons in scope of the survey had been enumerated.
A measure of the sampling error for a given sample estimate is provided by the standard error, which may be expressed as a percentage of the estimate (relative standard error). For more information refer to the Technical Note. In this publication estimates with relative standard errors (RSEs) of 25% to 50% are preceded by an asterisk (eg *3.4) to indicate that the estimate should be used with caution. Estimates with RSEs over 50% are indicated by a double asterisk (eg **0.6) and should be considered unreliable for most purposes.

NON-RESPONSE AND NON-SAMPLING ERROR

63 Non-response may occur when people cannot or will not cooperate, or cannot be contacted. Unit and item non-response by persons/households selected in the survey can affect both sampling and non-sampling error. The loss of information on persons and/or households (unit non-response) and on particular questions (item non-response) reduces the effective sample and increases sampling error.

64 Non-response can also introduce non-sampling error by creating a biased sample. The magnitude of any non-response bias depends upon the level of non-response and the extent of the difference between the characteristics of those people who responded to the survey and those who did not within population subgroups as determined by the weighting strategy. See paragraphs 49–58.

65 To reduce the level and impact of non-response, the following methods were adopted in this survey:

- face-to-face interviews with respondents;
- follow-up of respondents if there was initially no response;
- ensuring the weighted file is representative of the population by aligning the estimates with population benchmarks;
- use of pseudo-benchmarks for educational attainment, labour force status and household composition; and
- a Non-Response Follow-Up Study (NRFUS) was conducted to gain qualitative assessment of possible bias.

66 Every effort was made to minimise other non-sampling error by careful design and testing of questionnaires, intensive training of interviewers, and extensive editing and quality control procedures at all stages of data processing.

67 An advantage of the Computer-Assisted Interview (CAI) used for this survey is that it potentially reduces non-sampling errors by enabling edits to be applied as the data are being collected. These edits allow the interviewer to query respondents and resolve issues during the interview. Sequencing of questions is also automated so that respondents are asked only relevant questions and only in the appropriate sequence, eliminating interviewer sequencing errors.

68 Of the eligible dwellings selected in the 2007 SMHWB, 5,851 (40%) did not respond fully or adequately. Reflecting the sensitive topic for the survey, the average expected interview length (of around 90 minutes) combined with the voluntary nature of the survey, almost two-thirds (61%) of these dwellings were full refusals. Household details were provided by more than a quarter (27%) of these dwellings, but then the selected person did not complete the main questionnaire. The remainder of these dwellings (12%) provided partial or incomplete information. As the level of non-response for this survey was significant, extensive non-response analyses to assess the reliability of the survey estimates were undertaken.

EXPLANATORY NOTES *continued*

NON-RESPONSE AND NON-SAMPLING ERROR *continued*

69 A purposive small sample/short-form intensive Non-Response Follow-Up Study (NRFUS) was developed for use with non-respondents in Sydney and Perth. The NRFUS was conducted from January to February 2008 and achieved a response rate of 39%. It used a short-form questionnaire containing demographic questions and the Kessler Psychological Distress Scale (K10). The short-form approach used for the NRFUS precluded the use of the full diagnostic assessment modules. As a minor proxy of the mental health questions, the K10 was included for qualitative assessment against the 2007 SMHWB. The aim of the NRFUS was to provide a qualitative assessment of the likelihood of non-response bias. Respondents to the NRFUS were compared to people who responded fully to the 2007 SMHWB by a number of demographic variables, such as age, sex and marital status. The analysis undertaken suggests that there may be differences in the direction and magnitude of potential non-response bias between various geographical, age and sex domains that the weighting strategy does not correct for. The magnitude of potential non-response bias appears to be small at the aggregate level. The results of the study suggest there is possible underestimation in the prevalence of mental health conditions in Perth, for men, and for young persons. However, given the small size and purposive nature of the NRFUS sample, the results of the study were not explicitly incorporated into the 2007 SMHWB weighting strategy.

70 Analysis was also undertaken to compare the characteristics of respondents to the 2007 SMHWB with a number of ABS collections, including: the *2006 Census of Population and Housing*, *2004–05 National Health Survey*, *2007 Survey of Education and Work* and the monthly *Labour Force Survey*, to ascertain data consistency. From this analysis, it was determined that some of the demographic and socio-economic characteristics from the initial weighted data did not align with other ABS estimates. These additional (or 'pseudo') benchmarks were used to adjust for differential undercoverage of educational attainment, labour force status and household composition. See paragraphs 52–58.

71 Categorisation of interviewer remarks from the NRFUS and the 2007 SMHWB indicated that the majority of persons who refused stated that they were 'too busy' or 'not interested' in participating in the survey.

72 Further details of the non-response analysis will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008.

SEASONAL EFFECTS

73 The estimates in this publication are based on information collected from August to December 2007, and due to seasonal effects they may not be fully representative of other time periods in the year. Therefore, the results could have differed if the survey had been conducted over the whole year or in a different part of the year.

INTERPRETATION OF RESULTS

74 Care has been taken to ensure that the results of this survey are as accurate as possible. All interviews were conducted by trained ABS officers. Extensive reference material was developed for use and intensive training was provided to interviewers. There remain, however, other factors which may have affected the reliability of results, and for which no specific adjustments can be made. The following factors should be considered when interpreting these estimates:

- Information recorded in this survey is 'as reported' by respondents, and therefore may differ from information available from other sources or collected using different methodologies. Responses may be affected by imperfect recall or individual interpretation of survey questions.
- Some respondents may have provided responses that they felt were expected, rather than those that accurately reflected their own situation. Every effort has been made to minimise such bias through the development and use of culturally appropriate survey methodology.

INTERPRETATION OF RESULTS *continued*

75 For a number of survey data items, some respondents were unwilling or unable to provide the required information. Where responses for a particular data item were missing for a person or household they were recorded in a 'not known' or 'not stated' category for that data item. These 'not known' or 'not stated' categories are not explicitly shown in the publication tables, but have been included in the totals. Publication tables presenting proportions have included any 'not known' or 'not stated' categories in the calculation of these proportions.

76 The employment component of this survey is based on a reduced set of questions from the ABS monthly *Labour Force Survey*.

77 In terms of physical conditions, reported information was not medically verified, and was not necessarily based on diagnoses by a medical practitioner.

78 In terms of mental disorders, the WMH–CIDI 3.0 makes diagnoses against specific criteria. It has no facility for subjective interpretation. Therefore, it cannot always replicate diagnoses made by a health professional. Symptoms which have a considerable effect on people are likely to be better reported than those which have little effect.

79 The results of previous surveys on alcohol and illegal drug consumption suggest a tendency for respondents to under-report actual consumption levels.

80 The primary focus of the diagnostic modules is on the assessment of a lifetime mental disorder. This is based on the time when the respondent had the most symptoms or the worst period of this type. Where a number of symptoms have been endorsed across a lifetime, the respondent is asked about the presence of symptoms in the 12 months prior to the survey interview. To be included in the 12-month prevalence rates in the 2007 SMHWB, people must have met the criteria for lifetime diagnosis and had symptoms in the 12 months prior to interview. This differs from the 1997 SMHWB, where the diagnostic criteria were assessed solely on respondents' experiences in the 12 months prior to the survey interview.

81 The inclusion of lifetime diagnosis in the 2007 SMHWB may have led to higher prevalence of 12-month mental disorders compared to the 1997 survey. In the 2007 survey, people may have met the criteria for lifetime diagnosis and had symptoms in the 12 months prior to interview. However, they may not have met full diagnostic criteria within the 12-month time-frame, as was required in the 1997 survey. A number of other issues also need to be considered when comparing prevalence rates between the two surveys. For more information on comparability see paragraphs 85–95.

82 The exclusion of residents in special dwellings (eg hotels, boarding houses and institutions) and homeless people will have affected the results. It is therefore likely that the survey underestimates the prevalence of mental disorders in the Australian population.

83 Due to the higher than expected non-response rate, extensive analysis has been conducted to measure the reliability of the survey estimates. The Non-Response Follow-Up Survey (NRFUS) provided some qualitative analysis on the possible differing characteristics of fully-responding and non-responding persons. As non-response bias can impact on population characteristics, as well as across data items, users should exercise caution. More information on non-response is provided in paragraphs 63–72.

84 More information on interpreting the survey will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008.

COMPARABILITY WITH THE 1997 SURVEY

85 In 1997 the ABS conducted the National Survey of Mental Health and Wellbeing of Adults. The survey provided information on the prevalence of selected 12-month mental disorders, the level of disability associated with those disorders, health services used, and perceived need for help with a mental health problem for Australians aged 18 years and over. The survey was an initiative of, and was funded by, the then Commonwealth Department of Health and Family Services, as part of the National Mental Health Strategy. A key aim of the 1997 survey was to provide prevalence estimates for mental disorders in a 12 month time-frame. Therefore, diagnostic criteria were assessed solely on respondents' experiences in the 12 months prior to the survey interview.

86 The 2007 survey was designed to provide lifetime prevalence estimates for mental disorders. Respondents were asked about experiences throughout their lifetime. In the 2007 survey, 12-month diagnoses were derived based on lifetime diagnosis and the presence of symptoms of that disorder in the 12 months prior to the survey interview. The full diagnostic criteria were not assessed within the 12 month time-frame. Users should exercise caution when comparing data from the two surveys.

87 The diagnoses of mental disorders for the 2007 SMHWB are based on the WMH–CIDI 3.0, while the 1997 SMHWB diagnoses were based on an earlier version of the CIDI (version 2.1). Apart from the differences in time-frames, the WMH–CIDI 3.0 differs from earlier versions as it has a number of expanded modules, incorporates changes to diagnostic algorithms and sequencing, and utilises a diagnostic 'screener'. For example, the number of questions asked about scenarios which may have triggered a Post-Traumatic Stress Disorder (PTSD) has increased substantially, from 10 questions in 1997 to 28 questions in 2007. Additionally, in 1997 respondents were excluded if they said their extremely stressful or upsetting event was only related to bereavement, chronic illness, business loss, marital or family conflict, a book, movie or television show. A summary of the differences between the two surveys is provided in Appendix 2. The WMH–CIDI 3.0 diagnostic assessment criteria according to the ICD–10 for the 2007 SMHWB are provided in Appendix 1. For more information on the WMH–CIDI 3.0 visit the World Mental Health website <http://www.hcp.med.harvard.edu/wmh/>.

88 In this survey publication, the ICD–10 prevalence rates are presented with the hierarchy rules applied, except for the comorbidity data, which are presented without hierarchy. This varies from how the comorbidity data was presented in the 1997. All data in the 1997 survey publication were presented with the hierarchy rules applied. For more information on hierarchy rules and comorbidity see paragraphs 34–40.

89 Both surveys collected information from persons in private dwellings throughout Australia. The 2007 SMHWB collected information from people aged 16–85 years, while the 1997 SMHWB collected information on people aged 18 years and over. For more information on scope and sample design refer to paragraphs 7–20.

90 The enumeration period of each survey differs, which may impact on data comparisons. The 2007 SMHWB was undertaken from August to December, while the 1997 survey was undertaken from May to August. See seasonal effects in paragraph 73.

91 The classification of several demographic and socio-economic characteristics used in the 2007 SMHWB differ to those used in 1997, including: education, occupation, languages spoken and geography. Industry of employment was collected for the first time in 2007. See classifications in paragraphs 96–102.

EXPLANATORY NOTES *continued*

COMPARABILITY WITH THE 1997 SURVEY *continued*

92 Several of the scales and measures used to estimate disability and functioning in the 2007 SMHWB differ from those used in 1997. The 2007 survey includes a standard set of ABS questions on role impairment (ABS Short Disability Module), the World Health Organization Disability Assessment Schedule (WHODAS) and the Australian Assessment of Quality of Life (AQoL). In comparison, the 1997 survey collected information on disability and functioning using the Brief Disability Questionnaire, the Short–Form 12 and the General Health Questionnaire (GHQ–12). Both surveys contained questions on physical health, health related risk factors and 'days out of role'. However, the positioning of questions within each survey and the wording of questions varies. Information on physical activity and body mass were collected for the first time in 2007. The 2007 survey included a small number of questions on hypochondriasis and somatisation, whereas the 1997 survey assessed somatic disorder, neurasthenia, and the personality characteristic neuroticism (Eysenck Personality Questionnaire). Both surveys included the Kessler Psychological Distress Scale (K10).

93 As information on medications, social networks, caregiving, sexual orientation, homelessness and incarceration was collected for the first time in 2007 there are no data from the 1997 survey for comparison.

94 Standardisation is a technique used when comparing estimates for populations which have different structures. The 1997 SMHWB publication included data that had been age standardised. This technique was not administered in 2007, as age standardisation is no longer considered appropriate where there is a complex relationship between the variable of interest and age for the comparison populations.

95 A list of the differences between the data items collected in the two surveys is provided in Appendix 2. Further detailed information will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008.

CLASSIFICATIONS

96 Country of birth data were classified according to the STANDARD AUSTRALIAN CLASSIFICATION OF COUNTRIES (SACC), 1998 (cat. no. 1269.0).

97 Educational attainment data were classified according to AUSTRALIAN STANDARD CLASSIFICATION OF EDUCATION (ASCED), 2001 (cat. no. 1272.0).

98 Geography data were classified according to the AUSTRALIAN STANDARD GEOGRAPHICAL CLASSIFICATION (ASGC), JULY 2007 (cat. no. 1216.0).

99 Languages spoken were coded utilising the AUSTRALIAN STANDARD CLASSIFICATION OF LANGUAGES (ASCL), 2005–06 (cat. no. 1267.0).

100 Industry data were classified to the AUSTRALIAN AND NEW ZEALAND STANDARD INDUSTRIAL CLASSIFICATION (ANZSIC), 2006 (cat. no. 1292.0).

101 Occupation data were classified to the AUSTRALIAN AND NEW ZEALAND STANDARD CLASSIFICATION OF OCCUPATIONS (ANZSCO), FIRST EDITION, 2006 (cat. no. 1220.0).

102 Pharmaceutical medications reported by respondents were classified by generic type. The classification used was developed by the ABS for the *National Health Survey* and is based on the World Health Organization's (WHO) ANATOMICAL THERAPEUTIC CHEMICAL CLASSIFICATION and the framework underlying the listing of medications in the AUSTRALIAN MEDICINES HANDBOOK.

EXPLANATORY NOTES *continued*

PRODUCTS AND SERVICES

103 For users who wish to undertake more detailed analysis of the survey data, two confidentialised unit record files (CURFs) are expected to be available in early 2009. A Basic CURF will be available on CD-ROM, while an Expanded CURF (containing more detailed information than the Basic CURF) will be accessible through the ABS Remote Access Data Laboratory (RADL) system. Further information about these files, including how they can be obtained, and conditions of use, will be available on the ABS website <www.abs.gov.au>.

104 Summary of the products to be released:

- *National Survey of Mental Health and Wellbeing: Users' Guide, 2007* (cat. no. 4327.0)
- *Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded Confidentialised Unit Record Files, 2007* (cat. no. 4326.0.30.001)
- *Technical Manual: National Survey of Mental Health and Wellbeing, Confidentialised Unit Record Files* (cat. no. 4329.0)

105 Special tabulations are available on request. Subject to confidentiality and sampling variability constraints, tabulations can be produced from the survey to meet individual requirements. These can be provided in electronic or printed form. A list of data items from this survey will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide (cat. no. 4327.0)* planned for release on the ABS website <www.abs.gov.au> in late 2008.

106 Further information about the survey and associated products can also be obtained through the National Information and Referral Service, whose contact details are listed at the end of this publication.

ACKNOWLEDGMENTS

107 ABS publications draw extensively on information provided freely by individuals, businesses, governments and other organisations. Their continued cooperation is very much appreciated: without it, the wide range of statistics published by the ABS would not be available. Information received by the ABS is treated in strict confidence as required by the *Census and Statistics Act 1905*.

108 The ABS would like to acknowledge the extensive support provided by Dr Tim Slade and Ms Amy Johnston from the University of New South Wales, whose expertise in this subject matter area greatly assisted in the development and dissemination of this survey.

RELATED PUBLICATIONS

109 Current publications and other products released by the ABS are available on the ABS website <www.abs.gov.au>. ABS publications which may be of interest are:

- *Mental Health in Australia: A snapshot, 2004–05* (cat. no. 4824.0.55.001)
- *Health of Children in Australia: A snapshot, 2004–05* (cat. no. 4829.0.55.001)
- *National Health Survey, Summary of Results, Australia, 2004–05* (cat. no. 4364.0)
- *National Health Survey, Users' Guide – Electronic Publication, 2004–05* (cat. no. 4363.0.55.001)
- *Information paper: National Health Survey – Confidentialised Unit Record Files, 2004–05* (cat. no. 4324.0)
- *Private Health Insurance: A snapshot, 2004–05* (cat. no. 4815.0.55.001)
- *Overweight and Obesity in Adults, Australia, 2004–05* (cat. no. 4719.0)
- *Health Risk Factors, Australia, 2001* (cat. no. 4812.0)
- *National Health Survey: Mental Health, Australia, 2001* (cat. no. 4811.0)
- *National Health Survey: Injuries, Australia, 2001* (cat. no. 4384.0)
- *Work-Related Injuries, Australia, 2005–06* (cat. no. 6324.0)

APPENDIX 1 ICD–10 DIAGNOSES

OVERVIEW

This Appendix presents descriptions of the diagnostic algorithms devised for the World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH–CIDI 3.0). Diagnostic algorithms are specified in accordance with the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (DSM–IV) and the WHO INTERNATIONAL CLASSIFICATION OF DISEASES, TENTH REVISION (ICD–10) classification systems. As not all modules contained in the WMH–CIDI 3.0 were operationalised for the 2007 SMWHB, it was necessary to tailor the diagnostic algorithms to fit the Australian context.

Throughout this publication, mental disorder diagnosis is presented according to the ICD–10 criteria. Detailed information on the diagnosis of mental disorders according to the DSM–IV criteria will be available in the *National Survey of Mental Health and Wellbeing, Users' Guide, 2007 (cat. no. 4327.0)* planned for release on the ABS website <www.abs.gov.au> in late 2008 .

ASSESSMENT OF DIAGNOSTIC CRITERIA

Diagnostic criteria usually involve specification of the following:

- the nature, number and combination of symptoms required
- the level of distress or impairment required
- exclusion of a diagnosis due to symptoms being directly attributed to a general medical condition or substance use
- exclusion of a diagnosis where the criteria are met for a related disorder (eg Generalised Anxiety Disorder cannot be diagnosed where criteria are met for Obsessive-Compulsive Disorder).

HIERARCHY RULES

The classification system for some of the ICD–10 disorders contain diagnostic exclusion rules so that a person, despite having symptoms that meet diagnostic criteria, will not meet criteria for particular disorders because the symptoms are believed to be accounted for by the presence of another disorder. In these cases, one disorder takes precedence over another. These exclusion rules are built into the diagnostic algorithms.

The developers of WMH–CIDI 3.0 established two versions of the diagnoses in the algorithms for a number of the mental disorders: a 'with hierarchy' version and a 'without hierarchy' version. The 'with hierarchy' version specifies the full diagnostic criteria consistent with the ICD–10 classification system (ie the exclusion criteria are enforced). The 'without hierarchy' version applies all diagnostic criteria except the criterion specifying the hierarchical relationship with other disorders.

One example of a disorder specified with and without hierarchy is Alcohol Harmful Use. ICD–10 states that in order for diagnostic criteria for Harmful Use to be met, criteria cannot be met for Dependence on the same substance during the same time period. Therefore, the 'with hierarchy' version of Alcohol Harmful Use will exclude cases where Alcohol Dependence has been established for the same time period. The 'without hierarchy' version includes all cases of Alcohol Harmful Use regardless of coexisting Alcohol Dependence. Note that a person can meet criteria for Alcohol Dependence and the hierarchical version of Alcohol Harmful Use if there is no overlap in time between the two disorders.

Throughout this publication, the ICD–10 prevalence rates are presented with the hierarchy rules applied. The comorbidity data are presented without hierarchy, so as to provide a more complete picture of the combinations of symptoms and disorders experienced by individuals. The ICD–10 disorders specified with and without hierarchy are: Generalised Anxiety Disorder; Hypomania; Mild, Moderate and Severe Depressive Episode; Dysthymia; and the Harmful Use of Alcohol, Cannabis, Sedatives, Stimulants and Opioids.

MENTAL DISORDERS

ANXIETY DISORDERS

Anxiety disorders generally involve feelings of tension, distress or nervousness. A person may avoid, or endure with dread, situations which cause these types of feelings. The disorders within this group assessed in this survey are: Panic Disorder, Agoraphobia, Social Phobia, Generalised Anxiety Disorder (GAD), Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD).

PANIC DISORDER

A panic attack is a discrete episode of intense fear or discomfort that starts abruptly and reaches a peak within a few minutes and lasts at least some minutes. At least four symptoms must be present from the list below, one of which must be from the first four:

- pounding heart
- sweating
- trembling or shaking
- dry mouth
- difficulty breathing
- feeling of choking
- chest pain or discomfort
- nausea or abdominal distress
- dizziness or light-headed
- feelings of unreality or depersonalisation
- fear of passing out or losing control
- fear of dying,
- hot flushes or cold chills
- numbness or tingling sensations

The essential feature of Panic Disorder is recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances (ie do not occur in the presence of a phobia, or in situations of danger) and are therefore unpredictable.

AGORAPHOBIA

Characterised by marked and consistently manifest fear in, or avoidance of, at least two of the following situations:

- crowds
- public places (ie using public transport; standing in a line in a public place; being in a department store, shopping centre, or supermarket; being in a movie theatre auditorium, lecture hall, or church; being in a restaurant or any other public place)
- travelling alone (ie travelling alone or being alone away from home)
- travelling away from home

At least two of the following anxiety symptoms must have been present together with the feared situation and one of these symptoms must be from the first four listed:

- pounding heart
- sweating
- trembling or shaking
- dry mouth
- difficulty breathing
- feeling of choking
- chest pain or discomfort
- nausea or abdominal distress
- feeling dizzy or light-headed
- feelings of unreality or depersonalisation
- fear of passing out, or losing control
- fear of dying,
- hot flushes or cold chills

ANXIETY DISORDERS continued

- numbness or tingling sensations

The person also experiences significant emotional distress due to the avoidance or the anxiety symptoms and recognises that these are excessive or unreasonable.

SOCIAL PHOBIA

Characterised by fear and/or avoidance of one or more social or performance situations such as:

- meeting new people
- talking to people in authority
- speaking up in a meeting or class
- going to social gatherings
- performing in front of an audience
- taking an important exam
- working while someone watches
- entering a room when others are present
- talking with people who they don't know very well
- disagreeing with people
- writing or eating or drinking while someone watches
- using a public bathroom
- dating
- social or performance situation

The presence of Social Phobia is also characterised by:

- The fear of either being the focus of attention or of behaving in a way that will be embarrassing or humiliating; or the avoidance of either being the focus of attention, or of situations where there is fear of behaving in an embarrassing or humiliating way.
- At least two anxiety symptoms (from the list in Agoraphobia above) must be present in the feared situation at some time since the onset of the disorder, together with at least one of the following: blushing or shaking; nausea or fear of vomiting; or the urgency or fear of losing control of bowels or bladder.
- Significant distress caused by the symptoms or by the avoidance and the person recognises that these are excessive or unreasonable.

GENERALISED ANXIETY DISORDER

Characterised by a period of at least six months with tension, worry and apprehension about everyday events and problems. The disorder is not due to a physical disorder or substance use. At least four of the following symptoms must be present, with at least one of the first four:

- pounding heart
- sweating
- trembling or shaking
- dry mouth
- difficulty breathing
- feeling of choking
- chest pain
- nausea, stomach pain or discomfort
- dizziness
- feelings of unreality or depersonalisation
- fear of losing control or passing out
- fear of dying
- hot flushes or cold chills
- numbness or tingling sensations
- muscle tension or aches and pains

ANXIETY DISORDERS continued

- restlessness
- feeling on edge
- a sensation of a lump in the throat
- exaggerated response to minor surprises
- difficulty concentrating
- irritability
- trouble in getting to sleep because of worry

Hierarchy rules have been applied to Generalised Anxiety Disorder. To meet criteria for the 'with hierarchy' version:

- the Generalised Anxiety Disorder does not occur exclusively within the duration of Panic Disorder; and
- the Generalised Anxiety Disorder is not exclusively associated with social and performance situations (ie Social Phobia); and
- the Generalised Anxiety Disorder does not occur exclusively within the duration of (and is not exclusively associated with) obsessions and compulsions (ie Obsessive-Compulsive Disorder).

The original exclusion rules from the ICD–10 also consider the presence of other phobic disorders and hypochondriacal disorder. As the 2007 SMHWB did not collect information for Specific Phobia or Hypochondriacal Disorder, the Generalised Anxiety Disorder prevalence may include some persons with these disorders.

OBSESSIVE-COMPULSIVE DISORDER

Either obsessions or compulsions (or both) are present on most days for at least two weeks. Obsessions (thoughts, ideas or images) and compulsions (acts) share the following features, all of which must be present:

- repetitive and unpleasant, and at least one obsession or compulsion is acknowledged as excessive or unreasonable;
- the person tries to resist them, and at least one obsession or compulsion that is unsuccessfully resisted must be present; and
- the person derives no pleasure from the obsessive thought or compulsive act;
- the obsessions or compulsions cause distress or interfere with the person's social or individual functioning;
- the respondent considers that the obsessions and compulsions do not occur exclusively within episodes of depression (ie this is based on self report by the respondent, not according to diagnosis made by the CIDI).

POST-TRAUMATIC STRESS DISORDER

Characterised by symptoms experienced within six months of exposure to an extremely traumatic event which would be likely to cause pervasive distress in almost anyone. In order to be assessed for this disorder, the respondent had to have reported experiencing at least one of the following traumatic events:

- direct combat experience in a war
- a war or ongoing terror as a peacekeeper
- a war as an unarmed civilian
- living in a place with ongoing terror
- ever being a refugee
- being kidnapped or held captive
- being exposed to a toxic substance
- a life-threatening car accident
- a life threatening accident
- a fire, flood or other natural disaster
- a man-made disaster or bomb explosion
- a life-threatening illness

ANXIETY DISORDERS continued

- being beaten as a child
- being beaten by a spouse or partner
- being beaten by anyone else
- being held up or threatened with a weapon
- rape
- sexual molestation
- being stalked
- an unexpected death at a young age of someone very close
- a son or daughter with a life-threatening illness or injury
- traumatic experience (rape) of someone very close
- witness serious physical fights at home as a child
- someone being badly injured or killed, or unexpectedly seeing a dead body
- doing something that accidentally led to serious injury or death of another person
- seriously injure, torture or kill another person on purpose
- witnessing atrocities
- any other extremely traumatic or life-threatening events
- any other extremely traumatic or life-threatening events including events the respondent does not wish to describe

The respondent was asked to determine which event was their worst traumatic event. To meet the criteria for this disorder, the person must report all of the following reactions to their worst traumatic event:

- The traumatic event is persistently remembered or relived (eg flashbacks, dreams, or distress when reminded of the event), or the person experiences distress when exposed to circumstances resembling or associated with the event;
- The person exhibits an actual or preferred avoidance of circumstances resembling or associated with the event, which was not present before that event;
- The person exhibits either an inability to recall some or all aspects of the trauma or two or more symptoms of increased sensitivity and arousal (difficulty in falling or staying asleep; irritability; difficulty concentrating; hypervigilance; exaggerated startle response).

AFFECTIVE DISORDERS

Affective disorders involve mood disturbance, or change in affect. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations. Disorders within this group include: Depressive Episode, Dysthymia and Bipolar Affective Disorder (of which Hypomania and Mania are components).

HYPOMANIA

Hypomania is characterised by elevated or irritable mood to a degree that is abnormal for the individual concerned and sustained for at least four consecutive days. It leads to some interference with daily living but to a lesser degree than Mania. At least three of the following symptoms must be present:

- increased activity or restlessness
- increased talkativeness
- distractibility
- decreased need for sleep
- increased sexual energy
- overspending or other types of reckless or irresponsible behaviour
- over-familiarity or increased sociability

Hierarchy rules have been applied to Hypomania. To meet criteria for the 'with hierarchy' version, the person cannot have met criteria for an episode of Mania in their lifetime.

The original exclusion rules from the ICD–10 also consider the presence of any Depressive Episodes, Cyclothymia and Anorexia Nervosa. As the 2007 SMHWB did not

AFFECTIVE DISORDERS
continued

collect information for Cyclothymia or Anorexia Nervosa (and the presence of Depressive Episodes was not operationalised by the diagnostic algorithm), Hypomania may include some persons with these disorders.

MANIA

Mood is elevated, expansive or irritable and definitely abnormal for the person concerned. The episode lasts for at least seven days (unless the episode is severe enough to require hospitalisation), causes severe interference with personal functioning, is not directly caused by substance use or a physical condition, and is characterised by at least three of the following (four if the mood is merely irritable):

- increased activity or restlessness
- increased talkativeness
- flight of ideas or the feeling that thoughts are racing
- loss of normal social inhibitions
- decreased need for sleep
- inflated self-esteem or grandiosity
- distractibility
- reckless behaviour
- marked sexual energy or sexual indiscretions

DEPRESSIVE EPISODE

A Depressive Episode lasts for at least two weeks and is characterised by the presence of a number of the following symptoms:

- depressed mood
- loss of interest in activities
- lack of energy or increased fatigue
- loss of confidence or self esteem
- feelings of self-reproach or excessive guilt
- thoughts of death or suicide, or suicide attempts
- diminished ability to concentrate, think or make decisions
- change in psychomotor activity; agitation or retardation
- sleep disturbance
- change in appetite

The survey collected information to differentiate between three different types of Depressive Episode, based on the number of symptoms the person experienced:

- Severe Depressive Episode - all of the first three symptoms from the above list and additional symptoms from the remainder of the list to give a total of at least eight.
- Moderate Depressive Episode - at least two of the first three symptoms from the above list and additional symptoms from the remainder of the list to give a total of at least six.
- Mild Depressive Episode - at least two of the first three symptoms from the above list and additional symptoms from the remainder of the list to give a total of at least four.

Hierarchy rules have been applied to all of the Depressive Episodes. To meet criteria for the 'with hierarchy' versions, the person cannot have met criteria for either Hypomanic or Manic episodes in their lifetime.

The three types of Depressive Episode collected by the 2007 SMHWB are also mutually exclusive. A person cannot be diagnosed with Moderate Depressive Episode if the criteria for a Severe Depressive Episode have already been met and a diagnosis of a Mild Depressive Episode is considered only when the other two types of depression have been excluded. This criteria is applied regardless of whether the 'with hierarchy' or 'without hierarchy' versions of the disorder is used.

AFFECTIVE DISORDERS continued

DYSTHYMIA

A disorder characterised by at least two years of constant (or constantly recurring) chronic depressed mood, where intervening periods of normal mood rarely last for longer than a few weeks.

During some of the periods of depression at least three of the following are present:

- reduced energy or activity
- insomnia
- loss of self-confidence or feeling inadequate
- difficulty in concentrating
- frequent tearfulness
- loss of interest in or enjoyment of sex and other pleasurable activities
- feeling of hopelessness or despair
- feeling unable to cope with everyday responsibilities
- pessimism about the future or brooding over the past
- social withdrawal
- reduced talkativeness

Hierarchy rules have been applied to Dysthymia. To meet criteria for the 'with hierarchy' version:

- the person must not have met criteria for either Hypomanic or Manic episodes in their lifetime; and
- there must be no episodes of Severe or Moderate Depression identified within the first two years of Dysthymia.

BIPOLAR AFFECTIVE DISORDER

Characterised by episodes of Mania or Hypomania either alone or in conjunction with Depressive Episodes. For this survey, a diagnosis of Bipolar Affective Disorder was given if the person met criteria for Mania or Hypomania and had experienced one episode of mood disturbance (Mania, Hypomania or Depression). The survey does not allow differentiation according to the type of the current episode.

SUBSTANCE USE DISORDERS

Substance Use Disorders involve the Harmful Use and/or Dependence on alcohol and/or drugs. The misuse of drugs, defined as the use of illicit substances and the misuse of prescribed medicines, included the following drug categories: opioids, cannabinoids, sedatives, and stimulants.

Alcohol Use Disorders

Detailed questions about alcohol use were only asked if the person had at least 12 alcoholic drinks in the 12 months prior to interview.

ALCOHOL HARMFUL USE

There is clear evidence that the use of alcohol was responsible for (or substantially contributed to) physical or psychological harm, including impaired judgement or dysfunctional behaviour which may lead to disability or have adverse consequences for interpersonal relationships.

The nature of the harm should be clearly identifiable by including at least one of the following:

- frequent interference with work or other responsibilities
- causing arguments or other serious problems with family, friends, neighbours or co-workers
- jeopardising safety because of alcohol use
- being arrested or stopped by police for drunk driving or drunk behaviour.

Hierarchy rules have been applied to Alcohol Harmful Use. To meet criteria for the 'with hierarchy' version, a person cannot have met a diagnosis of Alcohol Dependence during the same time period (ie the duration of the two disorders must not overlap).

Alcohol Use Disorders continued

ALCOHOL DEPENDENCE SYNDROME

A maladaptive pattern of behaviour in which the use of alcohol takes on a much higher priority for a person than other behaviours that once had greater value. The central characteristic is the strong, sometimes overpowering, desire to consume alcohol despite significant alcohol-related problems. A diagnosis was achieved if three or more of the following occurred within the same year:

- strong desire or compulsion to consume alcohol
- difficulties in controlling alcohol consumption behaviour
- withdrawal symptoms (eg fatigue, headaches, diarrhoea, the shakes or emotional problems)
- tolerance to alcohol (eg needing to drink a larger amount for the same effect)
- neglect of alternative interests because of alcohol use
- continued use despite knowing it is causing significant problems.

Drug Use Disorders

Assessment for Harmful Use and Dependence was only conducted if use of an illicit drug or misuse of a prescription medication occurred more than five times in the respondents' lifetime. A general assessment was made for Harmful Use and Dependence of any drugs as well as separate assessments of Harmful Use and Dependence for four specific categories of drug categories: opioids (eg heroin, methadone, opium); cannabiniods (eg marijuana, hashish); sedatives (eg barbiturates, librium, serepax, sleeping pills, valium); and stimulants (eg amphetamines, dexedrine, speed).

OTHER SUBSTANCE HARMFUL USE

This survey collected information on:

- Harmful Use—opioids
- Harmful Use—cannabinoids
- Harmful Use—sedatives
- Harmful Use—stimulants

There is clear evidence that the use of opioids/cannabinoids/sedatives/stimulants were responsible for (or substantially contributed to) physical or psychological harm, including impaired judgement or dysfunctional behaviour which may lead to disability or have adverse consequences for interpersonal relationships.

The nature of the harm should be clearly identifiable by including at least one of the following:

- frequent interference with work or other responsibilities
- causing arguments or other serious problems with family, friends, neighbours or co-workers
- jeopardising safety because of substance use
- being arrested or stopped by police for driving while intoxicated or other behaviour while intoxicated.

Hierarchy rules have been applied to Other Substance Harmful Use. To meet criteria for the 'with hierarchy' versions, a person cannot have met a diagnosis of Dependence on the same substance during the same time period (ie the duration of the two disorders must not overlap).

OTHER SUBSTANCE DEPENDENCE SYNDROME

This survey collected information on:

- Dependence Syndrome—opioids
- Dependence Syndrome—cannabinoids
- Dependence Syndrome—sedatives
- Dependence Syndrome—stimulants

Opioids/cannabinoids/sedatives/stimulants Dependence Syndrome is a maladaptive pattern of substance use in which the use of the substance takes on a much higher

Drug Use Disorders continued

priority for a person than other behaviours that once had greater value. The central characteristic is the strong, sometimes overpowering, desire to take the substance despite significant substance-related problems. Diagnoses were achieved if three or more of the following occurred in the 12 months prior to interview:

- strong desire or compulsion to take the substance
- difficulties in controlling substance-taking behaviour
- withdrawal symptoms (eg fatigue, headaches, diarrhoea, the shakes or emotional problems)
- tolerance to the drug (eg needing to use a larger amount for the same effect)
- neglect of alternative interests because of substance use
- continued use despite knowing it is causing significant problems.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007

1997 SMHWB	*2007 SMHWB*
DIAGNOSIS OF MENTAL DISORDER	
The 1997 survey instrument (CIDI Version 2.1) operationalised two major mental disorder classification systems: the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV); and the WHO International Classification of Diseases, Tenth Revision (ICD–10).	The 2007 survey instrument (CIDI Version 3.0) operationalised two major mental disorder classification systems: the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV); and the WHO International Classification of Diseases, Tenth Revision (ICD–10).
	Some information about the diagnosis of mental disorders for the 2007 survey, according to the ICD–10 classification, is contained in Appendix 1.
For more detailed information on diagnosis of mental disorders for the 1997 survey see National Survey of Mental Health and Wellbeing of Adults, Users' Guide, 1997 (cat. no. 4327.0).	For more detailed information on diagnosis of mental disorders for the 2007 survey see the National Survey of Mental Health and Wellbeing, Users' Guide, 2007 (cat. no. 4327.0).
SCREENER	
No separate screener. Screener questions were asked at the start of each module.	This new module consists of diagnostic screening questions for the majority of disorders assessed in the survey (Depression, Mania, Panic Disorder, Generalised Anxiety Disorder (GAD), Social Phobia and Agoraphobia). Other disorders, such as Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD), are screened at the beginning of the individual module.
MENTAL DISORDERS	
	The same mental disorders were diagnosed in both the 1997 and 2007 surveys.
	Between 1997 and 2007 there was a high degree of change to the survey instrument, both structurally and in terms of question wording and consequently to the specification of the diagnostic algorithms. The main differences to the 2007 survey are outlined below for each mental disorder.
ANXIETY DISORDERS	
	Includes: Panic Disorder, Agoraphobia, Social Phobia, Generalised Anxiety Disorder (GAD), Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD)
PANIC DISORDER	
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Key Differences:
	The symptom-related criteria to determine the presence of panic attacks was assessed using two extra questions in 2007. The criteria for the "recurrent" and "unexpected" nature of those attacks, which is essential for a diagnosis of Panic Disorder, was assessed using a different combination of questions in 1997. In addition, the exclusion of a diagnosis of Panic Disorder due to co-occurring Affective disorders was not applied in 2007.

OVERVIEW

This Appendix presents a broad comparison between data items collected in the 1997 and 2007 surveys. Although many data items appear to be the same, there are a number of conceptual and operational differences between the two surveys (see Explanatory Notes paragraphs 85–95). The survey instruments used for the 1997 and 2007 SMHWB differ in content and structure. One major difference is the time-frame selected for assessment of diagnostic criteria.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

In 1997 the ABS conducted the National Survey of Mental Health and Wellbeing of Adults. The survey provided information on the prevalence of selected 12-month mental disorders, the level of disability associated with those disorders, health services used, and perceived need for help with a mental health problem for Australians aged 18 years and over. A key aim of the 1997 survey was to provide prevalence estimates for mental disorders in a 12 month time-frame. Therefore, diagnostic criteria were assessed solely on respondents' experiences in the 12 months prior to the survey interview.

The 2007 National Survey of Mental Health and Wellbeing was designed to provide lifetime prevalence estimates for mental disorders. Respondents aged 16–85 years were asked about experiences throughout their lifetime. In the 2007 survey, 12-month diagnoses were derived based on lifetime diagnosis and the presence of symptoms of that disorder in the 12 months prior to the survey interview. The full diagnostic criteria were not assessed within the 12 month time-frame.

Due to the differences described above and throughout this Appendix, 1997 data are not presented in this publication. Users should exercise caution when comparing data from the two surveys.

A list of the broad differences between the two surveys is also provided below. More detailed information will be available in the *National Survey of Mental Health and Wellbeing: Users' Guide, 2007 (cat. no. 4327.0)*, planned for release on the ABS website <www.abs.gov.au> in late 2008.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
COLLECTION METHODOLOGY	
The diagnostic component of the interview was administered through a computer-assisted interview (CAI) version 2.1 of the Composite International Diagnostic Interview (CIDI).	The diagnostic component of the interview was administered through a computer-assisted interview (CAI) using the World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH-CIDI 3.0)
SCOPE	
Persons aged 18 years and over	Persons aged 16–85 years
Usual residents of private dwellings in urban and rural areas across Australia.	Usual residents of private dwellings in urban and rural areas of Australia.
SAMPLE DESIGN/SIZE	
One randomly selected person per household	One randomly selected person per household
Final sample = 10,641	Final sample = 8,841
Response rate = 78%	Response rate = 60%
ENUMERATION PERIOD	
May – August 1997	August – December 2007
MAIN OUTPUT UNITS	
Persons	Persons
Household	Household
Mental health condition	Mental health condition
Service use	Service use
HOUSEHOLD CHARACTERISTICS	
Topics covered in the survey instrument include the following:	Topics covered in the survey instrument include the following:
Household details	Household details
Household demographic characteristics	Household demographic characteristics
Tenure type	Tenure type
Geography	Geography
–	Household income
–	Financial stress
DEMOGRAPHIC AND OTHER CHARACTERISTICS	
Sex	Sex
Age (18 years and over)	Age (16–85 years)
Country of birth	Country of birth
Year of arrival	Year of arrival
Marital status (combined social and registered)	Registered marital status
Number of times married	Social marital status
Number of children	Sexual orientation
Age when child/ren born (only/oldest/youngest)	Country of birth of mother and father
Language usually spoken at home	Proficiency in spoken English
–	Whether ever served in the Australian Defence Forces
–	Whether ever received Department of Veterans' Affairs benefit
–	Whether ever been homeless
–	Whether ever been incarcerated

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
EDUCATION	
Whether attending school	Whether attending school
Whether completed secondary school	Highest year of school completed
Whether completed qualifications since leaving school	Whether has a non-school qualification
Highest qualification	Level of highest non-school qualification
Whether currently studying	Main field of highest non-school qualification
	Highest level of post-school educational attainment
	Whether currently studying full-time or part-time
Data items were classified on the ABS Classification of Qualifications (ABSCQ).	Data items have changed since 1997 as a result of a change in the standard classification of education attainment. In 2001 the Australian Standard Classification of Education (ASCED) replaced the ABSCQ as the national standard classification.
EMPLOYMENT	
Labour force status	Labour force status
Occupation (main job)	Occupation (main job)
Hours usually worked each week (all jobs)	Hours usually worked each week (all jobs)
–	Industry (main job)
Duration of unemployment	–
Multiple job holders	–
	A redesign of the Labour Force Survey in 2001 saw a change of classification for persons who were unemployed or not in the labour force.
Occupation (main job) was classified by the Australian Standard Classification of Occupations (ASCO), First edition, 1986.	Occupation (main job) was classified by the Australian and New Zealand Standard Classification of Occupations (ANZSCO), First edition, 2006.
	Industry (main job) was classified by the Australian and New Zealand Standard Industrial Classification (ANZSIC), 2006.
PERSONAL INCOME	
Sources of income	Sources of income*
Main source of income	Main source of income*
–	Personal gross weekly cash income
–	Type of government pension/allowance received
	*Data items had Workers' compensation as a new response category

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
AGORAPHOBIA	
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Key Differences:
	The fear and/or avoidance of agoraphobic situations as defined in the ICD–10 criteria was assessed with the inclusion of seven extra situations in 2007. In addition, the exclusion of a diagnosis of Agoraphobia due to co-occurring Affective disorders or OCD was not applied in 2007.
SOCIAL PHOBIA	
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	–
	Key Differences:
	The ICD–10 criteria that determines the presence of fear and/or avoidance of social situations is assessed by more than double the number of questions in 2007. Extra questions were also used to determine the emotional distress caused by those situations in 2007. In addition, the exclusion of a diagnosis of Social Phobia due to co-occurring Affective disorders was not applied in 2007.
GENERALISED ANXIETY DISORDER (GAD)	
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Key Differences:
	The initial criteria to determine the presence of worry in the 2007 survey also considers the emotional distress caused by, and the amount of control over, that worry and anxiety. In addition, the exclusion of a diagnosis of GAD due to co-occurring Agoraphobia was not applied in 2007.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
OBSESSIVE-COMPULSIVE DISORDER (OCD)	
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Key Differences:
	The 1997 criteria ensured that the obsessions had to be severe enough to meet diagnosis without the presence of the compulsions (or vice versa) before an overall diagnosis of OCD could be met. The 2007 survey does not restrict the diagnosis in this manner. In addition, the exclusion of a diagnosis of OCD due to co-occurring Affective disorders was not applied in 2007.
POST-TRAUMATIC STRESS DISORDER (PTSD)	
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Key Differences:
	A key feature of the ICD–10 diagnosis for PTSD is that a person has experienced an event that is exceptionally threatening or catastrophic. An additional eighteen specific experiences were considered in the 2007 diagnosis, some of which were explicitly excluded in the 1997 diagnosis of PTSD. Criteria in 2007 also considered the distress caused by reactions to the event.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
	AFFECTIVE DISORDERS
	Includes: Depressive Episode, Dysthymia and Bipolar Affective Disorder (of which Hypomania and Mania are components).
	HYPOMANIA
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Key Differences:
	One of the criteria assesses the level of interference in daily living caused by the hypomanic episodes. This interference is explicitly defined by eight questions in the 2007 survey, but is only implied by two questions in 1997.
	In addition, the hierarchy rules applied in 1997 excluded a diagnosis of Hypomania where a co-occurring diagnosis was met for Mania, Bipolar Affective Disorder, Mild Depressive Episode or Moderate Depressive Episode. The 2007 survey excludes only where the diagnosis for Mania was met.
	Note: an error was detected in the 1997 CAI instrument whereby not all cases of Hypomania were coded correctly. It is likely that published data underestimates the prevalence of this disorder as a result. See National Survey of Mental Health and Wellbeing of Adults, Users' Guide, 1997 (cat. no. 4327.0) for further information.
	MANIA
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Key Differences:
	One of the criteria assesses the level of interference in daily living caused by the Manic episodes. This interference is explicitly defined by eight questions in the 2007 survey, but is only implied by two questions in 1997.
	Note: an error was detected in the 1997 CAI instrument whereby not all cases of Mania were coded correctly. It is likely that published data underestimates the prevalence of this disorder as a result. See National Survey of Mental Health and Wellbeing of Adults, Users' Guide, 1997 (cat. no. 4327.0) for further information.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
DEPRESSIVE EPISODE	
Key Output Items:	Key Output Items:
Mild Depressive Episode:	Mild Depressive Episode:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
–	Persistence (years)
Moderate Depressive Episode:	Moderate Depressive Episode:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
–	Persistence (years)
Severe Depressive Episode:	Severe Depressive Episode:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
–	Persistence (years)
	Key Differences:
	The assessment of symptom-related criteria for Depressive Episode differs across the two surveys because of extra symptom questions or wording changes that either restrict or broaden the concepts (eg the inclusion of "nearly every day" in 2007). In addition, the error noted above for Hypomania and Mania may have an impact on comparability as the co-occuring presence of these conditions will exclude a diagnosis of Depressive Episodes in both surveys.
DYSTHYMIA	
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Key Differences:
	The criteria used to define the length of episode states that a person can have periods of normal mood within episodes of Dysthymia. In assessing this criteria, the 1997 survey explicitly refers to this concept. Questions used to assess the symptom-related criteria also use a longer timeframe in 1997.
	In addition, the hierarchy rules applied in 1997 excluded a diagnosis of Dysthymia where the diagnosis of Recurrent Mild Depressive Episode was also met, but in 2007 the exclusion is for co-occurring Severe or Moderate Depressive Episode.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
	BIPOLAR AFFECTIVE DISORDER
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	–
	Key Differences:
	Bipolar Affective Disorder is characterised by episodes of Mania or Hypomania either alone or in conjunction with Depressive Episodes. Refer to any differences outlined above for changes to how these Affective disorders are diagnosed.
	Note: an error was detected in the 1997 CAI instrument whereby not all cases of Hypomania and Mania were coded correctly. It is likely that published data underestimates the prevalence of Bipolar Affective Disorder as a result. See National Survey of Mental Health and Wellbeing of Adults, Users' Guide, 1997 (cat. no. 4327.0) for further information.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
	SUBSTANCE USE DISORDERS
	Includes: Alcohol Harmful Use, Alcohol Dependence, Other Substance Harmful Use and Other Substance Dependence.
	ALCOHOL HARMFUL USE
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	Alcohol Harmful Use in the 2007 survey addressed behavioural problems associated with the abuse of alcohol (eg drink driving or being arrested by the police for drunken behaviour) whereas the 1997 survey addressed physical and psychological harm caused by alcohol consumption (eg liver disease, depression or strange thoughts).
	ALCOHOL DEPENDENCE
Key Output Items:	Key Output Items:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
Onset (timeframe, ie past month, 2–6 months ago)	Age at Onset (years)
Recency (timeframe, ie past month, 2–6 months ago)	Age at Recency (years)
Duration (years)	Persistence (years)
	One criteria in diagnosing Alcohol Dependence assesses the persistent use of alcohol despite clear evidence of harm. In the 1997 survey, this criteria is assessed by the presence of physical or psychological harm caused by alcohol (eg liver disease or depression). The 2007 survey also included social problems as a symptom of Alcohol Dependence. In addition, the assessment of withdrawal symptoms in 1997 required the presence of at least three specific symptoms (eg the shakes, sweating, nausea) but only one had to be present in 2007 for this criteria to be met.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
OTHER SUBSTANCE HARMFUL USE	
Key Output Items:	Key Output Items:
Harmful Use - Cannabinoids:	Harmful Use - Cannabinoids:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
–	Age at Onset (years)
–	Age at Recency (years)
Duration (years)	–
Harmful Use - Stimulants:	Harmful Use - Stimulants:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
–	Age at Onset (years)
–	Age at Recency (years)
Duration (years)	–
Harmful Use - Sedatives:	Harmful Use - Sedatives:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
–	Age at Onset (years)
–	Age at Recency (years)
Duration (years)	–
Harmful Use - Opioids:	Harmful Use - Opioids:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
–	Age at Onset (years)
–	Age at Recency (years)
Duration (years)	–
	Key Differences:
	Other Substance Harmful Use in the 2007 survey addressed behavioural problems associated with the misuse of drugs (eg driving under the influence of drugs or being arrested by the police for behaviour when under the influence) whereas the 1997 survey addressed physical and psychological harm caused by the misuse of drugs (eg overdose, hepatitis or depression).

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
OTHER SUBSTANCE DEPENDENCE	
Key Output Items:	Key Output Items:
Dependence - Cannabinoids:	Dependence - Cannabinoids:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
–	Age at Onset (years)
–	Age at Recency (years)
Duration (years)	–
Dependence - Stimulants:	Dependence - Stimulants:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
–	Age at Onset (years)
–	Age at Recency (years)
Duration (years)	–
Dependence - Sedatives:	Dependence - Sedatives:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
–	Age at Onset (years)
–	Age at Recency (years)
Duration (years)	–
Dependence - Opioids:	Dependence - Opioids:
–	Lifetime prevalence
12-month prevalence	12-month prevalence
–	30-day prevalence
–	Age at Onset (years)
–	Age at Recency (years)
Duration (years)	–
	Key Differences:
	One criteria in diagnosing Other Substance Dependence assesses the persistent use of drugs despite clear evidence of harm. In the 1997 survey, this criteria is assessed by the presence of physical or psychological harm caused by drug use (eg overdose, hepatitis or depression) but the 2007 survey also included social problems as a symptom of Dependence.
SUICIDALITY	
There were three questions about suicide in 1997, asking about thoughts and attempts. Note that the Depression module contained questions about thoughts, plans and attempts, specifically in relation to episodes of Depression.	This is a more detailed section than in 1997 including items on thoughts, plans, and attempts (including method and the number of attempts). Note that the Depression module contains questions about thoughts, plans and attempts, specifically in relation to episodes of Depression.
PSYCHOSIS	
This module contains seven questions about psychotic experiences in the 12 months prior to the interview.	The Psychosis section in 2007 includes questions about lifetime psychotic experiences as well as in the 12 months prior to the interview.
Personality disorder (screener)	–

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
MENTAL HEALTH AND PHYSICAL CONDITIONS	
Medical conditions	Chronic conditions
Somatic disorders	Hypochondriasis/Somatisation
Neurasthenia	–
Disability (Brief Disability Questionnaire (BDQ))	Disability (ABS Short Disability Module)
–	Health risk factors:
Smoker status	Smoker status
–	Level of exercise
–	Body Mass Index (BMI)
Kessler Psychological Distress Scale (K10)	Kessler Psychological Distress Scale (K10) Two questions from the K10 were asked in a slightly different order for 2007 compared with 1997. There have also been slight changes to the question wording. These changes are minimal and are not expected to impact greatly on comparability. There were also four questions on anger attached to the end of the K10 scale in the 2007 survey.
FUNCTIONING	
30-day functioning	The respondents' perceptions of their overall health and life in the 30 days prior to interview.
Short-Form 12	World Health Organization's Disability Assessment Schedule (WHODAS)
–	(Australian) Assessment of Quality of Life (AQoL) instrument.
Days out of role	Days out of role
The number of days in the 4 weeks prior to interview that the respondent was totally unable to work or carry out normal activities (or had to cut down on their usual activities) because of their health.	The number of days in the 30 days prior to interview that the respondent was totally unable to work or carry out normal activities (or had to cut down on their usual activities) because of their health.
OTHER SCALES AND MEASURES	
Mini mental state examination (MMSE)	Mini mental state examination (MMSE)
Asked of persons aged 65 years and over	Asked of persons aged 65–85 years
Self-assessed health rating	Self-assessed health rating
General Health Questionnaire (GHQ–12: 12 item scale)	–
Neuroticism (Eysenck Personality Questionnaire: 12 item scale)	–
Life satisfaction (Delighted-Terrible scale)	Life satisfaction (Delighted-Terrible scale).
MAIN PROBLEM	
Diagnosis which the respondent determined caused them the most trouble.	Diagnosis which the respondent determined caused them the most trouble.

APPENDIX 2 COMPARISON BETWEEN 1997 AND 2007 *continued*

1997 SMHWB	*2007 SMHWB*
SERVICE USE AND PERCEIVED HEALTH NEEDS	
Hospital admissions	Hospital admissions
–	Self-management strategies (eg using the internet, telephone counselling, self-help groups)
Health professional consultations (questions were asked about consultations with the following health professionals: General practitioner, radiologist, pathologist, physician or other medical specialist, surgical specialist or gynaecologist, psychiatrist, psychologist, social worker or welfare officer, drug/alcohol counsellor, other counsellor, nurse, mental health team, chemist for professional advice, ambulance officer, other).	Health professional consultations (questions were asked about consultations with the following health professionals: General practitioner, psychiatrist, psychologist, mental health nurse, other professional providing specialist mental health services, specialist doctor or surgeon, other professional providing general services, complementary/alternative therapist).
Perceived need for care	Perceived need for care
–	Medications for mental health

TECHNICAL NOTE

ESTIMATION PROCEDURES

1 Estimates from the survey were derived using a complex estimation procedure which ensures that survey estimates conform to independent population estimates by state, part of state, age and sex.

RELIABILITY OF THE ESTIMATES

2 Two types of error are possible in an estimate based on a sample survey: sampling error and non-sampling error. The sampling error is a measure of the variability that occurs by chance because a sample, rather than the entire population, is surveyed. Since the estimates in this publication are based on information obtained from occupants of a sample of dwellings they are subject to sampling variability; that is they may differ from the figures that would have been produced if all dwellings had been included in the survey. One measure of the likely difference is given by the standard error (SE). There are about two chances in three that a sample estimate will differ by less than one SE from the figure that would have been obtained if all dwellings had been included, and about 19 chances in 20 that the difference will be less than two SEs.

3 Another measure of the likely difference is the relative standard error (RSE), which is obtained by expressing the SE as a percentage of the estimate. The RSE is a useful measure in that it provides an immediate indication of the percentage errors likely to have occurred due to sampling, and thus avoids the need to refer also to the size of the estimate.

$$RSE\% = \left(\frac{SE}{estimate}\right) \times 100$$

4 Space does not allow for the separate presentation of the SEs and/or RSEs of all the estimates in this publication. However, RSEs for all estimates are available free-of-charge on the ABS website <www.abs.gov.au>, released in spreadsheet format as an attachment to this publication, *National Survey of Mental Health and Wellbeing: Summary of Results (cat. no. 4326.0)*. As a guide, the population and RSE estimates for Table 2 are presented on the following page.

RELIABILITY OF THE ESTIMATES *continued*

12-MONTH MENTAL DISORDERS(a), Relative Standard Error Estimates

	Males		*Females*		*Persons*	
	'000	RSE %	'000	RSE %	'000	RSE %
Any 12-month mental disorder						
Anxiety disorders						
Panic Disorder	180.5	15.6	229.8	10.9	410.3	9.3
Agoraphobia	170.5	17.4	279.9	9.6	450.4	8.3
Social Phobia	298.9	13.4	461.0	7.0	759.9	6.2
Generalised Anxiety Disorder	155.2	18.1	280.9	11.6	436.1	10.5
Obsessive-Compulsive Disorder	130.6	17.6	175.0	11.0	305.6	10.3
Post-Traumatic Stress Disorder	366.3	10.6	665.7	6.3	1 031.9	5.0
Any Anxiety disorder(b)	860.7	6.7	1 442.3	3.8	2 303.0	3.3
Affective disorders						
Depressive Episode(c)	245.0	13.7	407.4	8.2	652.4	7.2
Dysthymia	79.7	21.4	124.0	15.9	203.8	12.0
Bipolar Affective Disorder	145.3	17.3	140.3	13.2	285.6	10.8
Any Affective disorder(b)	420.1	9.8	575.8	7.1	995.9	5.5
Substance Use disorders						
Alcohol Harmful Use	300.8	10.5	169.3	15.6	470.1	8.2
Alcohol Dependence	174.9	15.7	55.3	18.5	230.2	12.2
Drug Use disorders(d)	165.7	13.5	65.7	16.8	231.4	10.0
Any Substance Use disorder(b)	556.4	8.8	263.5	10.7	819.8	6.5
Any 12-month mental disorder(a)(b)	1 400.1	5.5	1 797.7	2.9	3 197.8	2.7
No 12-month mental disorder(e)	6 549.7	1.2	6 267.8	0.8	12 817.5	0.7
Total persons aged 16–85 years	*7 949.8*	—	*8 065.5*	—	*16 015.3*	—

— nil or rounded to zero (including null cells)

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

(b) A person may have had more than one 12-month mental disorder. The components when added may therefore not add to the total shown.

(c) Includes Severe Depressive Episode, Moderate Depressive Episode, and Mild Depressive Episode.

(d) Includes Harmful Use and Dependence.

(e) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) but did not have symptoms in the 12 months prior to interview. See paragraphs 30–31 of Explanatory Notes.

5 The smaller the estimate the higher is the RSE. Very small estimates are subject to such high SEs (relative to the size of the estimate) as to detract seriously from their value for most reasonable uses. In the tables in this publication, only estimates with RSEs less than 25% are considered sufficiently reliable for most purposes. However, estimates with larger RSEs, between 25% and less than 50% have been included and are preceded by an asterisk (eg *3.4) to indicate they are subject to high SEs and should be used with caution. Estimates with RSEs of 50% or more are preceded with a double asterisk (eg **0.6). Such estimates are considered unreliable for most purposes.

6 The imprecision due to sampling variability, which is measured by the SE, should not be confused with inaccuracies that may occur because of imperfections in reporting by interviewers and respondents and errors made in coding and processing of data. Inaccuracies of this kind are referred to as the non-sampling error, and they may occur in any enumeration, whether it be in a full count or only a sample. In practice, the potential for non-sampling error adds to the uncertainty of the estimates caused by sampling variability. However, it is not possible to quantify the non-sampling error.

STANDARD ERRORS OF PROPORTIONS AND PERCENTAGES

7 Proportions and percentages formed from the ratio of two estimates are also subject to sampling errors. The size of the error depends on the accuracy of both the numerator and the denominator. For proportions where the denominator is an estimate of the number of persons in a group and the numerator is the number of persons in a sub-group of the denominator group, the formula to approximate the RSE is given by:

$$RSE(x-y) = \sqrt{([RSE(x)]^2 - [RSE(y)]^2)}$$

8 From the above formula, the RSE of the estimated proportion or percentage will be lower than the RSE of the estimate of the numerator. Thus an approximation for SEs of proportions or percentages may be derived by neglecting the RSE of the denominator, ie by obtaining the RSE of the number of persons corresponding to the numerator of the proportion or percentage and then applying this figure to the estimated proportion or percentage.

COMPARISON OF ESTIMATES

9 Published estimates may also be used to calculate the difference between two survey estimates. Such an estimate is subject to sampling error. The sampling error of the difference between two estimates depends on their SEs and the relationship (correlation) between them. An approximate SE of the difference between two estimates (x–y) may be calculated by the following formula:

$$SE(x-y) = \sqrt{([SE(x)]^2 + [SE(y)]^2)}$$

10 While the above formula will be exact only for differences between separate and uncorrelated (unrelated) characteristics of sub-populations, it is expected that it will provide a reasonable approximation for all differences likely to be of interest in this publication.

SIGNIFICANCE TESTING

11 For comparing estimates between surveys or between populations within a survey it is useful to determine whether apparent differences are 'real' differences between the corresponding population characteristics or simply the product of differences between the survey samples. One way to examine this is to determine whether the difference between the estimates is statistically significant. This is done by calculating the standard error of the difference between two estimates (x and y) and using that to calculate the test statistic using the formula below:

$$\frac{|x-y|}{SE(x-y)}$$

12 The imprecision due to sampling variability, which is measured by the SE, should not be confused with inaccuracies that may occur because of imperfections in reporting by respondents and recording by interviewers, and errors made in coding and processing data. Inaccuracies of this kind are referred to as non-sampling error, and they occur in any enumeration, whether it be a full count or sample. Every effort is made to reduce non-sampling error to a minimum by careful design of questionnaires, intensive training and supervision of interviewers, and efficient operating procedures.

GLOSSARY

Affective (mood) disorders	Disorders that involve mood disturbance. Examples include bipolar affective disorder, depressive episode and dysthymia.
Agoraphobia	Fear of being in public places from which it may be difficult to escape. Includes fears of leaving home, crowds, or travelling in trains, buses or planes. A compelling desire to avoid the phobic situation is often prominent.
Alcohol consumption	Frequency of consumption in the 12 months prior to interview. Only persons who had at least 12 standard drinks in a year were asked about their consumption. See Standard drink.
Anxiety disorders	Disorders that involve feelings of tension, distress or nervousness. In this survey the following anxiety disorders were collected; Panic Disorder, Social Phobia, Agoraphobia, Generalised Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD) and Obsessive-Compulsive Disorder (OCD).
Area of usual residence	State capital city is the capital city Statistical Division for each State or Territory. Balance of State/Territory covers the remaining areas. For more detailed information refer to the AUSTRALIAN STANDARD GEOGRAPHICAL CLASSIFICATION (ASGC), JULY 2007 (cat. no. 1216.0).
Assessment of Quality of Life (AQoL)	An Australian-developed quality of life instrument that is used to measure the burden of disease. Questions measure: illness, independence, social relationships, physical senses, and psychological wellbeing.
Bipolar Affective Disorder	Characterised by repeated episodes in which the person's mood and activity levels are significantly disturbed—on some occasions lowered (depression) and on some occasions elevated (mania or hypomania).
Body Mass Index (BMI)	Calculated from reported height and weight information, using the formula weight (kg) divided by the square of height (m). BMI values are grouped according to the list below which allows categories to be reported against both the World Health Organization (WHO) and the National Health and Medical Research Council (NHMRC) guidelines. ▪ Underweight: Less than 18.5 ▪ Normal weight range: 18.5 to less than 25.0 ▪ Overweight: 25.0 to less than 30.0 ▪ Obese: 30.0 and greater
Caregiving	The provision of care to an immediate family member who has cancer, serious heart problems, serious memory problems, an intellectual disability, a physical disability, chronic illness, alcohol or drug problems, depression, anxiety, schizophrenia or psychosis, bipolar affective disorder or other serious chronic mental problems. Provision of care includes helping with washing, dressing or eating, paperwork, housework, getting around or taking medications, or keeping company and giving emotional support.
Chronic conditions	A physical condition or disorder that has lasted, or is expected to last for six (6) months or more. May also be referred to as a long-term health condition or chronic disease.
Comorbidity	The occurrence of more than one mental disorder at the same time. Comorbidity may refer to the co-occurrence of mental disorders and the co-occurrence of mental disorders and physical conditions.
Composite International Diagnostic Interview (CIDI)	A comprehensive modular interview which can be used to assess lifetime and 12-month prevalence of mental disorders through the measurement of symptoms and their impact on day-to-day activities.
Contact with family or friends	Whether in contact with any family and/or friends, and the frequency of the contact. Contact includes visits, phone calls, letters, or electronic mail messages.

GLOSSARY *continued*

Country of birth The classification of countries is the Standard Australian Classification of Countries (SACC). For more detailed information refer to the STANDARD AUSTRALIAN CLASSIFICATION OF COUNTRIES (SACC), 1998 (cat. no. 1269.0).

Days out of role The number of days in the 30 days prior to interview that a person was unable to work or carry out normal activities or had to cut down what they did because of their health.

Dependence A maladaptive pattern of use in which the use of drugs or alcohol takes on a much higher priority for a person than other behaviours that once had greater value. The central characteristic is the strong, sometimes overpowering, desire to take the substance despite significant substance-related problems.

Depressive Episode A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Their sleep, appetite and concentration may be affected.

Disability status Whether has a disability, the level of core-activity limitation (none, mild, moderate, severe or profound), and whether has a schooling or employment restriction.

Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition (DSM–IV) The DSM–IV is a handbook for mental health professionals that lists different categories of mental disorders and the criteria for diagnosing them. The DSM–IV focuses on clinical, research and educational purposes, supported by an extensive empirical foundation.

Drug Use disorder Drug Use disorder involves the harmful use and/or dependence on drugs. Drugs include the use of illicit substances and the misuse of prescribed medicines. Four drug categories have been included in this survey:

- sedatives, eg serepax, sleeping pills, valium
- stimulants, eg amphetamines, speed
- marijuana, ie hashish
- opioids, eg heroin, methadone, opium.

Dwelling A suite of rooms contained within a building which are self-contained and intended for long-term residential use. To be self-contained, the suite of rooms must possess cooking and bathing facilities as building fixtures. Examples of types of dwelling include: separate house; semi-detached, row or terrace house or townhouse; flat, unit or apartment; and other dwellings, including caravan, cabin, houseboat, and house or flat attached to a shop.

Dysthymia A disorder characterised by constant or constantly recurring chronic depression of mood, lasting at least two years, which is not sufficiently severe, or whose episodes are not sufficiently prolonged, to qualify as recurrent depressive disorder. The person feels tired and depressed, sleeps badly and feels inadequate, but is usually able to cope with the basic demands of everyday life.

Employed People aged 15 years and over who had a job or business, or who undertook work without pay in a family business for a minimum of one hour per week. Includes persons who were absent from a job or business.

Employed full-time Employed persons who usually worked 35 hours a week (in all jobs) and those who, although usually working less than 35 hours a week, worked 35 hours or more during the reference week.

Employed part-time Employed persons who usually worked less than 35 hours a week (in all jobs) and either did so during the reference week, or were not at work in the reference week.

Family composition of household Refers to the family composition of the household to which the respondent belonged. In this publication households are categorised as lone person, couple only, couple family with child(ren), one parent family with child(ren), and other households.

GLOSSARY *continued*

Generalised Anxiety Disorder (GAD)	A disorder involving anxiety that is generalised and persistent, but not restricted to any particular environmental circumstances. It is chronic and exaggerated worry or tension, even though nothing seems to provoke it. Symptoms are variable, but include complaints of persistent nervousness, trembling, muscular tensions, sweating, light-headedness, palpitations, dizziness and epigastric discomfort. The person may also anticipate disaster or worry excessively about health, money, family or work.
Government support	Cash support from the government in the form of pensions, benefits or allowances.
Harmful Use	A pattern of use of alcohol or drugs that is responsible for (or substantially contributes to) physical or psychological harm, including impaired judgement or dysfunctional behaviour.
Health risk factors	Characteristics that may increase the likelihood of injury or illness, for example level of exercise, smoking, alcohol/drug consumption etc.
Hierarchy rule	When hierarchy rules are applied, a person is excluded from a diagnosis, even though they have sufficient symptoms to meet criteria, because they have another disorder that is thought to account for those symptoms.
Homelessness	Includes sleeping in public places, homeless shelters, a tent, an abandoned building or couch surfing when a person has no other choice.
Household	A group of residents of a dwelling who share common facilities and meals or who consider themselves to be a household. It is possible for a dwelling to contain more than one household, for example, where regular provision is made for groups to take meals separately and where persons consider their households to be separate.
Household income	Derived as the sum of the reported personal cash incomes of all household members aged 15 years and over. Household incomes were then divided into quintiles; 1st quintile is the lowest income, 5th quintile is the highest income. Cases where household income could not be derived are excluded before quintiles are created.
Hypomania	A lesser degree of mania characterised by a persistent mild elevation of mood and increased activity lasting at least four consecutive days. Increased sociability, over-familiarity and a decreased need for sleep are often present, but not to the extent that they lead to severe disruption.
Immediate family member	Parents, parents-in-law, grandparents, brothers and sisters, children, aunts, uncles, nieces, nephews and spouse/partner.
Incarceration	Time spent in gaol, prison or correctional facility.
Index of disadvantage	This is one of four Socio-Economic Indexes for Areas (SEIFAs) compiled by ABS following each Census of Population and Housing. The indexes are compiled from various characteristics of persons resident in particular areas. The index of disadvantage summarises attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. For more information refer to *Information Paper: An introduction to socio-economic indexes for areas (SEIFA), 2006* (cat. no. 2039.0).
Industry of main job	A group of businesses or organisations which perform similar sets of activities in terms of the production of goods and services. For more information refer to the Australian and New Zealand Standard Industrial Classification (ANZSIC), 2006 (cat. no. 1292.0).
International Classification of Diseases–Tenth Revision (ICD–10)	The ICD–10 is the tenth edition of the international standard diagnostic classification for all general epidemiological purposes, many health management purposes and in clinical use. The ICD is produced by the World Health Organization and is used in the diagnosis, study and classification of diseases.
Labour force status	Persons aged 15 years and over who were 'employed', 'unemployed' or 'not in the labour force' as defined.

GLOSSARY *continued*

Level of exercise

Based on frequency, intensity (ie walking, moderate exercise or vigorous exercise) and duration of exercise (for recreation, sport or fitness) in the week prior to interview. From these components, an exercise category was determined using factors to represent the intensity of the exercise. Categories were grouped according to the following levels of exercise:

- Very low: Less than 100 minutes (including no exercise)
- Low: 100 minutes to less than 1,600 minutes
- Moderate: 1,600–3,200 minutes, or more than 3,200 minutes, but less than 2 hours of vigorous exercise
- High: More than 3,200 minutes including 2 hours or more of vigorous exercise.

Level of highest non-school qualification

The highest level of educational attainment. For more information refer to the AUSTRALIAN STANDARD CLASSIFICATION OF EDUCATION (ASCED), 2001 (cat. no. 1272.0).

Main source of personal income

Includes employee cash income, unincorporated cash income, government cash pensions or allowances, property cash income, superannuation/annuities, transfer from private organisations and transfer from other households.

Mania

A disorder in which mood is happy, elevated, expansive or irritable out of keeping with the person's circumstances lasting at least seven days and leading to severe disruption with daily living. The person may exhibit hyperactivity, inflated self-esteem, distractibility and over-familiar or reckless behaviour.

Marital status

Based on registered marriage status with the inclusion of de facto relationship. See also Registered marital status and Social marital status.

Mental disorder

According to the ICD–10 Classification of Mental and Behavioural Disorders, a disorder implies 'the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions' (WHO 1992, p5). Most diagnoses require criteria relating to severity and duration to be met.

Mental health problem

Problems with mental health, such as stress, worry or sadness; regardless of whether they met criteria for mental disorders.

Misuse of drugs

Misuse of drugs in the 12 months prior to interview. Refers to the use of illicit drugs and/or the misuse of prescription drugs. People must have misused the same drug more than five times in their lifetime.

Not in the labour force

People who were not in the categories 'employed' or 'unemployed' as defined.

Obsessive-Compulsive Disorder

Characterised by obsessions (recurrent thoughts, ideas or images), compulsions (repetitive acts) or both, which cause distress or interfere with the person's normal functioning.

Occupation of main job

A set of jobs that require the performance of similar or identical sets of tasks. As it is rare for two actual jobs to have identical sets of tasks, in practical terms, an occupation is a set of jobs whose main tasks are characterised by a high degree of similarity. For further information refer to AUSTRALIAN AND NEW ZEALAND STANDARD CLASSIFICATION OF OCCUPATIONS (ANZSCO), FIRST EDITION, 2006 (cat. no. 1220.0).

Panic attack

A panic attack is a discrete episode of intense fear or discomfort that starts abruptly and reaches a peak within a few minutes and lasts at least some minutes.

Panic Disorder

Panic disorder is recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances (ie do not occur in the presence of a phobia, or in situations of danger) and are therefore unpredictable.

GLOSSARY *continued*

Perceived health needs

For each type of help, perceived health needs of respondents were classified as follows:
- no need - those who were not receiving help and felt that they had no need for it;
- need fully met - those who were receiving help and felt that it was adequate;
- need partially met - those who were receiving help but not as much as they felt they needed; and
- need not met - those who were not receiving help but felt that they needed it.

Physical condition

A medical condition, illness, injury or disability including: asthma; cancer; stroke (or the effects of a stroke); gout, rheumatism or arthritis; diabetes or high blood sugar levels; and any other heart or circulatory condition. Information was also collected about the presence of the following physical conditions only if they had lasted for six months or more: hayfever; sinusitis or sinus allergy; emphysema; bronchitis; anaemia;epilepsy; fluid problems/fluid retention/oedema (excluding those due to heart or circulatory problems); hernias; kidney problems; migraine; psoriasis; stomach ulcer or other gastrointestinal ulcer; thyroid trouble/goiter; tuberculosis; back or neck pain or back or neck problems. The presence of any other physical conditions were not determined.

Post-Traumatic Stress Disorder (PTSD)

A delayed and/or protracted response to a psychologically distressing event that is outside the range of usual human experience. Experiencing such an event is usually associated with intense fear, terror or helplessness. The characteristic symptoms involve re-experiencing the traumatic event (flashbacks), avoidance of situations or activities associated with the event, numbing of general responsiveness and increased arousal.

Prevalence of mental disorders

The proportion of people in a given population who met the criteria for diagnosis of a mental disorder at a point in time.

Psychological distress

Derived from the Kessler Psychological Distress Scale (K10). This is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the 30 days prior to interview. The K10 is scored from 10 to 50, with higher scores indicating a higher level of distress; low scores indicate a low level of distress. In this publication, scores are grouped as follows:
- Low 10–15;
- Moderate 16–21;
- High 22–29; and
- Very high 30–50.

Psychosis

A mental disorder in which the person has strange ideas or experiences which are unaffected by rational argument and are out of keeping with the views of any culture or group that the person belongs to.

Registered marital status

An individual's current status in regard to a registered marriage, ie whether he or she is widowed, divorced, separated, married or never married.

Section of state

This geographical classification uses population counts to define Collection Districts (CDs) as urban or rural. Population counts are used to define a geographical area as a major urban area (population of 100,000 or more), other urban area (population of 1,000–9,999), bounded locality (population of 200–999) and rural balance (the remainder of the state/territory). For more information refer to AUSTRALIAN STANDARD GEOGRAPHICAL CLASSIFICATION (ASGC), 2007 (cat. no. 1216.0).

Service for the Australian defence forces

Includes persons who had overseas qualifying service, serving and ex-serving Australian Defence Force members.

Services used for mental health problems

Services used for self-perceived mental health problems in the 12 months prior to interview. Services include admissions to hospitals and consultations with health professionals for mental health. An individual may have considered they had a mental health problem prior to using services, or may have come to the realisation following consultation with a health professional.

GLOSSARY *continued*

Smoker status

The extent to which an adult was smoking at the time of interview, and refers to regular smoking of tobacco, including manufactured (packet) cigarettes, roll-your-own cigarettes, cigars and pipes, but excludes chewing tobacco and smoking of non-tobacco products. Categorised as:

- Current daily smoker – an adult who reported at the time of the interview that they regularly smoked one or more cigarettes, cigars or pipes per day;
- Current smoker – other – an adult who reported at the time of interview that they smoked cigarettes, cigars or pipes at least once a week, but not daily, or less than weekly;
- Ex-smoker – an adult who reported they did not currently smoke, but had regularly smoked daily, or had smoked at least 100 cigarettes in their lifetime; and
- Never smoked – an adult who reported they had never regularly smoked daily, and had smoked less than 100 cigarettes in their lifetime.

Social marital status

Social marital status is the relationship status of an individual with reference to another person who is usually resident in the household. A marriage exists when two people live together as husband and wife, or partners, regardless of whether the marriage is formalised through registration. Individuals are, therefore, regarded as married if they are in a de facto marriage, or if they are living with the person to whom they are registered as married.

Social networks

For respondents who had contact with family and/or friends, whether they can rely on or confide in them if they were faced with a serious problem. See Contact with family or friends.

Social Phobia

A persistent, irrational fear of being the focus of attention, or fear of behaving in a way that will be embarrassing or humiliating. These fears arise in social situations such as meeting new people or speaking in public. A compelling desire to avoid the phobic situation may result.

Standard drink

A standard drink contains 12.5ml of alcohol. It is important to note that the serving size will determine the number of standard drinks per serve, as shown by these approximations:

- Can/Stubbie light beer = 0.8 standard drink
- Can/Stubbie medium light beer = 1 standard drink
- Can/Stubbie regular beer = 1.5 standard drinks
- 100ml wine (9 to 13% alcohol) = 1 standard drink
- 30ml nip spirits = 1 standard drink
- Can spirits (approx 5% alcohol) = 1.5 to 2.5 standard drinks

Substance Use disorder

Substance Use disorders include harmful use and/or dependence on drugs and/or alcohol.

Suicidal behaviours

Three experiences are included as suicidal behaviours:

- Ideation (ie the presence of serious thoughts about committing suicide);
- Plans; or
- Attempts.

Type of health professional

Type of health professionals:

- general practitioner
- psychiatrist
- psychologist
- mental health nurse
- other mental health professional - includes specialist mental health services, such as a social worker, counsellor or occupational therapist
- other health professional - includes those providing general services; a specialist or surgeon, such as a cardiologist, gynaecologist or urologist; or complimentary/alternative therapists, such as a herbalist or naturopath.

GLOSSARY *continued*

Type of help for mental health problems

A range of assistance provided by health services for mental health problems:
- information
- medication
- counselling
- social intervention (ie help to sort out practical issues such as housing or money problems, or for support or company, or to help meet people)
- skills training (ie help to improve ability to work, to care for self, or to use time more effectively)

Type of medication used for mental health

Refers to the type of medication reported by respondents as used for their mental health in the two weeks prior to interview. May include medications used for preventive health purposes as well as medications used for mental disorders and includes vitamins and minerals, natural and herbal medications and pharmaceutical medications.

Unemployed

People aged 15 years and over who were not employed during the reference week, and:
- had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week and were available for work in the reference week; or
- were waiting to start a new job within four weeks from the end of the reference week and could have started in the reference week if the job had been available then.

World Health Organization (WHO)

The WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

WHODAS

The WHO Disability Assessment Schedule (WHODAS) is a simple tool for assessing disturbances in social adjustment and behaviour in patients with a mental disorder. The current version (WHODAS II) represents a complete revision, reflective of WHO's current thinking about functioning and disability.

BIBLIOGRAPHY

Access Economics, 2007. *Smoking and mental illness: Costs*. A report for SANE Australia. Retrieved 18 August 2008 from http://www.accesseconomics.com.au/

Andrews, G and Slade, T, 2001. Interpreting scores on the Kessler Psychological Distress Scale (K–10) in the *Australian and New Zealand Journal of Public Health*, vol. 25, no. 6, pp494-497. Retrieved 18 June 2008 from Informit database.

Australian Bureau of Statistics (ABS), 2007. Education and Work, Australia, *2007* (cat. no. 6227.0). Canberra.

Australian Bureau of Statistics (ABS), 2006. National Health Survey: Summary of Results, *2004–05* (cat. no. 4364.0). Canberra.

Australian Health Ministers, July 2003. *National Mental Health Plan 2003–2008*. Retrieved 12 June 2008 from http://www.health.gov.au/

Australian Institute of Health and Welfare (AIHW), 2008. Australia's Health, *2008* (cat. no. AUS99). AIHW, Canberra.

Commonwealth Department of Health and Aged Care (CDHAC), 2001. *National Comorbidity Project*. A report on the National Comorbidity Workshop prepared by M Teesson and L Burns (eds) of the National Drug and Alcohol Research Centre. Commonwealth of Australia, Canberra.

Department of Health and Ageing (DoHA), 2007. *National Mental Health Report, 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993–2005*. Commonwealth of Australia, Canberra.

Department of Veteran's Affairs (DVA), 2004. *Alcohol and mental health*. Retrieved 10 September 2008 from http://www.therightmix.gov.au/

Fryers, T, Melzer, D, Jenkins, R, and Brugha, T, 2005. The distribution of the common mental disorders: Social inequalities in Europe in *Clinical Practice and Epidemiology in Mental Health* (online), vol. 1, no. 14. Retrieved 15 August 2008 from BioMed Central http://www.pubmedcentral.nih.gov/

Kessler, RC, and Ustun, TB, 2004. The World Mental Health (WMH) Survey Initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI) in the *International Journal of Methods in Psychiatric Research*, vol. 13, no. 2, pp93-121. Retrieved 2 July 2008 from http://www.hcp.med.harvard.edu/wmhcidi/

National Centre for Education and Training on Addiction (NCETA) Consortium, 2004. *Alcohol and Other Drugs: A handbook for health professionals*. Retrieved 11 September 2008 from http://www.aodgp.gov.au

World Health Organization (WHO), 2007. *International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10 online)*. Retrieved 19 June 2008 from http://www.who.int/

World Health Organization (WHO), 2005. *Promoting mental health: Concepts, emerging evidence, practice*. A report of the WHO, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne by Herman, Saxena, and Moodie (eds). Retrieved 28 August 2008 from http://www.who.int/

World Health Organization (WHO), 2001. *The World Health Report 2001- Mental health: New understanding, New hope*. Retrieved 12 June 2008 from http://www.who.int/

FOR MORE INFORMATION . . .

INTERNET **www.abs.gov.au** the ABS website is the best place for data from our publications and information about the ABS.

INFORMATION AND REFERRAL SERVICE

Our consultants can help you access the full range of information published by the ABS that is available free of charge from our website. Information tailored to your needs can also be requested as a 'user pays' service. Specialists are on hand to help you with analytical or methodological advice.

PHONE 1300 135 070

EMAIL client.services@abs.gov.au

FAX 1300 135 211

POST Client Services, ABS, GPO Box 796, Sydney NSW 2001

FREE ACCESS TO STATISTICS

All statistics on the ABS website can be downloaded free of charge.

WEB ADDRESS www.abs.gov.au

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RA -2

This is the attachment marked 'RA-2' referred to in the witness statement of Ro Allen dated "2 July 2019" .

SNAPSHOT OF MENTAL HEALTH AND SUICIDE PREVENTION STATISTICS FOR LGBTI PEOPLE

July 2016

Although most Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) Australians live healthy and happy lives, research has demonstrated that a disproportionate number experience poorer mental health outcomes and have higher risk of suicidal behaviours than their peers. These health outcomes are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of being LGBTI.

This document aims to provide a snapshot what is known of the current mental health and wellbeing outcomes of LGBTI people in Australia.

While Australian and international research provide evidence that demonstrate significant concern regarding mental health outcomes and suicidal behaviours among LGBTI people, it is vital to note that significant knowledge gaps still remain. This is due to lack of inclusion of sexual orientation, gender identity and intersex status in population research[i] and data collection in mental health services[ii]. As data informs evidence-based policy, this exclusion has lead to inaccuracy in reporting and significant underestimates that has left LGBTI people relatively invisible in mental health and suicide prevention policies, strategies and programmes.

Consequently, Australian national evidence on the health and wellbeing of LGBTI populations relies upon a growing but limited number of smaller scale studies that target LGBTI populations, or part thereof. While uniquely valuable, these can have methodological issues relating to representative data collection and limited ability to provide a comprehensive data analysis that is therefore unable to represent a holistic picture of LGBTI people[iii].

'LGBTI' is often viewed as a single category about which can be spoken about in broad generalisations, however it is vital to understand that within 'LGBTI' there are several distinct, but sometimes overlapping, demographics each with their own distinct histories, experiences and health needs. Research that collapsed these separate groups into a single group for their analysis risks conflating and reaching conclusions that may not be representative of all groups. Where possible, we have noted when this may have occurred, and these statistics should be used with caution when representing the experience of groups that underrepresented (mainly Transgender and Intersex people)

This document includes a range language of beyond that typically used by the National LGBTI Health Alliance[1]. This is to directly reflect the terminology and classifications used by the various research papers used as source data in this document, such as the classification of age ranges, terminology used

[1] For an outline of the language the National LGBTI Health Alliances utilises, please visit http://lgbtihealth.org.au/lgbti/

to describe gender, and descriptors and definitions of mental health concerns. Across this research, there is often little uniformity of demographic information or definitions of mental health concerns that supports direct comparison between LGBTI populations and the general population.

When considering data provided in this document it is important to note that this is not a comprehensive literature review, and we urge the reader to consider this broader context where adequately estimating the mental health outcomes and suicidal behaviours for LGBTI populations remains highly challenging.

Contents

SUICIDIALITY

Suicide Attempts[2]

Compared to the general population, LGBTI people are more likely to attempt suicide in their lifetime, specifically:

- LGBTI young people aged 16 to 27 are five times more likely
- Transgender people aged 18 and over are nearly eleven times more likely
- People with an Intersex variation aged 16 and over are nearly six times more likely
- LGBT young people who experience abuse and harassment are even more likely to attempt suicide

Statistics for LGBTI Population

- 16% of LGBTI[3] young people aged 16 to 27 reported that they had attempted suicide[iv]
- 35% of Transgender people aged 18 and over[4] have attempted suicide in their lifetime[v]

[2] Note: the majority of research targeting adult LGBTI populations in Australia has not included questions regarding if participants have attempted suicide.
[3] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation
[4] Scotland research of participants in the UK

- 19% of people with an Intersex variation aged 16 and over had attempted suicide on the basis of issues related their Intersex status[vi]
- 8% of Same-Gender Attracted and Gender Diverse young people between 14 and 21 years had attempted suicide, 18% had experienced verbal abuse, and 37% of those who experienced physical abuse[vii]

Statistics for General Population

- 3.2% of people (4.4% females; 2.1% males) aged 16 and over have attempted suicide in their lifetime; 0.4% of general population (0.5% females; 0.3% males) in the last 12 months[viii]
- 1.1% of people (1.7% females; 0.5% males) aged 16 to 24 have attempted suicide in the past 12 months[ix]

Suicide Ideation

Compared to the general population, LGBTI people are more likely to have thoughts of suicide, specifically:

- Lesbian, Gay and Bisexual people aged 16 and over are over six times more likely
- Transgender people aged 18 and over are nearly eighteen times more likely
- People with an Intersex variation aged 16 and over are nearly five times more likely
- LGBT young people who experience abuse and harassment are even more likely to have thoughts of suicide

Statistics for LGBTI Populations

- 15.15% of LGBTI[5] people aged 16 and over report current thoughts of suicide in the past 2 weeks[x]
- 41% of Transgender people and people with a Non-Binary gender aged 18 years and over report thoughts of suicide or self harm in the last 2 weeks[xi]
- 60% of people with an Intersex variation aged 16 and over had thoughts about suicide on the basis of issues related to having congenital sex variation[xii]
- 22% of Same-Gender Attracted and Gender Diverse young people between 14 and 21 years have thoughts of suicide, which increases to 30% for those who have experienced verbal abuse and to 60% who have experienced physical abuse[xiii]

Statistics for General Population

- 13.3% of the general population (15% females; 11.5% males) aged 16 and over in Australia have had suicidal ideation in their lifetime; 2.3% of general population (2.7% females; 1.8% males) in the last 12 months[xiv]
- 3.4% of the general population (1.7% of males and 5.1% of females) aged 16 to 24 in Australia have had suicidal ideation in the past 12 months[xv]

Self-Harm[6]

Compared to the general population, LGBTI people are more likely to have engaged in self harm in their lifetime, specifically:

- LGBT young people are nearly twice as likely to engage in self-injury
- Transgender people are six and a half times more likely
- People with an Intersex variation are three times more likely
- LGBT young people who experience abuse and harassment are even more likely to have self-

[5] Note: of 5467 survey participants, only 1.8% identified as Transgender, and 0.3% identified as having an Intersex variation

[6] Note: the majority of research targeting adult LGBTI populations in Australia has not included questions regarding if participants have engaged in self harm.

harmed

Statistics for LGBTI Populations

- 33% of LGBTI[7] young people aged 16 to 27 reported having self-harmed, 41% had thoughts of harming themselves[xvi]
- 53% of Transgender people aged 18 and over[8] have self-harmed in their lifetime, 11% currently self-harming.[xvii]
- 26% of people with an Intersex variation aged 16 and over have self-harmed on the basis of issues related to having a congenital sex variation, 42% have had thoughts about self harm[xviii]
- 18% of Same-Gender Attracted and Gender Diverse young people between 14 and 21 years have self-harmed, which increases to 32% for those who have experienced verbal abuse, and to 54% for those who have experienced physical abuse

Statistics for General Population

- 8.1% of people (8.7% females; 7.5% males) aged 16 and over have engaged in self-injury in their lifetime; and 1.1% of people (1.2% females; 1% males) in the past 4 weeks[xix]
- 14.1% of people (16.6% females; 11.6% males) aged between 15 and 19; and 21.25% of people (24.4% females; 18.1% males) aged between 20 and 24 have engaged in self injury in their lifetime[xx]

MENTAL HEALTH OUTCOMES

Mental Health Disorders[9]

Compared to the general population, LGBT people are more likely to experience and be diagnosed with a mental health disorder, specifically:

- Lesbian, Gay and Bisexual people are twice as likely to have symptoms that the criteria for a mental health disorder in the past 12 months
- LGBT people are twice as likely to be diagnosed and treated for mental health disorders

Statistics for LGBTI Population

- 41.4% of homosexual/Bisexual people aged 16 and over met the criteria for a mental disorder and had symptoms in the last 12 months[xxi]
- 37.2% LGBT people aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[xxii]

Statistics for the General Population

- 20% of people (22.3% female; 17.6% male) aged 16 and over met the criteria for a mental disorder and had symptoms in the last 12 months[xxiii]

Depression

Compared to the general population, LGBTI people are more likely to experience and be diagnosed with depression, specifically:

- Lesbian, Gay and Bisexual people aged 16 and over are nearly six times more likely to currently meet the criteria for a depressive episode
- LGBTI people aged 16 and over are nearly three times more likely to diagnosed with depression in their lifetime
- Transgender and Gender Diverse people aged 18 and over are nearly 5 times more likely to be diagnosed with depression in their lifetime

[7] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation
[8] Scotland research of participants in the UK
[9] Includes depression, anxiety and other mental disorders

- People with an Intersex variation are nearly twice as likely to be diagnosed with depression

Statistics for LGBTI Population

- 24.4% LGBTI people aged 16 and over[10] currently meet the full criteria for a major depressive episode [xxiv]
- 30.5% of LGBT people aged 16 and over[11] have been diagnosed or treated for depression in the last three years[xxv]
- 57.2% of Transgender and Gender Diverse people aged 18 and over have been diagnosed with depression in their lifetime[xxvi]
- 21.3% of people with Intersex variations aged 16 and over have been diagnosed with depression[xxvii]

Statistics for the General Population

- 11.6% of people (14.5% females; 8.8% males) aged 16 and over have experienced a depressive episode in their lifetime; 4.1% of people (5.1% females; 3.1% males) in the last 12 months[xxviii]

Anxiety

Compared to the general population, LGBTI people are more likely to experience and be diagnosed with anxiety, specifically:

- LGB people aged 16 and over are more than twice as likely to currently meet the criteria for ananxiety disorder
- LGB people aged aged 16 and over are three and a half times more likely to be diagnosed with anxiety in their lifetime
- Transgender people aged 18 and over are nearly three times more likely to be diagnosed with an anxiety disorder in their lifetime
- People with an Intersex variation aged 16 and over are twice as likely to be diagnosed with anxiety in their lifetime

Statistics for LGBTI Population

- 31.5% of homosexual/Bisexual people aged 16 and over in Australia met the criteria for an Anxiety Disorder in the last 12 months[xxix]
- 20.3% LGBTI people aged 16 and over[12] reported that they had been diagnosed with anxiety in their lifetime[xxx]
- 39.9% of Trans and Gender Diverse people aged 18 and over have been diagnosed with an anxiety disorder in their lifetime[xxxi]
- 12.9% of people with an Intersex variation aged 16 and over reported being diagnosed with anxiety[xxxii]

Statistics for the General Population

- 26.3% of people (32% females; 20.4% males) aged 16 and over have had an Anxiety Disorder in their lifetime; 14.1% of people (17.9% females; 10.8% of males) in the last 12 months (includes panic disorders, social phobia, generalised anxiety disorder, Obsessive Compulsive Disorder, and Post Traumatic Stress Disorder)[xxxiii]
- 5.9% of people (7.3% females; 4.4% males) aged 16 and over have had Generalised Anxiety Disorder in their lifetime; 2.7% of people (3.5% females; 2% males) in the past 12 months[xxxiv]

[10] Note: of 5467 survey participants, 1.8% identified as Transgender, and 0.3% identified as having an Intersex variation

[11] Note: of 3835 survey participants, 7.41% identified as Transgender, and people with an Intersex variation were not included in data collection

[12] Note: of 5467 survey participants, only 1.8% identified as Transgender, and 0.3% identified as having an Intersex variation

Psychological Distress

Compared to the general population LGBTI people experience higher levels of psychological distress, specifically:

- LGBT people score higher on the Kessler Psychological Distress (K10) Scale indicating moderate levels of psychological distress.
- LGBT people who have experienced verbal abuse, physical abuse and harassment score higher on the K10 scale indicating high levels of psychological distress

Statistics for LGBTI Population

- LGBT people aged 16 and over[13] scored an average K10 score of 19.6, indicating moderate psychological distress[xxxv]
- LGBT people aged 16 and over who have experienced abuse and harassment scored an average K10 score of 22.83, indicating a high level of psychological distress
- 7.7% of people with an Intersex variation reported being diagnosed with Post-Traumatic Stress Disorder[xxxvi]

Statistics for the General Population

- National average K10 score for the general population aged 16 and over in Australia is 14.5 indicating low psychological distress[xxxvii]
- 70% of the general population aged 16 and over in Australia has a K10 score in the low range, 20% in the moderate range, 7% in the high range and 3% in the very high range[xxxviii]

DISAGGREGATING LGBTI

Lesbian and Gay People

There are differences between the mental health and wellbeing of Gay men and Lesbian women, specifically:

- Lesbian women are more likely to be diagnosed and treated for mental disorder or anxiety, and are more likely to engage in self harm and attempt suicide than Gay men
- Gay men are more likely to have thoughts about suicide, but are less likely to attempt suicide than Lesbian women
- Gay men and Lesbian women have a similar level of psychological distress

Population Statistics for Lesbian Women

- 44% of Lesbian women aged 16 to 27 reported thoughts about suicide, 20% have attempted suicide[xxxix].
- 46% of Lesbian women aged 16 to 27 reported having self-harmed, 48% reported thoughts about harming themselves[xl]
- 39.1% of Lesbian women aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[xli]
- 31% of Lesbian women aged 16 and over reported being diagnosed or treated for anxiety in the last 3 years[xlii]
- Lesbian women aged 16 and over average a K10 score of 19, indicating a Moderate level of psychological distress[xliii]

Population Statistics for Gay Men

- 46% of of Gay men aged 16 to 27 reported thoughts about suicide, 14% have attempted suicide[xliv].

[13] Note: of 3835 survey participants, 7.41% identified as Transgender, and people with an Intersex variation were not included in data collection

- 21% of of Gay men aged 16 to 27 reported having self-harmed, 40% have had thoughts about harming themselves[xlv].
- 29.8% of Gay men aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[xlvi]
- 23.5% of Gay men aged 16 and over reported being diagnosed or treated for anxiety in the last 3 years[xlvii]
- Gay men aged 16 and over average a K10 score of 18.8, indicating a moderate level of psychological distress[xlviii]

Bisexual People

There are differences between the mental health and wellbeing of Gay men and Lesbian women, and Bisexual people, specifically:

- Bisexual people are more likely to be diagnosed and treated for mental disorder or anxiety
- Bisexual people have higher levels of psychological disress
- Gay men and Lesbian women are more likely to self harm, have thoughts about suicide, and attempt suicide

There are also differences between the mental health and wellbeing of Bisexual men and Bisexual women, specifically:

- Bisexual women are more likely to be diagnosed or treated for a mental disorder or anxiety, to have higer levels of psychologcal distress, and to self harm
- Bisexual men are more likely to think about suicide, but both Bisexual women and Bisexual men have similar rates of suicide attempts

Statistics for Bisexual Women

- 29% of Bisexual women aged 16 to 27 reported thoughts about suicide, 10% have attempted suicide[xlix]
- 30% of Bisexual women aged 16 to 27 reported having self-harmed, 31% reported thoughts of harming themselves[l]
- 50.6% of Bisexual women aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[li]
- 38.8% of Bisexual women aged 16 and over reported being diagnosed or treated for anxiety in the last 3 years[lii]
- Bisexual women aged 16 and over average a K10 score of 21.8, indicating moderate levels of psychological distress[liii]

Statistics for Bisexual Men

- 32% of Bisexual men aged 16 to 27 reported thoughts about suicide, 9% have attempted suicide[liv]
- 17% of Bisexual men aged 16 to 27 reported having self-harmed, 32% reported thoughts about harming themselves[lv]
- 34.1% of Bisexual men aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[lvi]
- 20.9% of Bisexual men aged 16 and over reported being diagnosed or treated for anxiety in the last 3 years[lvii]
- Bisexual men aged 16 and over average a K10 score of 20.5, indicating moderate levels of psychological distress[lviii]

Transgender People

There are differences between the mental health and wellbeing of Lesbian, Gay and Bisexual people, and Transgender and Gender Diverse people people, specifically:

- Transgender people higher rate of suicide attempts than LGB people, which is nearly eleven times more likely to attempt suicide than the general population
- Trans people are nearly three times more likely to have had thoughts of suicide than LGB people combined, and are twelve times more likely to have thoughts about suicide than the general population
- Trans people experience high levels of psychologcal distress, compared to moderate levels experienced by Lesbian, Gay and Bisexual people
- Trans people are nearly twice as likely to be diagnosed or treated with a mental disorder and anxiety than Lesbian and Gay people, and nearly three times than the general population

There are also differences between the mental health and wellbeing of Transgender men, Transgender women and people with Non-Binary gender, specifically:

- Transgender women are more likely to have thoughts of suicide than Trans men and people with a Non-Binary gender
- Trans men are more likely to be diagnosed with depression and anxiety in their lifetime than Trans women
- Trans men and Trans women have similar levels of psychological distress
- Transgender people are more likely to experience depression than people with a Non-Binary gender, but people with a Non-Binary gender are more likely to experience anxiety than Transgender people

Statistics for Transgender and Gender Diverse People

- 35% of Transgender people aged 18 and over[14] have attempted suicide in their lifetime[lix]
- 41% of Trans and people with a Non-Binary gender aged 18 years and over report thoughts of suicide or self harm in the last 2 weeks[lx]
- 39.9% of Trans and Gender Diverse people aged 18 and over have been diagnosed with an anxiety disorder in their lifetime, with 62.1% of of these were diagnosed in the past 12 months[lxi]
- 57.2% of Trans and Gender Diverse people aged 18 and over have been diagnosed with depression in their lifetime, with 54.2% of these were diagnosed in the past 12 months[lxii]

Statistics for Transgender Women

- 44.2% of Trans women aged 18 and over and report current thoughts about suicide or self-harm in the last 2 weeks[lxiii]
- 57.4% of Trans women aged 16 and over reported being diagnosed or treated with any mental disorder in the past three years [lxiv]
- 58.9% of Trans women aged 18 and over have been diagnosed with depression in their lifetime [lxv]
- 34.4% of Trans women aged 16 and over reported being diagnosed or treated for anxiety in the last 3 years[lxvi]
- Trans female average a K10 score of 23.2, indicating high levels of psychological distress [lxvii]

Statistics for Transgender men

- 40.5% of Trans men aged 18 and over and report current thoughts about suicide or self-harm in the last 2 weeks[lxviii]
- 55.3% of Trans women aged 16 and over reported being diagnosed or treated with any mental disorder in the past three years [lxix]
- 62.1% of Trans men aged 18 and over have been diagnosed with depression in their lifetime [lxx]

[14] Scotland research of participants in the UK

- 42.6% of Trans men aged 16 and over reported being diagnosed or treated for anxiety in the last 3 years[lxxi]
- Trans men average a K10 score of 23.2, indicating high levels of psychological distress [lxxii]

Statistics for people with a Non-Binary gender

- 37.5% of non binary assigned female at birth, and 30.2% of Non-Binary assigned male at birth aged 18 years and over report thoughts of suicide or self harm in the last 2 weeks[lxxiii]
- 54.4% of Non-Binary people assigned female at birth, and 40.6% of Non-Binary people assigned male at birth aged 18 and over have been diagnosed with depression in their lifetime[lxxiv]
- 49.3% of Non-Binary assigned female at birth and 30.2% Non-Binary assigned male at birth aged 18 and over have been diagnosed with an anxiety disorder in their lifetime [lxxv]

Intersex

There are significant differences between the mental health and wellbeing of Lesbian, Gay, Bisexual and Transgender people, and people with an Intersex variation with social and medical constructions playing an important role in how people feel about their own bodies and Intersex variation. For many there is also a negative impact on wellbeing is a result of having undergone medical interventions including having undergone a traumatising or unwanted surgery, beginning hormone therapies and feeling emotionally impacted or unlike themselves [lxxvi]

Statistics for People with an Intersex variation

- 60% of the group reported that they had experienced a medical treatment intervention related to their Intersex variation, with over half being before they were aged under 18 years [lxxvii]
- 19% of people with an Intersex variation aged 16 and over had attempted suicide on the basis of issues related to having a congenital sex variation[lxxviii]
- 60% of people with an Intersex variation aged 16 and over had thought about suicide on the basis of issues related to having a congenital sex variation[lxxix]
- 42% of people with an Intersex variation aged 16 and over had thought about self harm, and 26% had engaged in self-harm on the basis of issues related to having a congenital sex variation[lxxx]
- 41% of people with an Intersex variation aged 16 and over describe their mental health as fair or poor[lxxxi]
- 21.3% of people with Intersex variations aged 16 and over have been diagnosed with depression[lxxxii]
- 12.9% of people with an Intersex variation aged 16 and over have been diagnosed with anxiety[lxxxiii]
- 7.7% of people with an Intersex variation have being diagnosed with Post-Traumatic Stress Disorder[lxxxiv]

ACROSS THE LIFE SPAN

There are differences between the mental health and wellbeing of younger LGBTI people and older LGBTI people, specifically:

- LGBTI young people are five times more likely to attempt suicide than their peers of a similar age
- LGBT young people are nearly twice as likely to engage in self-injury than their peers of a similar age
- LGBT young people aged 16 to 24 have a higher rate of being diagnosed with a mental

disorder than older LGBT people
- LGBT young people aged 16 to 24 have the highest level of psychological distress across all age groups
- Rates of psychological distress for Gay men, Lesbian women, Bisexual men, Bisexual women and Trans women declined with age. Rates for psychological distress among Trans men were consistently high across all age groups.
- The number of Transgender people who met the criteria for a depressive or anxiety disorder decreased with age[lxxxv]

Statistics for LGBTI Younger People
- 16% of LGBTI[15] young people aged 16 to 27 reported that they had attempted suicide[lxxxvi]
- 42% of LGBTI[16] young people aged 16 to 27 reported having thoughts about suicide[lxxxvii]
- 33% of LGBTI[17] young people aged 16 to 27 reported having self-harmed, 41% reported thoughts of harming themselves[lxxxviii]
- 47.7% of LGBT people (48.2% women; 29.3% men) aged 16 to 24 reported being diagnosed or treated for any mental disorder in the past three years[lxxxix]
- 43.5% of Transgender and Gender Diverse people aged 18 to 19 have a major depressive syndrome[xc]
- 21.7% of Transgender and Gender Diverse people aged 18 to 19 have an anxiety syndrome
- LGBT young people aged 16 to 24 average K10 score of 23.8, indicating high levels of psychological distress [xci]

Statistics for LGBTI Older People
- 32.5% of LGBT people aged 45 to 59 (28.7% men and 36.2% women) reported being diagnosed or treated for any mental disorder in the past three years[xcii]
- 19.2% of LGBT people aged 60 to 89 (21.6% men and 16.7% women) reported being diagnosed or treated for any mental disorder in the past three years[xciii]
- 19.4% of Transgender and Gender Diverse people aged 50 and over have a major depressive syndrome
- 10.2% of Transgender and Gender Diverse people aged 50 and over have an anxiety syndrome
- LGBT older people aged 49 to 59 average a K10 score of 19.11, indicating moderate levels of psychological distress [xciv]
- Gay men and Lesbian women and Transgender women and aged 60 to 89 average a K10 score is 16, indicating moderate levels of psychological distress

Statistics for the General Population aged 16 to 24
- 1.1% of people (1.7% females; 0.5% males) aged 16 to 24 have attempted suicide in the past 12 months[xcv]
- 3.4% of the general population (1.7% of males and 5.1% of females) aged 16 to 24 in Australia have had suicidal ideation in the past 12 months[xcvi]
- 14.1% of people (16.6% females; 11.6% males) aged between 15 and 19; and 21.25% of people (24.4% females; 18.1% males) aged between 20 and 24 have engaged in self injury in their lifetime[xcvii]
- 26.4% of young people (30.1% females, 22.8% males) aged 16 to 24 met the criterial for a diagnosis of a mental disorder in the last 12 months.[xcviii]
- 6.3% of young people (8.4% females, 4.3% males) in the general population aged 16 to 24 met the criteria for an affective disorder, and 2.8% for a depressive episode in the past 12 months[xcix]
- 15.4% of of young people (21.7% females, 9,3% males) aged 16 to 24 met the criteria for an anxiety disorder, 1.3% for a Generalised Anxiety disorder in the past 12 months[c]

[15] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation
[16] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation
[17] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation

Statistics for the General Population aged 55 and over

- 1.5% of people (1.7% males; 1.4% females) aged 55 to 64, 1.1% aged 65 to 77 and 0.8% aged 75 to 85 have had suicidal ideation in the past 12 months[ci]
- 13.6% of the general population aged 55 to 64, 8.6% aged 65 to 74, and 5.9% aged 75 to 85 have been diagnosed with a mental disorder in the last 12 months
- 11.3% of the general population aged 55 to 64, 6.3% aged 65 to 74, and 4% aged 75 to 85 have been diagnosed with a anxiety disorder in the last 12 months
- 4.2% of the general population aged 55 to 64, 2.8% aged 65 to 74, and 1.8% aged 75 to 85 have been diagnosed with a affective disorder in the last 12 months

INTERSECTIONS

When considering mental health statics for LGBTI people, it is vital to consider how intersections with other identities and experiences may impact on an individuals wellbeing, however available research hasn't often provided a comprehensive analysis of data.

Population Group	What We Know
Aboriginal and Torres Strait Islander People	• 4% of people with an Intersex variation[cii] • 1.5% of LGBTI young people aged 16 to 27 [ciii] • 3% of LGBT young people aged 14 to 21[civ] • 4% of Trans and Gender Diverse young people aged 14 to 25 [cv] • 2.3% LGBT people aged 16 and over[cvi] • 2.3% of Trans and Gender Diverse people aged 18 and over[cvii]
People with a Cultural and Linguistic Diversity	• 28.6% of LGBTI young people aged 16 to 27 identify with a racial or ethnic background other than Anglo-Celtic. 18% of these report having experienced a conflict between their cultural background and their sexuality or gender identity[cviii] • 18% of LGBT young people aged 14 to 21 identified as being culturally and linguistically diverse [cix] • 16% of Trans and Gender Diverse young people aged 14 to 25 were born outside of Australia[cx] • 18.2% LGBT aged 16 and over were born overseas[cxi] • 20.2% of Trans and Gender Diverse people aged 18 and over were born overseas, and 5.5% are from a non-English speaking background[cxii]
People with Disabilities	• 27% of people with an Intersex variation aged 16 and over identified as having one or more disabilities.[cxiii] • 36% of Transgender people aged 18 and over[18] identified as having a mental health issue that they described as being a disability or chronic health condition[cxiv]
Rural, Regional and Remote	• 5.9% Trans and Gender Diverse people aged 18 and over (1.7% Trans men, 8.1% Trans women) lived in regional or remote Australia[cxv] • 18% of LGBT young people aged 14 to 21 lived in rural areas, 2% in remote areas [cxvi] • 20% LGBT aged 16 and over live in inner and outer regional areas, and 0.7% in rural and remote areas [cxvii]
Homelessness	• 6% of Intersex people reported they had precarious

[18] Scotland research of participants in the UK

	accommodation or homelessness, couch surfing or living on the street.[cxviii] ▪ 51% of LGB young people, and 71% of Gender Diverse young people aged 14 to 21 don't live at home with family [cxix]

REFERENCE LIST

[i] Ansara, G. (2016) Making The Count: Addressing Data Integrity Gaps In Australian Standards For Collecting Sex And Gender Information [White Paper]. Sydney, National LGBTI Health Alliance.
[ii] National LGBTI Health Alliance (2013) LGBTI Data: Developing An Evidence-Informed Environment For LGBTI Health Policy, Sydney, National LGBTI Health Alliance.
[iii] National LGBTI Health Alliance (2013)
[iv] Robinson, K.H., Bansel, P., Denson, N., Ovenden, G. & Davies, C. (2014), Growing Up Queer: Issues Facing Young Australians Who Are Gender Variant and Sexuality Diverse, Young and Well Cooperative Research Centre, Melbourne.
[v] McNeil, J., Bailey, L., Ellis, S., Morton, J. & Regan, M. (2012) Trans Mental Health Study 2012, Scottish Transgender Alliance, Scotland
[vi] Jones, T., Carpenter, M., Hart, B., Ansara, G., Leonard, W. and Lucke, J. (2016). *Intersex: Stories and Statistics from Australia*. Open Book Publishers: London.
[vii] Hillier. L, Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J. & Mitchell, A. (2010) Writing Themselves in 3: The third national study on the health and wellbeing of same sex attracted and gender questioning young people, Australian Research in Sex, Health and Society, La Trobe University, Melbourne
[viii] Johnston, A., Pirkis, J. & Burgess, P. (2009) Suicidal thoughts and behaviours among Australian Adults: findings from the 2007 National Survey of Mental Health and Wellbeing, The Royal Australian and New Zealand Journal of Psychiatry, 43, pp. 635-643
[ix] Johnston, et al. (2009)
[x] Pitts, M., Smith, A. Mitchell, A. and Patel, S. (2006) Private Lives: A report on the health and wellbeing of GBLTI Australians Australians Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne
[xi] Hyde, Z., Doherty, M., Tilley, P.J.M., McCaul, K.A, Rooney, R. & Jancey, J. (2014) The First Australian National Trans Mental Health Study: Summary of Results. School of Public Health, Curtin University, Perth
[xii] Jones, et al. (2016)
[xiii] Hillier, et al. (2010)
[xiv] Johnston, et al. (2009)
[xv] Johnston, et al. (2009)
[xvi] Robinson, et al. (2014)
[xvii] McNeil, et al. (2012)
[xviii] Jones, et al. (2016).
[xix] Martin, G., Swannell, S. V., Hazell, P. L., Harrison, J. E., & Taylor, A. W. (2010). Self-injury in Australia: a community survey. *Medical Journal of Australia*, 193(9), 506.
[xx] Martin, et al. (2010)
[xxi] Australian Bureau of Statistics (2007) National Survey of Mental Health and Wellbeing: Summary of Results. 4326.0. Australian Government, Canberra
[xxii] Leonard, W., Lyons, A. & Bariola, E. (2015) A Closer Look at Private Lives 2: Addressing the mental health and well-being of LGBT Australians Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne
[xxiii] Australian Bureau of Statistics (2007)
[xxiv] Pitts, et al. (2006)
[xxv] Leonard, et al. (2015)
[xxvi] Hyde, et al. (2014)
[xxvii] Jones, et al. (2016).
[xxviii] Australian Bureau of Statistics (2007)
[xxix] Australian Bureau of Statistics (2007)
[xxx] Pitts, et al. (2006)
[xxxi] Hyde, et al. (2014)
[xxxii] Jones, et al (2016)
[xxxiii] Australian Bureau of Statistics (2007)
[xxxiv] Australian Bureau of Statistics (2007)
[xxxv] Leonard et al (2015)
[xxxvi] Jones, et al. (2016)
[xxxvii] Slade, T., Grove, R., & Burgess, P. (2011). Kessler Psychological Distress Scale: normative data from the 2007 Australian National Survey of Mental Health and Wellbeing. Australian and New Zealand Journal of Psychiatry, 45(4), 308-316.
[xxxviii] Slade et al. (2011)
[xxxix] Robinson, et al. (2014)

[xl] Robinson, et al. (2014)
[xli] Leonard, et al. (2015)
[xlii] Leonard, et al. (2012)
[xliii] Leonard et al (2015)
[xliv] Robinson, et al. (2014)
[xlv] Robinson, et al. (2014)
[xlvi] Leonard, et al. (2015)
[xlvii] Leonard, et al. (2012)
[xlviii] Leonard et al (2015)
[xlix] Robinson, et al. (2014)
[l] Robinson, et al. (2014)
[li] Leonard, et al. (2015)
[lii] Leonard, et al. (2012)
[liii] Leonard et al (2015)
[liv] Robinson, et al. (2014)
[lv] Robinson, et al. (2014)
[lvi] Leonard, et al. (2015)
[lvii] Leonard, et al. (2012)
[lviii] Leonard et al (2015)
[lix] McNeil, et al. (2012)
[lx] Hyde, et al. (2014)
[lxi] Hyde et al. (2014)
[lxii] Hyde, et al. (2014)
[lxiii] Hyde et al. (2014)
[lxiv] Leonard, et al. (2012)
[lxv] Hyde, et al. (2014)
[lxvi] Leonard, et al. (2012)
[lxvii] Leonard et al. (2015)
[lxviii] Hyde et al. (2014)
[lxix] Leonard, et al. (2012)
[lxx] Hyde, et al. (2014)
[lxxi] Leonard, et al. (2012)
[lxxii] Leonard, et al. (2015)
[lxxiii] Hyde, et al. (2014)
[lxxiv] Hyde, et al. (2014)
[lxxv] Hyde et al (2014)
[lxxvi] Jones, et al. (2016).
[lxxvii] Jones, et al. (2016).
[lxxviii] Jones, et al. (2016)
[lxxix] Jones, et al. (2016)
[lxxx] Jones, et al. (2016)
[lxxxi] Jones, et al. (2016)
[lxxxii] Jones, et al. (2016)
[lxxxiii] Jones, et al. (2016)
[lxxxiv] Jones, et al. (2016)
[lxxxv] Hyde et al. (2014)
[lxxxvi] Robinson, et al. (2014)
[lxxxvii] Robinson, et al. (2014)
[lxxxviii] Robinson, et al. (2014)
[lxxxix] Leonard, et al. (2015)
[xc] Hyde, et al. (2014),
[xci] Leonard et al. (2015)
[xcii] Leonard, et al. (2015)
[xciii] Leonard, et al. (2015)
[xciv] Leonard et al (2015)
[xcv] Johnston et al (2009)
[xcvi] Johnston et al (2009)
[xcvii] Martin, et al. (2010)
[xcviii] Australian Bureau of Statistics (2007) Mental Health of Young People. 4840.0.55.001 Australian Government, Canberra
[xcix] Australian Bureau of Statistics (2007) Mental Health of Young People. 4840.0.55.001 Australian Government, Canberra
[c] Australian Bureau of Statistics (2007) Mental Health of Young People. 4840.0.55.001 Australian Government, Canberra
[ci] Johnston et al (2009)
[cii] Jones et al (2016)

[ciii] Robinson, et al. (2014)
[civ] Hillier, et al. (2010)
[cv] Smith, E., Jones, T., Ward, R., Dixon, J., Mitchel, A., & Hillier, L. (2014) *From Blues to Rainbows: the mental health and well-being of gender diverse and transgender young people in Australia*. The Australian Research Centre in Sex, Health and Society. La Trobe University. Melbourne
[cvi] Leonard, et al. (2012)
[cvii] Hyde, et al (2014)
[cviii] Robinson, et al. (2014)
[cix] Hillier, et al. (2010)
[cx] Smith, et al. (2014)
[cxi] Leonard, et al. (2012)
[cxii] Hyde, et al. (2014)
[cxiii] Jones et al. (2016)
[cxiv] McNeil, et al. (2012)
[cxv] Hyde et al. (2014)
[cxvi] Hillier, et al. (2010)
[cxvii] Leonard, et al. (2012)
[cxviii] Jones, et al. (2016)
[cxix] Hillier, et al. (2010)

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RA -3

This is the attachment marked 'RA-3' referred to in the witness statement of Ro Allen dated "2 July 2019" .

Recognising and addressing the mental health needs of the LGBTIQ+ population

March 2019

Position statement 83

Summary

Evidence shows that discrimination and marginalisation experienced by the LGBTIQ+ population increases their risk of developing mental health issues, and also creates barriers to accessing services.

Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is concerned that a disproportionate number of Australia and New Zealand's lesbian, gay, bisexual, trans, intersex and queer/questioning (LGBTIQ+) populations experience mental illness and psychological distress. Evidence shows that the discrimination and marginalisation experienced by LGBTIQ+ people increases the risk of developing mental health issues, and also creates barriers to accessing supportive services. This position statement provides an overview of some of the key issues relevant to mental health and LGBTIQ+ identity, and makes recommendations for enhancing the mental health sector's responsiveness to the needs of LGBTIQ+ people.

Key messages

- A disproportionate number of Australia and New Zealand's LGBTIQ+ populations experience mental illness and psychological distress.
- People who identify as LGBTIQ+ are at increased risk of exposure to institutionalised and interpersonal discrimination and marginalisation which increases vulnerability to mental illness and psychological distress.
- LGBTIQ+ identity has historically been criminalised, pathologised and invisibilised by the legal and medical institutions of Australia and New Zealand although many of these institutions are becoming increasingly inclusive.
- Mental health policy and practice for LGBTIQ+ people should be informed by the prevalence and aetiologies of mental disorder and distress among this population group, along with consideration of the need for culturally competent and sensitive services.
- Particular consideration should be given to the needs of individual population groups within LGBTIQ+ populations including young people, older people, and Indigenous people.

- Using the right terminology is important when discussing issues of sexual orientation, and sex and gender identity. Which term is correct can vary considerably according to time, community attitudes and individual preferences.

Definition

The RANZCP acknowledges the importance of using appropriate terminology when discussing issues of sexual, sex and gender identity (Smith et al., 2014). Inclusive language engenders respect and promotes visibility for important issues, and this is integral to improving the health of the LGBTIQ+ population (AHRC, 2015). The text box below provides an overview of some key terms used in Australia and New Zealand. Clinicians should, however, be mindful of the importance of individual preferences regarding terminology and identity, as well as preferred pronouns. Clinicians should never refer to someone with the use of terms or pronouns against the individual's wishes. For example, an individual may wish for the pronouns 'they/them' to be used, so as to avoid gendering, and this should be respected. Clinicians should also be aware of the rapidity with which language and terminology can change and develop in this area. Clinicians should undertake additional research or inquiry with relevant organisations as appropriate (please refer to the list of resources below for more information).

Key terminology in Australia and New Zealand

- The acronym LGBTIQ+ refers collectively to people who are lesbian, gay, bisexual, trans, intersex, queer (see below) or questioning (those who are exploring their orientation and identity). The '+' is used to include people with alternative sexual, orientation, or sex or gender identities who do not identify with the terms contained within the 'LGBTIQ' acronym.
- The term LGBTIQA+ may also be used. The 'A' may refer to people who identify as asexual (LGBTQIA+ Resource Center, 2018) or alternatively to allies of LGBTIQ+ communities (Kelly, 2014).
- The word queer can be used to refer to a sexual or gender identity that is non-binary. The term has been historically used as a derogatory word but has recently been 'reclaimed' by some individuals as a political term as a means of challenging homophobia. People may therefore have varying relationships to the word, and some may find it offensive (Smith et al., 2014).
- Sexual diversity can include people who are lesbian, gay or bisexual, as well as a range of other expressions of sexuality. This may include people who identify as asexual (experiencing an absence of sexual attraction, distinct from celibate) or pansexual (experiencing sexual or romantic attraction that is not based on gender identity or sex) (Smith et al., 2014).
- Trans, or TGD (trans and gender diverse) are commonly used to describe a broad range of non-conforming gender identities or expressions including transgender, agender (having no gender), bigender (identifying as both a woman and a man), or non-binary (neither woman nor man).. The term transsexual may be used to refer to a person who has an internal sense of gender that differs from their birth sex. Some people may describe themselves as MTF/M2F (male-to-female), FTM/F2M (female-to-male), AFAB (assigned female at birth) or AMAB (assigned male at birth). The terms genderqueer and gender fluid are also used to refer to shifting gender identity.
- Using preferred names and pronouns is important for TGD people. This may be 'he/him', 'she/her', 'they/them' or 'zi'/zem'.
- Some Aboriginal and Torres Strait Islander peoples use the term sistergirl to refer to male-assigned people who live partly or fully as women and brotherboy to refer to female-assigned people who live partly or fully as men (Smith et al., 2014).
- Takatāpui as a self-descriptor is often used by Māori to describe non-binary gender and/or sexual identity. Specific meaning can vary depending on context (Henrickson, 2006).
- People born with intersex variations encompass a diversity of experiences. Intersex traits are a naturally occurring biological phenomenon, with at least 40 different variations. People may use

diagnostic or chromosomal labels for their variations, including XXY, Complete Androgen Insensitivity, XY Woman, Swyer Syndrome or Turner Syndrome (OII Australia, 2009).

Population

Statistical information about LGBTIQ+ populations in Australia and New Zealand is limited. It is estimated that 9% of Australian men and 15% of Australian women report same-sex attraction (Rosenstreich, 2013). At the 2016 Australian Census there were around 46,800 same-sex couples, representing around 1% of all couples in Australia (ABS, 2016). Equivalent statistics are not currently available for New Zealand though questions about sexual identity are being considered for inclusion in the 2018 census (Statistics New Zealand, 2018).

Statistical information on gender diversity in Australia and New Zealand is scarcer still although how best to gather this information is being considered for both the Australian and New Zealand censuses (Statistics New Zealand, 2018; ABS, 2018). One study of New Zealand high school students found that approximately 1.2% identify as trans (Hyde, 2014).

There are no firm figures for people with intersex variations, and estimates range considerably although 1.7% of the population is broadly accepted as an evidence-based approximation (OII Australia, 2013).

Background

LGBTIQ+ identity has historically been criminalised, pathologised and invisibilised by the legal and medical institutions of Australia and New Zealand. Many gay or bisexual Australian and New Zealander men have a lived experience of sodomy laws, which were repealed in 1986 in New Zealand and between 1975 and 1994 in the various jurisdictions of Australia (Crameri et al., 2015). Approximately 72 countries worldwide continue to legislate against homosexuality, including 8 where homosexuality is punishable by death (Duncan, 2017).

Many LGBTIQ+ people also have a lived experience of their sexual identity being defined as a mental disorder or abnormality. The Diagnostic and Statistical Manual of Mental Disorders (DSM) included homosexuality in its diagnostic classifications until 1973, and 'ego-dystonic homosexuality', indicated by a persistent lack of heterosexual arousal causing distress, until 1987 (Mendelson, 2003). Similarly, the International Statistical Classification of Diseases and Related Health Problems (ICD) previously included homosexuality as a 'sexual deviation' or 'mental disorder'. ICD-10, published in 1992, included diagnosis code F66, 'sexual maturation disorder'; indicated by experience of uncertainty about gender identity or sexual orientation which causes anxiety or depression (Mendelson, 2003). ICD-11 has undergone significant revisions to ensure that disorders relating to sexuality and gender identity reflect contemporary evidence while appropriately distinguishing between health conditions and private behaviours (Reed et al., 2016).

Legal and medical institutions are becoming increasingly inclusive. Same-sex marriage was legalised in New Zealand in 2013 and in Australia in 2018. The RANZCP supports marriage equality based on the evidence that legislative inequality has a significant and deleterious impact on mental health (beyondblue, 2015; Obergefell v. Hodges, 2015) and conversely, that there is a strong link between improved health outcomes and legislative change of this sort (Kealy-Bateman and Pryor, 2015; PHAA, 2015). Further, sexual orientation change efforts, or other often non-consensual therapies intended to change the sexual orientation of a person, are now broadly understood to be harmful and unethical (RANZCP, 2015).

There is still a significant amount of work to be done in fostering more inclusive institutions, however, and this is discussed below in more detail. Greater awareness of intersex and gender diverse identities

in particular is urgently needed to begin to address the high vulnerability and low mental health outcomes of these groups.

Evidence

People who identify as LGBTIQ+ are at increased risk of exposure to institutionalised and interpersonal discrimination and marginalisation which in turn increases vulnerability to mental illness and psychological distress (King and Nazareth, 2006). Mental health outcomes for the LGBTIQ+ populations of Australia and New Zealand are amongst the lowest of any demographic (Chakraborty et al., 2011).

In Australia, LGBTIQ+ people have very high rates of suicidality. One study have found current suicidal ideation is experienced by 20% of trans people and 15.7% of lesbian, gay and bisexual people (Rosenstreich, 2013). However, these numbers increase dramatically among subpopulations; for example, one study found 38% of young trans and gender diverse people experienced suicidal ideation (Smith et al., 2014) while another found that 84% of AFAB/FTM people had thought about suicide with 35% attempting it (Jones et al., 2014).

LGBTIQ+ people also experience high rates of mental illness. One study into the mental health of trans and gender diverse people found more than half of participants (57.2%) had been diagnosed with depression during their lives, the majority of which (43.7%) were experiencing clinically significant depressive symptoms at the time. The study also found high lifetime rates of anxiety diagnoses (39.95%). Same-sex attracted people are up to twice as likely to experience anxiety disorders and three times more likely to experience affective disorders compared with the broader population (Rosenstreich, 2013; ABS, 2007).

In New Zealand, LGBTIQ+ people are similarly vulnerable. Gay men experience mental health problems at over five times the rate of opposite-sex attracted men, with an estimated 28.6% of same-sex attracted men having attempted suicide and 71.4% reporting suicidal ideation, compared with 1.6% and 10.9% of heterosexual men respectively (Adams et al., 2013). A survey of New Zealand secondary students found that 20% of same-sex attracted students had attempted suicide in the past year, compared with 4% of their opposite-sex attracted peers (Rossen et al., 2009).

The birth of an intersex child continues to be treated as a 'psychosocial emergency', leading to non-essential medical interventions from infancy (Latham and Barrett, 2015). Across Australia and New Zealand it has been found that intersex adults exhibit psychological distress at levels comparable with traumatised non-intersex women, such as those who have experienced severe physical or sexual abuse (Rosenstreich, 2013).

Considerations for mental health policy and practice

Diversity of experience

Concern that medical professionals will not have an understanding of their identity is commonly identified by LGBTIQ+ people as one of the key barriers to accessing timely supports (Smith et al., 2014). Psychiatrists should maintain an up-to-date understanding of the key issues for this population, including an understanding of the prevalence of mental health issues, as well as the importance of making sensitive enquiry, avoiding assumptions, and using inclusive language.

Different groups will have various specific needs and sensitivities linked to personal and historical backgrounds. For example, international research shows that bisexual people have the highest rate of mental health issues of any sexual identity group, and often experience marginalisation and discrimination in ways distinct from people who are gay or lesbian (Barker et al., 2012). People

Cultural competence

Mental health and related services must be safe spaces for LGBTIQ+ people. That is often not the case with many people too fearful to disclose matters relating to their sexual identity and relationships. This presents a significant barrier to care, leaving many people without access to services with which they feel comfortable enough to explore sensitive health matters. Tis may be particularly so in rural areas where access to culturally competent services may be limited with privacy considerations further compounding access issues.

Health, aged care, child and adolescent, family violence and other services should take steps to promote inclusiveness and cultural safety for LGBTIQ+ people (Crameri et al., 2015). This includes ensuring assessment forms, databases and other mechanisms for collecting information avoid assumptions and discriminatory language (Ansara, 2015). Services should also consider registering with relevant LGBTIQ+ health directories and displaying inclusive signage. Services should make reasonable steps to accommodate the needs of LGBTIQ+ consumers, including recognising partners, addressing personal care issues and ensuring privacy.

Children and adolescents

During adolescence, young people undergo biopsychological development phases during which they must establish their social and sexual identities. This can be a particularly challenging period for young LGBTIQ+ people, and a time of heightened vulnerability to mental health issues (Smith et al., 2014).

At this critical juncture, experience of homophobia, transphobia and heteronormativity can be devastating (Robinson et al., 2014). An Australian survey of gender variant and sexually diverse young people found that almost two thirds had experienced homophobia and/or transphobia, and that more than two in five young people interviewed had had thoughts of self-harm (41%) and/or suicide (42%). In addition, 33% of respondents reported having self-harmed in the past, and 16% had attempted suicide (Robinson et al., 2014). LGBTIQ+ young people are at particularly high risk of suicide in the period prior to 'coming out', or identifying oneself as LGBTIQ+ to others (Rosenstreich et al., 2013). Family support and acceptance can enhance outcomes for LGBTIQ+ children and adolescents across a range of indicators (Smith et al., 2014).

For children and adolescents experiencing gender dysphoria, puberty can be a time of particularly severe emotional distress. Child and adolescent psychiatrists are the primary care managers and decision-makers for this group, in collaboration with other specialists such as paediatric endocrinologists (Australian Paediatric Endocrine Group, 2010). International consensus guidelines recommend that adolescents who fulfil minimum criteria undergo treatment to (reversibly) suppress puberty, generally with the use of gonadotrophin releasing hormone (GnRH) analogues (WPATH, 2012; Hembree et al., 2009). Evidence suggests good outcomes associated with this approach (Wallien and Cohen-Kettenis, 2008). In New Zealand, this can be undertaken following rigorous assessment and diagnosis, and after obtaining informed consent (Counties Manukau District Health Board, 2012). In Australia, it should occur in accordance with treatment guidelines from the Royal Children's Hospital Melbourne (Telfer et al., 2018).

Mainstream health services may not always seem relevant or accessible to LGBTIQ+ children and adolescents, many of whom report feeling uncomfortable about approaching, and having to 'come out' to, health professionals (Robinson et al., 2014). One study of gender diverse and transgender young people in Australia found that over half had experienced at least one negative experience with a healthcare professional, and one quarter of the participants avoided medical services due to their gender presentation.

LGBTIQ+ identity and ageing

Many older LGBTIQ+ people have a lived history of direct discrimination by legal and medical institutions, as discussed above. These experiences can create ongoing barriers to accessing aged care, mental healthcare and other supports (Brown et al., 2015). Older LGBTIQ+ people experience anxiety regarding whether their needs will be met in a dignified manner as they age, and some report feeling forced 'back into the closet' due to the lack of availability of inclusive services (Latham and Barrett, 2015).

With an increasing proportion of the populations of Australia and New Zealand aged over 65, mental health and aged care facilities must consider the needs of the ageing LGBTIQ+ population. This includes how LGBTIQ+-specific needs intersect with dementia, personal care needs, end-of-life decision-making and advance care plans (Barrett et al., 2015; Hughes and Cartwright, 2015).

Visibility in data and research

There are many gaps in administrative data and generic research relating to LGBTIQ+ populations. More consistent statistical information is required, as well as more research into LGBTIQ+ mental health, including protective factors, comorbidity, effective interventions and specific issues faced by high-risk population groups (Rosenstreich, 2013). Enhanced statistics and research must be carefully balanced with the entitlement of each person to privacy and dignity and undertaken with sensitivity and awareness (Imran, 2012).

Sexual and family violence

Statistics indicate that LGBTIQ+ people experience family and sexual violence at rates similar to, or higher than, heterosexual women (Fileborn and Horsley, 2015). Despite this, current policy and program responses to family violence tend to be geared towards heterosexual relationships, with some notable exceptions (see additional resources below). A Senate inquiry into family violence in Australia found a lack of data, reporting and understanding of the impact of violence in LGBTIQ+ communities as well as a lack of services and programs. Of particular concern is the acute shortage of appropriate housing for LGBTIQ+ survivors of family violence (SFPAC, 2015).

Aboriginal and Torres Strait Islander and Māori LGBTIQ+ people

People from Aboriginal and Torres Strait Islander or Māori backgrounds who are LGBTIQ+ often face particularly complex layers of discrimination and identity (Tovey, 2015). A small number of remote, traditional Aboriginal and Torres Strait Islander cultures, such as the Tiwi Islands, have traditionally included and supported people of diverse gender identities. However, many other LGBTIQ+ Indigenous people experience multiple levels of marginalisation and discrimination (National LGBTI Health Alliance, 2013). Some may face rejection from their community, or alternatively be required to renegotiate cultural and spiritual standing, including gender-specific roles in ceremonies and the community, and the passing on of knowledge (Creative Spirits, 2015). Similar issues may be faced by LGBTIQ+ people from other culturally and linguistically diverse communities.

Recommendations

- Psychiatrists should maintain an up-to-date understanding of LGBTIQ+ issues, including appropriate referral pathways should specialised support be required. Psychiatrists should be mindful of balancing the sometimes diverse views of the consumer and their family or carer.

- In undertaking clinical assessment and interviews, psychiatrists should ensure enquiries into LGBTIQ+ identities are undertaken with sensitivity, avoiding assumptions in language and approach.
- All training programs for medical, nursing and other health service staff should include basic cultural sensitivity training for LGBTIQ+-specific issues such as how to elicit disclosures and remove heteronormative biases from interviewing methods.
- The needs of LGBTIQ+ people should be included in all national health frameworks and strategies with consideration given to the benefits of health promotion strategies service accreditation standards for the provision of culturally appropriate services for the LGBTIQ+ communities.
- Services should make reasonable steps to accommodate the needs and ensure the cultural safety of LGBTIQ+ people.
- Services for older people should consider the intersection of LGBTIQ+ identities with issues such as dementia, end-of-life decision-making and advanced care plans.
- Services for children and adolescents should maintain an awareness of the particular stressors faced by LGBTIQ+ young people, including issues to do with 'coming out', experience of bullying and the potentially traumatic experience of puberty for gender diverse young people.
- Services working with Aboriginal and Torres Strait Islander peoples and Māori who identify as LGBTIQ+ should in particular consider the intersection of LGBTIQ+ identities with issues such as traditional gender roles, community acceptance and the impact of multiple layers of discrimination.
- Enhanced statistical information and research into LGBTIQ+ mental health is required which should be undertaken with sensitivity and awareness.
- Services for LGBTIQ+-specific services, including for LGBTIQ+ people experiencing sexual and family violence should be supported with ongoing funding.

Additional resources

- RANZCP Position Statement 60: Sexual orientation change efforts
- Australian and New Zealand Professional Association for Transgender Health: Peak body actively promoting communication and collaboration amongst professionals involved in the health, rights and wellbeing of people who experience difference in sexual formation and/or gender expression.
- American Medical Association's LGBTI resources include resources for promoting inclusiveness in health services and information for health practitioners.
- Australian Government Guidelines on the Recognition of Sex and Gender provide guidance for incorporating LGBTIQ+-awareness into data collection.
- Mental Health Professional Online Development includes a topic on 'Mental health for same sex attracted persons'.
- *Australasian Journal on Ageing*: Special Issue: LGBTI Ageing and Aged Care Special Edition, Volume 34, Issue Supplement S2, pages 1–44.
- National LGBTI Health Alliance: Peak health organisation in Australia, providing health-related programs, services and research.
- Another Closet: An online resources for people in LGBTIQ+ relationships who are, or may be, experiencing domestic and family violence.

Responsible committee: Practice Policy and Partnerships Committee

References

Adams J, Dickinson P, Asiasiga L (2013) Mental health promotion for gay, lesbian, bisexual, tansgender and intersex New Zealanders. *Journal of Primary Health Care* 5(2): 105–13.

Ansara GY (2015) Challenging cisgenderism in the ageing and aged care sector: Meeting the needs of older people of trans and/or non-binary experience. *Australasian Journal on Ageing* 34(S2): 14 –8.Australian Bureau of Statistics (2007) National Survey of Mental Health and Wellbeing: Summary of Results. 4326.0. Australian Government, Canberra.

Australian Bureau of Statistics (2016) Same-Sex Couples in Australia, 2016. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Sar Sex%20Couples~85 (accessed 9 August 2018).

Australian Bureau of Statistics (2018) Sex and gender diversity in the 2016 census. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Se (accessed 9 August 2018).

Australian Human Rights Commission (2015) *Resilient Individuals: Sexual Orientation, Gender Identity and Intersex Rights*. National Consultation Report. Available at: https://www.humanrights.gov.au/sites/default/files/document/publication/SOGII%20Rights%20Report% (accessed 29 September 2015).

Australian Paediatric Endocrine Group (2010) *Gender Identity Disorder Guidelines*. Disorders of Sex Development Working Group. Available at: http://www.apeg.org.au/Portals/0/guidelines.pdf (accessed 20 January 2016).

Barker M, Richard C, Jones R, Bowes-Batton H, Plowman R, Yockney J, Morgan M (2012) *The Bisexuality Report: Sexual inclusion in LGBT equality and diversity*. Available at: http://www.bisexualindex.org.uk/uploads/Main/TheBisexualityReport.pdf (accessed 9 August 2018).

Barrett C, Crameri P, Lambourne S, Latham J, Whyte C (2015) Understanding the experiences and needs of lesbian, gay, bisexual and trans Australians living with dementia, and their partners. *Australasian Journal on Ageing* 34(S2): 34-38.

beyondblue (2015) Media release: Statement from beyondblue Board in support of marriage equality. (Accessed 18 December 2015). Available at: https://www.beyondblue.org.au/connect-with-others/news/news/2015/08/31/statement-from-beyondblue-board-in-support-of-marriage-equality

Brown A, Hayter C, Barrett C (2015) Editorial. *Australasian Journal on Ageing* 34(S2): 1–2.

Chakraborty A, McManus S, Brugha T, Bebbington P, King M (2011) Mental health of the non-heterosexual population of England. *The British Journal of Psychiatry* 198: 143–8.

Crameri P, Barrett C, Latham J, Whyte C (2015) It is more than sex and clothes: Culturally safe services for older lesbian, gay, bisexual, transgender and intersex people. *Australasian Journal on Ageing* 34(S2): 21–5.

Creative Spirits (2015) Aboriginal sexual health. Available at: http://www.creativespirits.info/aboriginalculture/health/aboriginal-sexual-health#axzz3rohneD3Z (accessed 17 November 2015).

Duncan P (2017) Gay relationships are still criminalised in 72 countries, report finds. *The Guardian* 27 July. Available at: https://www.theguardian.com/world/2017/jul/27/gay-relationships-still-criminalised-countries-report (accessed 9 August 2018).

Fileborn B, Horsley P (2015) Beyond gender: LGBTIQ abuse shows it's time to shift the debate on

partner violence. *The Conversation* 12 November. Available at: https://theconversation.com/beyond-gender-lgbtiq-abuse-shows-its-time-to-shift-the-debate-on-partner-violence-50238 (accessed 9 August 2018).

Hembree W, Cohen-Kettenis P, Delemarre-van de Waal H, Gooren L, Meyer W, SPack N, Tangpricha V,
Montori V (2009) Endocrine treatment of transsexual persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology and Metabolism* 94: 3132–54.

Henrickson M (2006) Kō wai ratou? Managing multiple identifies in lesbian, gay and bisexual New Zealand Māori. *New Zealand Sociology* 21(2): 251–73.

Hewitt J, Paul C, Kasiannan P, Grover S, Newman L, Warne G (2012) Hormone treatment of gender identity disorder in a cohort of children and adolescents. *Medical Journal of Australia* 196(9): 578–81.

Hughes M, Cartwright C (2015) Lesbian, gay, bisexual and transgender people's attitudes to end-of-life decision-making and advance care planning. *Australasian Journal on Ageing* 34(S2): 39–43.

Hyde Z, Doherty M, Tilley P, McCaul K, Rooney R, Jancey J (2014) *The First Australian National Trans Mental Health Study: Summary of Results*. School of Public Health. Curtin University. Perth, Australia.

Irlam C (2012) *LGBTI Data: Developing an evidence-informed environment for LGBTI health policy*. National LGBTI Health Alliance. Sydney, Australia.

Jones T, del Pozo de Bolger A, Dunne T, Lykins A, Hawkes G (2014) *Female-to-Male (FtM) Transgender People's Experiences in Australia*. Dordrecht: Springer.

Kealy-Bateman W, Pryor L (2015) Marriage equality is a mental health issue. *Australasian Psychiatry*. 23(5): 540–3.

Kelly M (2014) Adding 'allies' to LGBT acronym sparks controversy. *Iowa State Daily*, 29 October. Available at: http://www.iowastatedaily.com/news/article_50e5e8f6-5edc-11e4-a17f-f77a797314c5.html (accessed 4 September 2018).

King M, Nazareth I (2006) The health of people classified as lesbian, gay and bisexual attending family practitioners in London: a controlled study. *BioMed Central Public Health*. 6: 127.

Latham J, Barrett C (2015) Appropriate bodies and other damn lies: Intersex and ageing and aged care. *Australasian Journal on Ageing* 34(S2): 19–20.

LGBTQIA+ Resource Center, University of California (2018) Glossary. Available at: https://lgbtqia.ucdavis.edu/educated/glossary (accessed 4 September 2018).

National LGBTI Health Alliance (2013) *LGBTI Cultural Competency Framework: Including LGBTI people in mental health and suicide prevention organisations*. Available at: http://www.lgbtihealth.org.au/sites/default/files/Cultural%20Competancy%20Framework.pdf (accessed 9 August 2018).

Mendelson G (2003) Homosexuality and psychiatric nosology. *Australian and New Zealand Journal of Psychiatry*. 37: 678–83.

Obergefell et al., v. Hodges et al. (2015) *The US Supreme Court Decision on Marriage Equality*. First Melville House Printing, Brooklyn, United States.

Organisation International Intersex Australia (OII) (2013) On the number of intersex people. Available at: https://oii.org.au/16601/intersex-numbers (accessed 9 August 2018).

Organisation International Intersex Australia (OII) (2009) Style guide: on intersex and terminology. Available at: https://oii.org.au/style (accessed 9 August 2018).

Public Health Association Australia (2015) Media release: Public health professionals call for marriage equality. Available at: https://www.phaa.net.au/documents/item/821 (accessed 9 August 2018).

Reed GM, Drescher J, Krueger RB, Atalla E, Cochran SD, First MB, Cohen-Kettenis PT, Arango-de Montis I, Parish SJ, Cottler S, Briken P, Saxena S (2016) Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry* 15(3): 205–21.

Robinson K, Bansel P, Denson N, Ovenden G, Davies C (2014) *Growing Up Queer: Issues facing young Australians who are gender variant and sexuality diverse*. Young and Well Cooperative Research Centre, Melbourne, Australia.

Rosenstreich (2013) *LGBTI People Mental Health and Suicide*. Revised 2nd Edition. National LGBTI Health Alliance. Sydney, Australia.

Rossen F, Lucassen M, Denny S Robinson E (2009) *Youth'07 the health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes*. University of Auckland, New Zealand.

Royal Australian and New Zealand College of Psychiatrists (2015) Position Statement 60 'Sexual orientation change efforts'. Available at: https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-60-PS-Sexual-Orientation-Change-Efforts-(Ju-(1).aspx (accessed 9 August 2018).

Senate Finance and Public Administration Committee (2015) *Domestic Violence in Australia*. Senate Printing Unit, Parliament House, Canberra, Australia.

Smith E, Jones T, Ward R, Dixon J, Mitchell A, Hillier L (2014) *From Blues to Rainbows: Mental health and wellbeing of gender diverse and transgender young people in Australia*. The Australian Research Centre in Sex, Health and Society. Melbourne, Australia.

Statistics New Zealand (2018) Sex, gender, and sexual orientation. Available at: https://www.stats.govt.nz/reports/sex-gender-and-sexual-orientation (accessed 9 August 2018).

Telfer MM, Tollit MA, Pace CC, Pang KC (2018) *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.1*. Melbourne: The Royal Children's Hospital.

Tovey N (2015) Little black bastard. *Australasian Journal on Ageing* 34(S2): 3–4.

Wallien M, Cohen-Kettenis P (2008) Psychosexual outcome of gender-dysphoric children. *Journal of America Academy of Child and Adolescent Psychiatry* 47: 1413–23.

World Professional Association for Transgender Health (2011) Standards of Care for the Health of Transsexual,
Transgender, and Gender Nonconforming People. Available at:
https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf (accessed 4 September 2018).

- Discuss this topic on our Forums
- Email a policy officer policy@ranzcp.org

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RA -4

This is the attachment marked 'RA-4' referred to in the witness statement of Ro Allen dated "2 July 2019" .

LGBTI People
Mental Health & Suicide

Briefing Paper,
Revised 2nd Edition, 2013
Gabi Rosenstreich

Suggested citation: Rosenstreich, G. (2013) LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance. Sydney

Contents

Lesbian, gay, bisexual, trans, intersex and other sexuality, sex and gender diverse (LGBTI) people make up a significant part of Australian society

- Lesbian, gay and bisexual people are sexually attracted to and/or have romantic relationships with people of the same sex as themselves. 9% of adult men and 15% of women in Australia report same-sex attraction or having had sexual contact with someone of the same sex, although only approximately 2% actually identify as lesbian, gay or bisexual.[1]
- Trans people have an internal sense of gender (their gender identity) that differs from their birth sex. The term 'trans' is an umbrella term that includes transsexual, genderqueer, sistergirl and other identities. Transgender is another common umbrella term. Recent international estimates of the prevalence of trans people lie between 1:500 and 1:11,500.[2]

"Imagine living within a body opposing your mental gender, - it's tough. This is what I go through every day of my life"

(transwoman, 17 years, in Simply Trans 2007)

- Intersex people are born with a physical variation that differs from current expectations of male or female sex, e.g. they have atypical genitals, XXY chromosomes or unusual hormone production levels. Estimates of the number of intersex people vary from 1:200 to 1:2000 depending on the conditions included.[3]
- Most intersex people and many trans people simply identify as male or female most or all of the time.

Never make assumptions about people's sexual orientation, sex or gender identity or what this means to them

- Sexual orientation, sex and gender identity are different aspects of identity and not directly connected (i.e. trans and intersex people can be heterosexual, homosexual or bisexual, just like everyone else).
- 'LGBTI' is a commonly used acronym that encompasses all people whose sexual orientation, gender identity or sex differ from heterosexual or male/female sex and gender norms, regardless of the identity labels people use. Sometimes the term 'sexuality, sex and gender diversity' is used to be inclusive of all these groups.
- There is great diversity of identities and experiences within and between LGBTI communities, influenced by age, ethnicity, geographical location, (dis)ability, migration experience, socioeconomic status, etc. LGBTI people are part of all other population groups, while also forming a specific marginalized population group, with specific health needs.

LGBTI people have significantly poorer mental health and higher rates of suicide than other Australians

Although most LGBTI Australians live healthy, happy lives, a disproportionate number experience worse health outcomes than their non-LGBTI peers in a range of areas, in particular mental health and suicidality. These disproportionately poor outcomes are found in all age groups of LGBTI people.

Mental health:

- The mental health of LGBTI people is among the poorest in Australia.[4]
- At least 36.2% of trans and 24.4% of gay, lesbian and bisexual Australians met the criteria for experiencing a major depressive episode in 2005, compared with 6.8% of the general population.[5] This rate soars to 59.3% of trans women (male to female) under 30 in a La Trobe University study[6]
- Lesbian, gay and bisexual Australians are twice as likely to have a high/very high level of psychological distress as their heterosexual peers (18.2% v. 9.2%).[7] This makes them particularly vulnerable to mental health problems. The younger the age group, the starker the differences: 55% of LGBT women aged between 16 and 24 compared with 18% in the nation as a whole and 40% of LGBT men aged 16-24 compared with 7%. Results only begin to be similar across the population groups at age 65.[8]

"As a GLBT person, what is the most important thing that has happened in your life in the last year?"
Respondent A: "Nothing. Too scared to live"
Respondent B "Not killing myself"

(Survey respondents, in Leonard et al. 2012)

- More than twice as many homosexual/bisexual Australians experience anxiety disorders as heterosexual people (31% vs 14%) and over three times as many experience affective disorders (19% vs 6%). The rates are higher across any age group, country of birth, income level, area of residence or level of education/employment.[9] Nearly 80% of LGBT respondents reported having experienced at least one period of intense anxiety in the 12 months prior to completing a 2011 survey, with the highest proportion of those experiencing frequent episodes of anxiety in this period being lesbian, bisexual and transwomen and transmen.[10]
- Where differentiated data is available, it indicates that rates of depression, anxiety and generally poor mental health are highest among trans and bisexual people, especially bisexual women.[11]
- Intersex adults show psychological distress at levels comparable with traumatized non-intersex women, e.g. those with a history of severe physical or sexual abuse.[12]

Suicide and Self-Harm:

- LGBTI people have the highest rates of suicidality of any population in Australia.
- 20% of trans Australians[13] and 15.7% of lesbian, gay and bisexual Australians[14] report current suicidal ideation (thoughts). A UK study reported 84% of trans participants having thought about ending their lives at some point.[15]
- Up to 50% of trans people have actually attempted suicide at least once in their lives.[16]
- Same-sex attracted Australians have up to 14x higher rates of suicide attempts than their heterosexual peers.[17] Rates are 6x higher for same-sex attracted young people (20-42% cf. 7-13%).[18]

"Knowing what was facing me religion-wise and with my family I was pretty suicidal between the ages of about 16 and 19 … Not so much because of people's homophobia but because of feeling totally trapped between a religion/family that didn't accept homosexuality and being who I was"

("Peggy", aged 20, in Hillier et al. 2008)

- The average age of a first suicide attempt is 16 years – often before 'coming out'.[19]
- There is a lack of data on intersex people but overseas research and anecdotal evidence in Australia indicate that intersex adults have rates of suicidal tendencies and self-harming behaviour well above those of the general population.[20]
- Indigenous LGBTI Australians, LGBTI migrants and refugees, LGBTI young people and LGBTI people residing in rural and remote areas are likely to be at particularly high risk of suicide, in line with tendencies of high risk identified in the population as a whole.[21]
- There is increasing concern that older LGBTI Australians may also have a particularly high risk of suicide, with many having endured persecution, including legal condemnation and ostracism and fearing dependency on potentially discriminatory mainstream aged care services, especially as they are less likely to have children to care for them.[22]
- Many LGBTI people who attempt suicide have not disclosed their sexual orientation, gender identity or intersex status to others, or to only very few people.[23]

Discrimination and exclusion are the key causal factors of LGBTI mental ill-health and suicidality

- The elevated risk of mental ill-health and suicidality among LGBTI people is not due to sexuality, sex or gender identity in and of themselves but rather due to discrimination and exclusion as key determinants of health.[24] This is sometimes referred to as minority stress.[25]
- Homophobia and transphobia are a fear of and/or prejudice against people who are perceived to be homosexual or trans respectively, or more generally to not conform to mainstream male or female gender norms. They are often expressed as stereotyping, ostracizing, discrimination, harassment, and violence. Heterosexism is discrimination in favour of heterosexual and against homosexual and bisexual people as well as people who challenge assumptions that there are only two genders. It can be regarded as encompassing homophobia and transphobia and the discrimination of intersex people. Thus for LGBTI people, exposure to heterosexism can be a key determinant of health.
- Exposure to and fear of discrimination and isolation can directly impact on people's mental health, causing stress, psychological distress and suicidality.[26]

Be very clear that being lesbian, gay, bisexual, trans, intersex and/or questioning is not in itself a problem

- There is currently a lack of protection from discrimination on the basis of gender identity, gender expression, sex and sex characteristics and sexual orientation at a Commonwealth level and the level of protection offered in the states and territories varies. At both levels of government, significant exemptions apply, in particular for faith-based organisations providing community services. 2012 the Commonwealth government began consultation on proposed new federal anti-discrimination legislation that includes greater protection for LGBTI people.[27]
- Despite recent improvements to legislative equality in Australia and advances in the general acceptance of homosexuality and – to a lesser extent – of trans and intersex people in some sectors, experience of homophobic and transphobic discrimination and exclusion both within families and in broader society remains very high for many LGBTI Australians: LGBTI people remain a marginalised group.[28]

"I might hate myself for it but I wish she had died instead. What a trivial existence it seems, the life of a gay person… Betrayal is all I can see, betrayal of me as a mother. She rejects my beliefs, my principles and my femininity. … I can't forgive her, I can't respect her and I certainly can't understand her. I don't want to love her any longer"

(mother of a lesbian daughter, quoted in McDougall 2006)

- Up to 80% of same-sex attracted and gender questioning young Australians experience public insult, 20% explicit threats and 18% physical abuse and 26% 'other' forms of homophobia (80% of this abuse occurs at school).[29]
- The most common types of heterosexist abuse experienced by LGBT people during the 12 months prior to a 2011 survey were non-physical: verbal abuse (25%), harassment (15%), threats of physical violence (9%) and written abuse (7%).[30]
- Rates of almost all types of violence are highest against trans people. Approximately 50% of adult trans Australians experience verbal abuse, social exclusion and having rumours spread about them. A third have been threatened with violence, with 19% having been physically attacked (and a similar number reporting discrimination by the police), 11% experience obscene mail and phone calls and damage to personal property. 64% modify their behaviour due to fear of stigmatization and discrimination.[31] 49% of trans respondents to a NSW study reported having been sexually assaulted.[32]
- Little data is available on the experiences of intersex Australians, however extensive consultation in New Zealand affirmed anecdotal evidence in Australia that the secrecy and shame associated with intersex conditions leave intersex people vulnerable to discrimination and abuse and that some intersex people also experience similar discrimination to trans people.[33]

"For me, the worst thing about discrimination has been the way I have, in the past, taken responsibility for it, thinking it was my job to stay out of the firing line… I was always trying to second guess what people were thinking and act accordingly to manage what I thought were their expectations. As a result, I faced little direct discrimination, but that came at great cost to my happiness."

(gay man, 25-45 years, metropolitan Victoria, quoted in beyondblue 2012)

- Many LGBTI people avoid certain situations due to fear of discrimination and/or fear of being 'outed',[34] thus limiting the very social connectedness known to contribute to developing resilience and wellbeing.

Combat transphobia, homophobia, biphobia, heterosexism and heteronormativity within your own sphere of influence and support antidiscrimination campaigns led by others

- LGBTI people can also internalize homophobia and transphobia: they are socialized in the same environment as their peers, thus receiving the same negative messages in relation to sexuality, sex and gender diversity. The vast majority have been told directly and/or via more diffuse 'public opinion' that they are not 'normal'.[35] The lack of visible positive role models and difficulty accessing affirming peer support can hinder the development of positive self-concepts, self-esteem and resilience and cause significant mental distress.
- Heteronormativity is the assumption of heterosexuality as the default or 'norm' and associated simplistic understandings of biological sex and gender always being identical and stable and as exclusively binary (a person is either male or female). It does not necessary involve prejudice, but rather invisibility due to the reproduction of norms that exclude LGBTI people, for example through language and social institutions such as marriage.
- Both explicit discrimination and the invisibility that results from heteronormativity also occur within primary health care, mental health services and other community services. Even where LGBTI identity is acknowledged, indirect discrimination can occur. For example, the treatment intersex people receive often focuses on physical issues such as hormone replacement therapy. Psychological issues may be brushed over during medical appointments or left out altogether.[36] The failure of generic health interventions and prevention strategies to be inclusive of LGBTI people and their needs thus also exacerbates mental health problems and suicidality not directly linked to sexual orientation, sex or gender identity issues by reducing LGBTI people's ability to access support in times of need. [37] See below "Existing initiatives are not effective for this high-risk group".
- Discrimination and social exclusion also contribute to LGBTI people experiencing a higher prevalence of other risk factors associated with mental ill-health and suicidality than the rest of the population, such as
  - More harmful and frequent levels of alcohol and other drug misuse[38]
  - Homelessness and poverty, in particular among trans people[39]
  - Disengagement from schooling[40]
  - Chronic health conditions[41]
- There is some evidence that older LGBTI people exhibit crisis competence – indicating resilience and hardiness.[42]

There is a robust evidence base but still significant knowledge gaps

- While Australian and international research demonstrate areas of significant concern and provide a robust evidence base of mental health indicators, suicidal ideation (thoughts) and self harm among LGBTI people, knowledge gaps remain. These relate in particular to protective factors, comorbidity (the co-occurrence of more than one type of ill-health),[43] effective interventions and the specific issues of population groups known to face particularly high risk, such as intersex people, bisexual people, trans people, and Indigenous, elderly and rural LGBTI people. This is due to a lack of inclusion in most administrative data and generic research, and to a lesser extent to some methodological issues relating to data collection for these populations.[44]
- Sexual orientation, gender identity and intersex status, unlike other demographic characteristics, are not necessarily known, even by family members, nor are they readily identifiable through existing data collection methods (such as coronial records, surveys, administrative data collected by services).[45]

Include sexual orientation, sex and gender identity and related factors in data collection to monitor who you are reaching (acknowledging that disclosure issues will invariably lead to underestimates)

- From those who have survived suicide attempts it is known that many LGBTI people attempt suicide before having disclosed their sexual orientation or gender identity to others.[46] Therefore even where attempts are made to gather such data on suicides, a significant underestimate can be assumed.
- Due to homophobia, transphobia and stigma around intersex status, agencies often hesitate to ask about sexual orientation, sex and gender identity even when questions are included in forms or surveys. In addition many LGBTI people will not disclose unless they are confident of anonymity or confidentiality.[47] This leads to inaccuracy in reporting and significant underestimates.

"Some of us are still haunted by the spectre of our identity as circus freaks in the not-too-distant past. It is time that our identities and experiences were given the same respect as the rest of the community."

(Woman born with an intersex condition, quoted in Human Rights Commission 2008)

- Estimating mental health outcomes, and in particular suicide mortality or suicidal behaviours, for LGBTI populations therefore remains highly challenging.
- Even where LGBTI data is collected, it is frequently not analysed or made available, and rarely taken into account in policy, research or practice.
- LGBTI people and services are seldom consulted in the development of research, policies or programs in relation to mental health or suicide prevention, resulting in existing knowledge not being utlised. As has long been acknowledged in relation to other marginalised population groups, the failure to fully involve LGBTI people in all stages of research design and implementation reduces both its effectiveness in reaching LGBTI people and the validity of its results as their needs and experiences are unlikely to have been appropriately considered.
- While LGBTI-community specific research provides an extremely valuable evidence base for the development of policies and programs, the inclusion of LGBTI variables and issues in generic research is also essential to enable robust comparison across population groups and identification of the factors that contribute to or pose a risk to mental health and wellbeing. This remains the exception.[48]
- The inclusion of sexual orientation, gender identity and intersex status in the baseline data provided by the Australian Census as well as in all major surveys would contribute significantly to understanding and addressing the issues identified in the research reviewed for this paper.[49]
- International best practice with the robust collection of sexual orientation data as a demographic variable is now well advanced.[50] It can be applied to both research and administrative data collection.
- The challenges that remain in relation to the capture of robust gender identity data that meets user needs are beginning to be explored.[51] The consistent collection and utilisation of sex and gender data by Commonwealth and state/territory government agencies is one of the key recommendations of the 2012 Australian National Diverse Sex and Gender Roundtable.[52]

LGBTI people have specific issues

Aside from discrimination and exclusion causing and contributing to mental ill-health and barriers to support, a number of other issues may be relevant when working with LGBTI people, for example:

- Due to the high rates of suicide in LGBTI populations, LGBTI people are disproportionately affected by the suicide of friends and community figures. In addition, until recently a large proportion of LGBTI characters in film and books suicided. Both lived experience and fictional models thus increase the likelihood of perceiving suicide as an option and of contagion. The lack of LGBTI-inclusive bereavement support services and, in some cases, secrecy, also exacerbate the risk factor of distress.
- 'Coming Out' refers to identifying ones self as LGBTI. Lesbian, gay, bisexual and trans people often go through a process of questioning their sexual orientation and/or gender identity which they may not disclose to others for some time, if at all. This is sometimes referred to as 'coming out' to yourself. For many people there is stress associated with coming to terms with one's sexual orientation, gender identity or sex identity and the potential impact of associated life changes and (feared or actual) experience of discrimination. Research shows that the majority of first suicide attempts by LGBT people are made prior to coming out to others.[53] Suicide attempts by trans people are usually made before the person has engaged in any gender-related treatment, counselling or therapy.[54] For some people an 'internal coming out' is concluded with self-identifying as lesbian, gay, bisexual, trans, intersex or another identity label and then 'coming out' to others. However, for other people this can be a complex, fluid and multidimensional process that is revisited at various times in their lives, with associated changes in their identity over time.
- Heteronormativity means people generally assume heterosexuality and cisgender status (not being trans or intersex). Therefore the decision on whether and how to communicate one's sexual orientation, sex or gender identity to others is faced in almost every new social contact, including contact with health professionals and other service providers. This too can be a source of stress given considerations of potential impact. Many LGBTI people are only 'out' in some contexts and may hide their sexual orientation, gender identity or intersex status for fear of discrimination or abuse, especially when accessing services and in public,[55] for example, not acknowledging having a partner or describing them as a 'friend'. One in five trans Australians have been threatened with being involuntarily 'outed'.[56] Given high rates of discrimination, including physical violence, refusal of employment, etc, on the basis of being identified as trans, such threats have significant psychological and practical impact.
- Sexual orientation, sex and gender identity usually have implications for more than sexual behaviour. They are sometimes described as cultural belongings, with shared language, knowledge, history, customs, literature, social settings, institutions, media, etc into which LGBTI people are socialised. LGBTI communities are very diverse and represent a potential resource for LGBTI people. They can be a source of empowerment, in particular by providing access to positive role models, peer support, social belonging, etc. Social connectedness is known to be a key determinant of health.[57] Numerous groups and organisations have grown out of LGBTI communities in Australia, especially in urban centres. They provide a wide range of services and social activities. The Internet has facilitated community development for LGBTI people, however connecting with LGBTI communities still often remains challenging.[58]
- Lesbian, gay and bisexual Australians are twice as likely as heterosexual Australians to have no contact with family or no family to rely on for serious problems (11.8% v. 5.9%).[59] Figures are likely to be even higher for trans people. Many LGBTI people are more likely to seek or receive primary emotional support and health information and advice from friendship/peer support networks, in particular LGBTI friends, sometimes referred to as 'families of choice'.[60] At the same time, less than half of LGBTI people state that they would feel confident dealing with the situation if someone close to them had a mental health problem or had thoughts of suicide or self-harm.[61]

"When making the decision to come out we often feel a sense of isolation and disconnection of country we identify with and the land location we identify our kinship, often resulting in drug and alcohol dependency to suppress feelings connected to the whole 'Coming Out' process. ... There is a mental challenge to balance culture, connection to land and sexuality acceptance within our kinships"

(Aboriginal lesbian, personal communication 2010)

Be sensitive around issues of disclosure. Have clear policies around confidentiality and make them known. Remember that family and friends may not know certain things, or if they do, may not necessarily be supportive

- Although children of LGBTI people are generally at least as well adjusted as other children, they often also experience homophobic and transphobic discrimination and prejudice in relation to their parents.[62] This can also be the case for other family members and associates.
- Consensual sex between men was a criminal offence in Australia until the 1990s and the World Health Organisation did not remove homosexuality from its International Classification of Diseases until 1992. Most older LGBTI people in Australia have thus grown up in an environment of legal persecution and pathologisation by the medical profession. People in same-sex relationships also experienced the economic disadvantage of exclusion from tax concessions available to their heterosexual peers. Those who grew up pre 'gay liberation' experience ageing differently and have different needs to the baby boomer cohort which is now approaching retirement.[63]
- Being trans remains classified as a psychological disorder (gender dysphoria) and transsexual people seeking medical interventions are required to have this diagnosis and gain approval from a psychiatrist in order to access them. This can be a source of significant tension for people seeking to affirm a positive identity. Without significant medical interventions it is currently impossible for trans people to change their sex on their legal documentation.
- For some transsexual people, access to medical interventions to affirm their gender of identity (eg realignment surgery, hormones) represents, quite literally, a matter of life or death.[64] Certainly, a 2012 UK study showed that those trans people who wanted "gender reassignment or transition" but were as yet unable to access it and those who were unsure whether or not they wanted to had the lowest rates of life satisfaction. Most trans people who had undergone such a process reported being more satisfied with their lives since then (70%), with improved mental health (74%) and lower rates of suicidal ideation (thoughts) and attempts (63%). The 2% who reported being less satisfied with their lives post-intervention explained this in terms of experiences of transphobia, including loss of family, friends and employment, and/or poor surgical outcomes.[65] There are a range of barriers to accessing such medical interventions, including approval from psychiatrists and high financial costs (with simultaneously reduced economic opportunities).[66]
- Not all trans people wish to access medical interventions to affirm their gender identity, however, most experience the process of beginning to express rather than supress their gender identity as a transition with wide-reaching implications, both in terms of
    - challenges, such as increased vulnerability to discrimination and rejection (and associated loss) and the stress of having to manage a potentially complex process while also adjusting to a new gender role with its associated social expectations
    - increased wellbeing gained from self-expression and self-acceptance, knowledge, insight, confidence, better quality relationships, community and a sense of belonging (in particular by connecting with other trans people) and feeling they have a future.[67]
- Practical barriers to accessing health services face many trans and some intersex people where they present as one gender but their official documentation reflects another. The 'involuntary outing' associated with accessing services or participating in some other areas of life (such as renting, voluntary or paid work that required police checks or international travel) is often avoided where possible, with implications for health and wellbeing. Those trans people who change their official documentation of gender (dependent on extensive medical

interventions not accessible to all) still face barriers where, for example, old documentation carries a name and/or gender that no longer applies. This can, for example, lead to problems providing academic transcripts or job references.

- The birth of an intersex child is often treated by health professionals as a 'psycho-social emergency', however, little support and information is available to parents or, later, the children themselves. Intersex infants and children are often subjected to non-consensual, non-essential medical interventions (including genital surgery) to make them more 'normal. This can impact on their lives and health in various ways. There is a significant risk that this assignment of the child's sex may not be consistent with their adult gender identity. Whether (and to what extent) such intervention is necessary for the child's physical and mental health, or whether it is both physiologically and psychologically harmful, remains a contentious issue. The 2012 Australian Diverse Sex and Gender National Health Roundtable criticised use of medical intervention aimed at 'normalising' rather than addressing actual health issues and recommended regulation of surgery performed on intersex children (in consultation with intersex representatives).[68]

I was never asked if I would agree to be changed. I didn't know I was XXY. They knew but they never told me.

(Intersex person, quoted in Human Rights Commission 2008)

- Sometimes parents and medical professionals do not inform people of their intersex condition due to stigma and shame. Discovering that they are intersex can be a shock. Combined with having limited information and often no access to medical records, this can leave people feeling very isolated and betrayed.[69]
- Many intersex people have experienced trauma from medical examinations during the process of being diagnosed, often in childhood or adolescence. Intersex people may be reluctant to ask for psychological help and other forms of support due to feelings of mistrust, shame and/or embarrassment.[70] Some intersex people feel that intrusive examinations combined with stigma and secrecy within the family also made them vulnerable to sexual abuse as children, with resulting impact on mental health.[71]
- Gay and bisexual men continue to have the highest risk of HIV in Australia, with associated specific issues in relation to responses to diagnosis, living with HIV, medication related side-effects, AIDS related dementia, etc.

Existing initiatives are not effective for this high-risk group

- Recently there has been increased acknowledgement of LGBTI people's risks and issues in relation to mental health and suicide in Australia. Some mainstream mental health organisations, such as *beyondblue* and Headspace, are beginning to contribute to LGBTI visibility in health promotion activities and there have been recent government moves towards inclusion. However, exclusion from generic mental health and suicide prevention policies and programs continues to result in LGBTI people not being reached and their needs not being addressed.[72]
- Barriers to health service access include LGBTI people's fear of discrimination or rejection,[73] as well as fear of breach of confidentiality.[74] Unless services are explicitly inclusive, many LGBTI people will often assume a lack of understanding and/or potential discrimination. This is particularly the case in faith-based services, due to a history of explicit homophobia from some religious institutions.[75] Fear of discrimination and stigma can result in

Build diversity competence, including soft skills, use of gender neutral language, specific LGBTI knowledge

  - LGBTI people not accessing preventative or responsive mental health services at all, or
  - delaying their access to services, exacerbating the health issue.[76]
- A UK study showed that trans people who are so distressed that they feel they need urgent support either don't approach anyone or if they do, are most likely to contact their friends, followed by their GP or partner. Relatively few choose to approach designated mental health or suicide prevention services.[77] Australian LGBTI studies show a similar pattern.[78] At the same time less than half of LGBTI Australians report feeling confident in dealing with the situation if they or someone close to them had a mental health problem (46%) or thoughts of suicide (40%).[79]
- Where LGBTI people do access mainstream services, the quality of care they receive is often unsatisfactory: In at least some cases the fear of discrimination and/or inappropriate behaviour by service staff is justified. Experiences of LGBTI people include violence, refusal or reluctance to treat or if treating to acknowledge a health concern directly related to their sexual orientation, gender identity or intersex status.[80] They also include homophobic and transphobic treatment paradigms, for example, pathologising LGBTI identity as a symptom of mental ill-health[81] and using conversion therapies for same-sex attracted people (also known as reparative therapy). This practice claims to change sexual orientation and has been condemned the Australian Psychological Society and numerous other Australian and international professional associations as not only not working (as it is based on false premises) but also as unethical and harmful to the wellbeing of those who undergo it.[82]
- Discrimination is also anticipated and experienced from other clients, with few organisations taking steps to protect LGBTI clients in such cases.[83]
- Heteronormativity is a further, associated barrier. It results in some mental health professionals not automatically considering the possibility that their client may be LGBTI and expressing their assumptions in language choice, etc. Thus if they do access services, LGBTI people are required to challenge this assumption if they wish to address anything associated with their sexual orientation, sex or gender identity. Due to a fear of discrimination or withdrawal of care LGBTI people may have difficulty disclosing even where they believe these issues are directly relevant.[84]
- Failure to consider LGBTI needs can result in structural exclusion,e.g.where clients are separated on the basis of sex and no appropriate policies are in place regarding the placement of trans and intersex clients.[85]

"Seeing health professionals in general is often a scary and intimidating experience for transfolk. I've learnt the hard way that being a medical professional doesn't make someone knowledgeable about trans issues... if I wanted to see some kind of mental health professional in the future, I would only see one that had previous exposure to Trans issues so I wouldn't have to educate them and wouldn't feel violated."

(Transsexual, queer, 24-45 years, Metropolitan South Australia, quoted in Beyondblue 2012)

- Lack of acknowledgement of social determinants of health,e.g.social isolation and discrimination, can result in key causal or contributing factors for LGBTI people not being addressed.
- Lack of capacity in targeted services,e.g.no dedicated funding for LGBTI community-based services, results in few dedicated services being available. Those that are available having limited outreach and often limited ability to build the skills and provide the services LGBTI people seek.

- A lack of LGBTI knowledge and cultural competence in generic services[86] result in poor quality service provision, for example ill- or uninformed advice and inappropriate treatment [87] (e.g. pathologising their sexual orientation or gender identity) and failure to take the person's (potential) strengths/social resources into account (e.g. engaging with the family of origin but not friends or LGBTI community groups).
- LGBTI people often feel that they need to educate the health professional first in order to receive satisfactory service. This places a significant burden on a person when they are already in a vulnerable state.
- Where LGBTI people are identified as such, service providers often focus on their sexual orientation, their trans identity or their intersex status rather than the mental health issue or suicidality with which they are presenting. For trans and intersex people this can be a focus on physical issues such as hormone treatment or surgery. Psychological issues may be brushed over or left out altogether.[88] This can exacerbate the mental health problems and suicidality.[89]
- Where mental health issues are acknowledged by services, there is a tendency to focus on individual psychological intervention, rather than on social intervention to minimize risk factors such as homophobia, transphobia and heterosexism or empowerment approaches to build resilience and develop strategies to effectively respond to discrimination. While research indicates strong linkages between experience of discrimination and exclusion associated with sexual orientation, sex and gender identity and poor mental health, to date few initiatives have sought to reduce these causal factors.[90]
- LGBTI people seldom inform service providers that the service they have received has not been satisfactory, leaving organisations often unaware that they are not fulfilling their mission for this population group.[91]
- There are few mental health or suicide prevention initiatives targeting LGBTI people. Those that do exist are generally poorly resourced and occur in relative isolation from one another and from the generic initiatives and stakeholders. This limits their ability to provide the level of support required.

"I haven't accessed GLBTI services due to my internalised doubt about my legitimacy. In my teens, I didn't think I had the right to access them because I'd never had a girlfriend and so couldn't 'prove' I was bi. Later, I didn't think I could access them because I had an opposite-sex partner, even though my anxiety was about my bisexuality. Now I have a hard time thinking I should access them because I'd be draining limited resources when my problems are much smaller than many others. And I don't want to access mainstream resources because they might be discriminatory."

(bisexual woman, 25-45 years, metropolitan South Australia, quoted in beyondblue 2012)

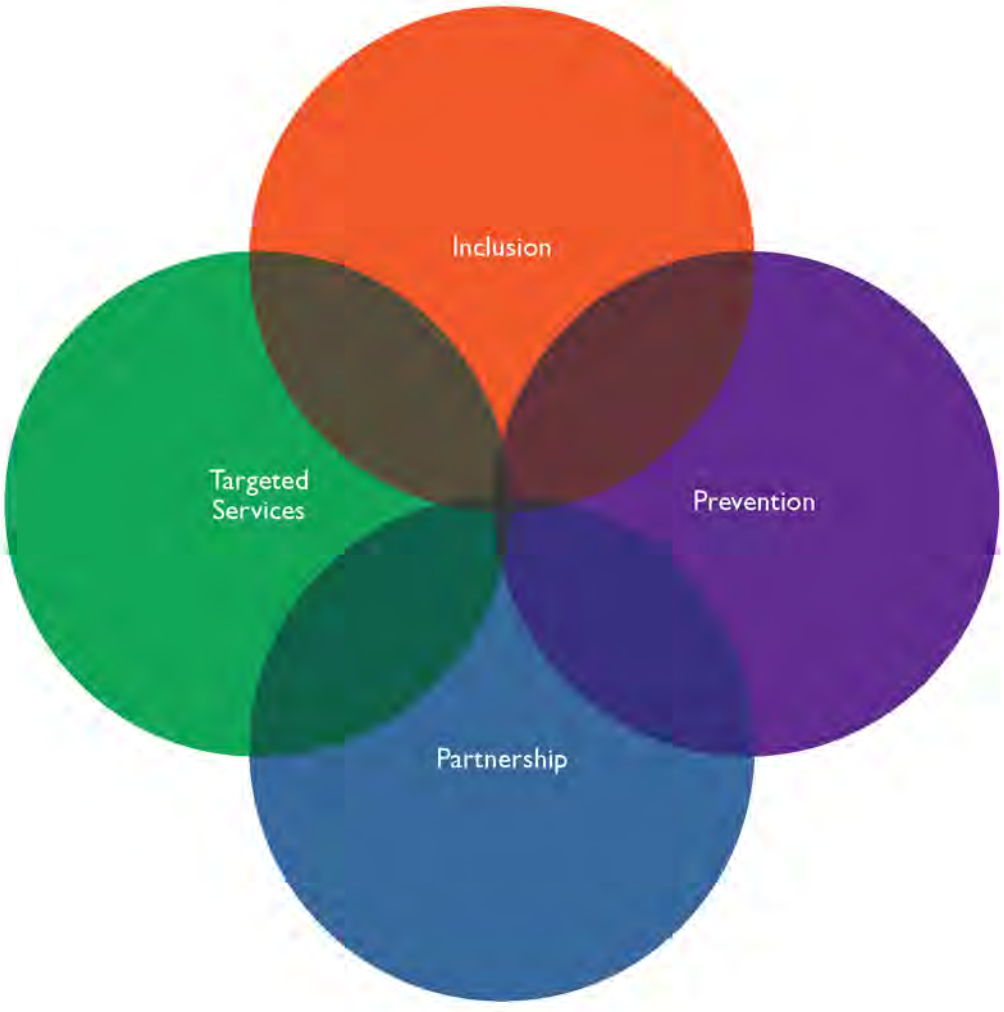
It is necessary to prioritize inclusion, targeted initiatives, prevention and partnership

The mental health needs of LGBTI people are complex and diverse. Addressing them requires specific effort and a range of interrelated mechanisms.[92]

Inclusion

- Most LGBTI people access generic/mainstream mental health and suicide prevention services so these services must serve the needs of this population.
- Generic mental health and suicide prevention initiatives (research, policy and practice) must be proactively inclusive of LGBTI people and their diverse issues and demonstrate this in order to reduce access barriers and provide appropriate services. 97% of LGBTI respondents to the 2011 MindOut! Survey considered it important that mainstream mental health and suicide prevention services are LGBTI sensitive and aware.[93]
- LGBTI specific services must be proactively inclusive of mental health and suicide related issues. As of 2011 although 89% and 72% of LGBTI organisations considered mental health and suicide respectively to be one of the most significant issues in the LGBTI community, only 35% included mental health and suicide prevention in their goals and/or strategic plans and less than half felt that their staff and volunteers would be confident and competent dealing with someone who presented with a mental health problem or risk of suicide.[94] Adequate inclusion of these issues is often challenging given the limited resourcing of this sector and its reliance on volunteers and peer support models. It thus requires investment in LGBTI community sector capacity.

Demonstrate that your organisation is inclusive, e.g. posters, signage, forms, advertising in LGBTI media, examples and images used in resources, LGBTI-specific resources easily accessible



"When my GP made the referrals, it was important to her that she find me gay-friendly providers. Having bipolar disorder was/is unrelated to me being gay, but some of the pressures of life as a gay man mean that those stressors need to be examined and put into order to prevent life stresses from contributing to a situation where I could become unwell."

(gay man, 25-45 years, rural Victoria, quoted in beyondblue 2012)

- Inclusion requires above all visibility of LGBTI people and their issues in
  - programs, services and resources
  - policy frameworks and guidelines
  - research, monitoring and reporting
- Awareness training for GPs and mainstream mental health and suicide prevention service providers were named as two of the top three priorities by LGBTI respondents to the 2011 MindOut! Survey when asked what could make a positive difference to mental health and suicide prevention (the third being targeted LGBTI services).[95] It should be noted, however, that while training to promote awareness and diversity competence are essential to inclusive practice, they are not sufficient in isolation.
- Inclusive practice is a multidimensional approach that encompasses human resources (e.g. recruitment, diversity competence, workforce development), paradigms (e.g. client-centred care, strengths-based approaches, supervision that addresses heteronormative assumptions), scope (e.g. types of services, target groups), tools (e.g. screening forms), organisational structures (e.g. physical setting, policies, procedures, governance and decision making), marketing strategies (e.g. niche marketing), stakeholder relationships, evaluation, resources (e.g. funding criteria, resource allocations), etc.[96]
- To be effective, inclusive practice requires a multidimensional approach to diversity, considering issues of sexual orientation, sex and gender identity in a differentiated manner and in relation to all population groups, e.g. Aboriginal and Torres Strait Islanders, older people, people with disabilities, rural and remote communities, refugees, multicultural communities, parents, children and young people, etc. This applies equally to LGBTI and mainstream organisations.
- LGBTI organisations can support mainstream organisations with both the development and the evaluation of their inclusive practice (see also 'partnership' below).

Targeted initiatives

- Targeted LGBTI-specific initiatives are required to complement inclusive generic initiatives. 86% of LGBTI respondents to the MindOut! survey feel that having LGBTI specific mental health and suicide prevention services is important, as do 82% of LGBTI organisations.[97] These include both LGBTI-specific services and custom-made/tailored services within inclusive generic programs.[98]

"I believe access to mental health services is incredibly poor if non-existent. My only free psych care was after a suicide attempt I'm one who has hidden, we tend to break down and come out in our 40s. Coming out then is very dramatic and sudden and [we have] lives that we're in the process of tearing down, and you need help… I really needed help initially to survive and function and then I guess I needed help to come to terms with and learn to accept myself for who I was"

(Transwoman, in Human Rights Commission 2008)

- LGBTI community ownership reduces barriers and contributes to effectiveness of initiatives, for example by enabling peer support, empowerment and community development.
- The current underresourcing of the LGBTI community sector requires the prioritisation of LGBTI services in mental health and suicide prevention funding allocations and strategic planning.
- Targeted research and monitoring is required to address knowledge gaps in particular in relation to small populations such as trans people (alongside inclusion in generic research).
- There are barriers to inclusion in generic consultations that make targeted consultations and specific strategies necessary to engage with this disparate and hard-to-reach population.

Prevention

Support programs and activities that help LGBTI people to flourish, eg donate, publicize, advocate

A focus on health promotion and prevention as well as intervention and postvention will make a long term improvement in the health outcomes of LGBTI Australians.

- The current focus on crisis intervention and predominantly medical models of mental health needs to be expanded into a comprehensive approach that builds protective factors and addresses the social determinants of suicide and mental ill-health..
- Ultimately, to improve LGBTI mental health outcomes and reduce suicidality, heterosexism, homophobia, transphobia and the stigma associated with intersex conditions must be addressed at the interpersonal, sociocultural, and institutional level.

Partnership

- Collaboration between government agencies, mainstream mental health and suicide prevention services and LGBTI organisations can effectively bring together the respective expertise of the sectors.
- "Not about us without us" – effective mechanisms are required to utilise the expertise of the LGBTI community in development, delivery and evaluation of initiatives, with targeted inclusion of particularly marginalised groups.[99]
- Working in partnership builds the capacity of both LGBTI community services (in mental health promotion and suicide prevention) and mainstream services (to deliver culturally relevant and accessible services).
- Efficient use of the respective resources of the sectors.
- Improved service coordination – a 'no wrong door' approach and robust referral pathways.[100]
- Cross-sectoral initiatives that address the underlying determinants of suicide and mental-ill health.
- Targeted investment is required to build the capacity of the LGBTI community sector to engage with the mental health and suicide prevention sector as partners.

In 2010 the Australian Senate Community Affairs Reference Committee recommended that LGBTI people be recognised as an at-risk group in suicide prevention strategies, policies and programs.[101] Some initial steps have been taken to implement this recommendation, alongside increased government attention being given to mental health issues for this population group. These steps include Federal and some state funding of initiatives that address all four of these areas: inclusion, targeted initiatives, prevention and partnership. For example the MindOut! LGBTI Mental Health and Suicide Prevention Project, delivered by the National LGBTI Health Alliance (2011-13). This project strives to strengthen linkages between the LGBTI sector and mainstream mental health and suicide prevention agencies, increasing awareness and providing the foundation for appropriate and targeted policy responses for LGBTI people.[102]

Refer people to LGBTI organisations as appropriate, work with them to increase inclusion within your organisation, support them to build their own capacity around mental health and suicide prevention, collaborate on targeted activities

Role of the National LGBTI Health Alliance

The National LGBTI Health Alliance is the peak, national body representing organisations and individuals that work to improve the health and wellbeing of LGBTI Australians. The Alliance currently has 177 members across Australia, including 82 organisations representing the vast majority of the LGBTI community services sector in addition to key researchers, health practitioners and individual consumers and carers.

If you can't treat someone with respect and openness, ensure that they get support from someone who can

Members of the National LGBTI Health Alliance share the vision of healthy, resilient and flourishing LGBTI people and communities fully participating in a socially inclusive Australian society They work on the basis of a holistic understanding of health and wellbeing, and consider social as well as medical determinants.

Members of the Alliance provide a wide variety of programs, services and research in the area of LGBTI health and wellbeing. They often combine consumer/carer and practitioner perspectives.

The Alliance works on a national level to address systemic barriers experienced by people of diverse sexuality, sex and gender in accessing preventative and responsive healthcare from mainstream healthcare providers, as well as gaps in community-specific services.

It provides a national voice on LGBTI health issues and builds the capacity of the health and wellbeing sector to address them.

Mental health and suicide prevention are key health issues for LGBTI people and a priority area for the Alliance. Alliance members include organisations whose work to improve LGBTI health and wellbeing includes a mental health component and organisations whose work specifically focuses on mental health issues across population groups, including but not limited to LGBTI people. The Alliance is a member of the Mental Health Council of Australia and Suicide Prevention Australia, among other national peak bodies.

The Alliance:

- initiates, facilitates and delivers national projects. For example, the multifaceted MindOUT! LGBTI Mental Health and Suicide Prevention Project
- provides advice to government and other key stakeholders, for example, in formal submissions, by participating in advisory bodies and providing ad hoc advice. For example, providing written and oral submissions to the Senate Community Affairs References Committee Inquiry into Suicide in 2009-2010 and jointly chairing a steering committee for the development of a National LGBTI Ageing and Aged Care Strategy in 2012[103]
- develops tools and resources to support organisations to work inclusively of LGBTI people. For example, Practice Wisdom Resources for Australian mental health professionals for the counselling and therapy of LGBTI clients and a Cultural Competency Framework for mainstream mental health and suicide prevention organisations and services[104]
- facilitates partnerships or referrals to its members. For example, the Alliance is worked with beyondblue to develop a national database of LGBTI counselling services[105]
- facilitates consultation with the LGBTI community. For example, as part of the Federal Government's 2012 national consultation on ageing and aged care
- builds capacity within the LGBTI community sector by facilitating collaboration and the sharing of ideas and resources among its members. For example, hosting Australia's first National Diverse Sex and Gender Health Roundtable 2012[106]
- proactively builds and disseminates knowledge. For example, in the 'Health in Difference' National LGBTI Health Conference, presentations, such as the key note speech at the National GLBT Mental Health Roundtable 2009,[107] and publications, such as this one and *Pathways to inclusion: Frameworks to include LGBTI people in mental health and suicide prevention services and organisations* (2012).

  See www.lgbtihealth.org.au to find out more and to identify Alliance member organisations in your state/territory.

References

1 Smith et al. (2003)

2 Department of Health (2008); Olyslager and Conway (2007)

3 Diamond (2004); Blackless, et al. (2000)

4 Leonard et al. (2012); Corboz et al. (2008); Suicide Prevention Australia (2009)

5 Pitts et al. (2006)

6 Couch et al. (2007). See also McNeil et al. (2012): 88% of trans respondents to a UK study report either currently or previously experiencing depression.

7 Australian Bureau of Statistics. Unpublished data

8 Leonard et al. (2012)

9 Australian Bureau of Statistics (2007)

10 Leonard et al. (2012). See also McNeil et al. (2012), which showed 75% of UK trans respondents to have experienced significant anxiety, however, often without this having been diagnosed.

11 Leonard et al. (2012); Dodge and Sandfort (2007); Jorm et al. (2002)

12 Schutzmann et al (2009)

13 Couch et al. (2007). Cf. 27% in a recent UK study and 63% reporting suicidal ideation within the past year, McNeil et al. (2012)

14 Pitts et al. (2006)

15 McNeil et al. (2012)

16 Di Ceglie (2000); Holman and Goldberg (2006); Perkins (1991: 53) quoted in National Transgender HIV/AIDS Needs Assessment Project (Australia) et al. (1994); Ontario Public Health Association (2003); McNeil et al. (2012)

17 Commonwealth Department of Health and Aged Care (2000); Suicide Prevention Australia (2009)

18 Dyson et al. (2003)

19 Nicholas and Howard (1998)

20 Schutzmann et al (2009)

21 National LGBT Health Alliance (2009)

22 Institute of Medicine (2011); Suicide Prevention Australia (2009); National LGBTI Health Alliance (2009)

23 Dyson et al. (2003); Nicholas and Howard (1998); Hillier and Walsh (1999)

24 Wilkinson and Marmot (eds)(2003); Rosenstreich (2011)

25 Meyer (2007); Institute of Medicine (2011)

26 Hillier et al. (2010); Suicide Prevention Australia (2009)

27 See www.ag.gov.au/consultations/pages/ConsolidationofCommonwealthanti-discriminationlaws.aspx and www.antidiscrimination.gov.au [viewed 8/3/13]

28 Leonard et al. (2012); Australian Medical Association (2002); Flood and Hamilton (2005)

29 Hillier et al. (2010); Howard and Arcuri (2006); Hillier et al. (2004)

30 Leonard et al. (2012)

31 Couch et al. (2007); See also Leonard et al. (2012) and McNeil et al. (2012).

32 National Transgender HIV/AIDS Needs Assessment Project (Australia) et al. (1994); N.B. this figure relates to 'ever' having been sexually assaulted. National data collected using a different methodology indicated a rate of 6.8% of trans women reporting a sexual assault over the previous 12 months. This was almost 2.5 times the average of the total LGBT survey sample. Leonard, W. et al. (2012).

33 Human Rights Commission (2008)

34 McNeil et al. (2012); Pitts et al. (2006); Leonard et al. (2012)

35 E.g. McNeil et al. (2012)

36 AIS Support Group Australia (AISSGA), personal communication 2011

37 Dyson et al. (2003); Couch et al. (2007); Hillier et al. (2005)

38 AIHW (2011); Pitts et al. (2006); Howard and Arcuri (2006); McNair et al (2003); Leonard et al. (2012)

39 Ray (2006); McNeil et al. (2012)

40 Hillier et al. (2010)

41 Australian Bureau of Statistics. Unpubl. data

42 Institute of Medicine (2011)

43 Hughes et al. (2010) identified a link between sexual orientation, mental health and at risk use of alcohol and other drugs. Further research is required to understand the interrelationships.

44 Institute of Medicine (2011); Pega et al.(2010)

45 Suicide Prevention Australia (2009)

46 Dyson et al. (2003); Nicholas and Howard (1998); Hillier and Walsh (1999); Cole (1997)

47 Dyson et al. (2003); Gibbons et al. (2008)

48 Most notably in Australia, the National Survey of Mental Health and Wellbeing included sexual orientation indicators in 2007, Australian Bureau of Statistics (2007 and unpubl. data) as did the 2010 National Drug Strategy Household Survey, AIHW (2011)

49 This is, for example, a key recommendations of the 2012 Australian National Diverse Sex and Gender Roundtable, National LGBTI Health Alliance (2012b)

50 Pega et al. (2010)

51 Office for National Statistics (2009)

52 National LGBTI Health Alliance (2012b)

53 Dyson et al. (2003); Nicholas and Howard (1998); Hillier and Walsh (1999)

54 Cole (1997)

55 Leonard et al. (2012); McNeil et al. (2012)

56 Couch et al. (2007)

57 Leonard et al. (2012)

58 Leonard et al. (2012)

59 Australian Bureau of Statistics. Unpubl. data

60 Institute of Medicine (2011); Leonard et al. (2012)

61 Price Waterhouse Coopers (2011)

62 Institute of Medicine (2011)

63 National LGBT Health Alliance (2010)

64 Kotula (2002)

65 McNeil et al. (2012)

66 Grant et al. (2010)

67 McNeil et al. (2012)

68 National LGBTI Health Alliance (2012b)

69 Human Rights Commission (2008)

70 AIS Support Group Australia (AISSGA), personal communication 2011

71 Personal communications

72 Rosenstreich et al. (2011)

73 Mayer et al. (2008); Heck et al. (2006); Birkenhead and Rands (2012); McNeil et al. (2012)

74 Gibbons et al (2008)

75 National LGBTI Health Alliance (2012a)

76 Pitts et al. (2006); Pitts et al. (2009); McNeil et al. (2012)

77 McNeil et al. (2012)

78 Institute of Medicine (2011); Leonard et al. (2012)

79 Price Waterhouse Coopers (2011)

80 Israel et al. (2011); Lucksted (2004); Birkenhead and Rands (2012); Couch et al. (2007); Senreich (2011); McNeil et al. (2012)

81 E.g. McNeil et al. (2012); National LGBTI Health Alliance (2012b)

82 See, for example, www.psychology.org.au/publications/inpsych/lgtiq/ [viewed 8/3/13]

83 Clarke (2004)

84 Semp (2006); Huygen (2006)

85 Birkenhead and Rands (2012); McNeil et al. (2012); National LGBTI Health Alliance (2012b)

86 Leonard (2002); Price Waterhouse Coopers (2011); Gibbons et al. (2008)

87 Pitts et al. (2006)

88 AIS Support Group Australia (AISSGA), personal communication 2011

89 Dyson et al. (2003); Couch et al. (2007); Hillier et al. (2005)

90 Corboz et al. (2008)

91 Gibbons et al. (2008)

92 See Rosenstreich et al. (2011) for a discussion of primary health care reform in relation to LGBTI health inequities.

93 Price Waterhouse Coopers (2011)

94 Price Waterhouse Coopers (2011)

95 Price Waterhouse Coopers (2011)

96 Some examples of good practice measures can be found in Rosenstreich (2010b); National LGBTI Health Alliance (2012a); Barrett and Stephens (2012)

97 Price Waterhouse Coopers (2011)

98 The funding of targeted programs for trans and intersex people, developed and delivered in conjunction with representatives of the diverse sex and gender community, is a recommendation of the Australian National Diverse Sex and Gender Roundtable, National LGBTI Health Alliance (2012b)

99 Rosenstreich (2010a); National LGBTI Health Alliance (2012b)

100 Birkenhead and Rands (2012)

101 Community Affairs References Committee (2010)

102 See Price Waterhouse Coopers (2011); www.lgbtihealth.org.au/mindout [viewed 2/3/13]

103 Australian Government 2012

104 National LGBTI Health Alliance (2012a)

105 National LGBTI Health Alliance (2012a)

106 National LGBTI Health Alliance (2012b)

107 Rosenstreich (2009)

Literature

AIHW (2011) 2010 *National Drug Strategy Household Survey Report*. Australian Institute of Health and Welfare. Canberra www.aihw.gov.au/publication-detail/?id=32212254712 [viewed 8/3/13]

Australian Bureau of Statistics (2007) National Survey of Mental Health and Wellbeing: Summary of Results 4326.0. Australian Government. Canberra.

Australian Bureau of Statistics. Unpublished data from the 2007 National Survey of Mental Health and Wellbeing provided to Queensland Association of Healthy Communities in 2010

Australian Government (2012) *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy*. Australian Government. Canberra. www.health.gov.au/lgbtistrategy [viewed 6/3/13]

Australian Medical Association (2002) AMA Position Statement; Sexual Diversity and Gender Identity. AMA

Barrett, C. and Stephens, K. (2012) Beyond: *'we treat everyone the same'. A report on the 2010-2011 program: How2 create a gay, lesbian, bisexual, transgender and intersex inclusive service*. Gay and Lesbian Health Victoria. Melbourne.

Beyondblue (2012) *In My Shoes: Experiences of discrimination, depression and anxiety among gay, lesbian, bisexual, trans and intersex people*. beyondblue. Melbourne. www.beyondblue.org.au/index.aspx?link-id=4.1167&tmp=FileDownload&fid=2456 [viewed 8/3/13]

Birkenhead, A. and Rands, D. (2012) Let's Talk About Sex. Auckland District Health Board. Auckland. www.mentalhealth.org.nz/file/downloads/pdf/file_346.pdf [viewed 8/3/13]

Blackless, M. et al. (2000) How Sexually Dimorphic Are We? Review and Synthesis. American Journal of Human Biology, 12: 151-166

Clarke, S. (2004) *Acute Inpatient Mental Health Care: Education, Training and Continuing Professional Development for All*. NIMHE/SCMH. London www.centreformentalhealth.org.uk/pdfs/acutetrainingguide.pdf [viewed 8/3/13]

Cole, C. et al. (1997) Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses. Archives of Sexual Behavior, 26(1):13-26

Commonwealth Department of Health and Aged Care (2000) LIFE – A framework for prevention of suicide and self-harm in Australia: Learnings about suicide, CDHAC. Canberra

Community Affairs References Committee (2010) The Hidden Toll: Suicide in Australia. Commonwealth of Australia. Canberra.

Corboz, J. et al. (2008) *Feeling Queer and Blue: A Review of the Literature on Depression and Related Issues among Gay, Lesbian, Bisexual and Other Homosexually Active People.* A Report from the Australian Research Centre in Sex, Health and Society, LaTrobe University, prepared for beyondblue: the national depression initiative. Melbourne

Couch, M. et al. (2007) *Tranznation – a report on the health and wellbeing of transgender people in Australian and New Zealand.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Department of Health (2008) *Trans: A practical guide for the NHS. Department of Health.* London www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089941 [viewed 16/4/11]

Di Ceglie, D (2000) 'Gender Identity Disorder in Young People', Advances in Psychiatric Treatment, 6: 458-466

Diamond, M. (2004) Pediatric Management of Ambiguous and Traumatized Genitalia. Contemporary Sexuality, 38(9): i-vi

Dodge, J. and Sandfort, TGM (2007) A review of mental health research on bisexual individuals when compared to heterosexual individuals. In B. Firestein (ed) *Becoming Visible: Counselling Bisexuals Across the Lifespan.* Columbia University Press. New York. Pp. 28-51

Dyson, S et al. (2003) *Don't ask, don't tell. Report of the same-sex attracted youth suicide data collection project.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Flood, M. and C. Hamilton (2005) *Mapping Homophobia in Australia.* Australia Institute Webpaper http://unilife.curtin.edu.au/sexualdiversity/documents/MappingHomophobiainAustralia.pdf [viewed 16/4/11]

Gibbons, M. et al. (2008) *Recognising LGB Sexual Identities in Health Services. The Experiences of Lesbian, Gay and Bisexual People with Health Services in North West Ireland.* The Equality Authority. www.hse.ie/eng/services/Publications/topics/Sexual/LGBExperienceHealth_Services.html [viewed 8/3/13]

Grant, J. et al. (2010) *Injustice at every turn.* National Gay and Lesbian Task Force and National Centre for Transgender Equality. Washington

Heck, J. et al. (2006) Health care access among individuals involved in same-sex relationships. *American Journal of Public Health* 96(6); 1111-1118

Hillier, L. and J. Walsh (1999) Abused, silenced and ignored: Creating more supportive environments for same sex attracted young people. *Suicide Studies Bulletin*, 3: 23-27

Hillier, L. et al. (2004) Drug-use patterns of heterosexual and non-heterosexual women: Data from the Women's Health Australia Study. In D.W. Riggs and G.A. Walker (eds) *Out in the Antipodes: Australian and New Zealand Perspectives on Gay and Lesbian Issues in Psychology.* Bently

Hillier, L. et al. (2005). *Writing themselves in again: 6 years on - the 2nd national report on the sexuality, health & well-being of same-sex attracted young people.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Hillier, L. et al. (2008) 'I couldn't do both at the same time': same-sex attracted youth and the negotiation of religious discourse. *Gay and Lesbian Issues and Psychology Review*, 4(2): 80-93 www.glhv.org.au/files/Hillier_Mitchell_Mulcare_2008.pdf [viewed 12/2/13]

Hillier, L. et al. (2010) *Writing Themselves In 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people.* Australian Research Centre in Sex, Health and Society, La Trobe University. Melbourne

Howard, J, & Arcuri, A (2006) Drug use among same-sex attracted young people. In P. Aggleton et al. *Sex, Drugs and Young People.* Routledge

Human Rights Commission (2008) *To Be Who I Am. Report of the Inquiry into Discrimination Experienced by Transgender People.* Human Rights Commission. Auckland.

Huygen, C. (2006) Understanding the needs of lesbian, gay, bisexual and transgender people living with mental illness. *Medscape General Medicine*, 8(2): 29

Institute of Medicine (2011) *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.* National Academies Press. Washington

Israel, T. et al. (2011) Policies and Practices for LGBT Clients: Perspectives of Mental Health Services Administrators. *Journal of Gay and Lesbian Mental Health*, 15(2): 152-168

Jorm, A. et al. (2002) Sexual orientation and mental health: Results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry*, 180: 423-427

Kotula, D. (2002) *In the Phallus Palace.* W.E. Parker (consulting editor). Alyson Publications. Los Angeles

Leonard, W (2002) *What's the Difference? Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians: Research Paper.* Ministerial Advisory Committee on Gay and Lesbian Health, Victorian Government Department of Human Services. Melbourne

Leonard, W. et al. (2012) *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Lucksted, A. (2004) Lesbian, Gay, Bisexual and Transgender People Receiving Services in the Public Mental Health System. *Journal of Gay and Lesbian Psychotherapy*, 8(3/4): 25-42

Mayer, K. et al. (2008) Sexual and gender minority health: What we know and what needs to be done. *American Journal of Public Health* 98(6): 989-995

McDougall, B. (2006) *My Child is Gay. How parents react when they hear the news.* Allen & Unwin, Crows Nest

McNair, R. et al (2003) Addressing health inequalities in Victorian lesbian, gay, bisexual and transgender communities. *Health Promotion Journal of Australia.* 11(1): 32-38

McNeil, J. et al. (2012) *Trans Mental Health Study 2012.* Scottish Transgender Alliance. Edinburgh. www.scottishtrans.org [viewed 8/3/13]

Meyer, I. (2007) Prejudice and discrimination as social stressors. In I. Meyer and M. Northridge (eds) *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations.* Springer. Pp.242-267

National LGBT Health Alliance (2009) *Submission to the Senate Community Affairs References Committee Inquiry into Suicide in Australia.* National LGBT Health Alliance. www.lgbthealth.org.au/publications [viewed 14/4/11]

National LGBT Health Alliance (2010) *Submission to the Productivity Commission Inquiry into the Aged Care System in Australia 'Caring for Older Australians'.* National LGBT Health Alliance. Sydney. www.lgbthealth.org.au/ageing [viewed 15/4/2011]

National LGBTI Health Alliance (2012a) *Pathways to Inclusion: Frameworks to include LGBTI people in mental health and suicide prevention services and organisations.* National LGBTI Health Alliance. Sydney. www.lgbthealth.org.au/ageing [viewed 15/2/13]

National LGBTI Health Alliance (2012b) *Diversity in Health: Improving the health and wellbeing of transgender, intersex and other sex and gender diverse Australians.* National LGBTI Health Alliance. Sydney. www.lgbthealth.org.au/dsg [viewed 15/2/13]

National Transgender HIV/AIDS Needs Assessment Project (Australia) et al. (1994) *Transgender lifestyles and HIV/AIDS risk.* National Transgender HIV/AIDS Needs Assessment Project. School of Sociology, University of New South Wales, Kensington, N.S.W

Nicholas, J. and J. Howard (1998) Better Dead Than Gay? Depression, Suicide Ideation and Attempt Among a Sample of Gay and Straight-Identified Males Aged 18-24. *Youth Studies Australia*, 17(4): 28-33

Office for National Statistics (2009) *Trans Data Position Paper.* Office for National Statistics (UK). Newport. www.ons.gov.uk/ons/guide-method/measuring-equality/equality-data-review/trans-data-position-paper.pdf [viewed 8/3/13]

Olyslager, F. and L. Conway (2007) *On the Calculation of the Prevalence of Transsexualism.* Paper presented at WPATH 20th International Symposium, Chicago, Illinois, Sept 5-8 2007. http://ai.eecs.umich.edu/people/conway/TS/Prevalence/Reports/Prevalence%20of%20Transsexualism.pdf [viewed 16/4/11]

Ontario Public Health Association (2003) Trans Health Project. *A position paper and resolution adopted by the Ontario Public Health Association.* Toronto www.opha.on.ca/our_voice/ppres/papers/2003-06_pp.pdf [viewed 16/4/11]

Pega, F. et al. (2010) *Sexual orientation data in probability surveys: Improving data quality and estimating core population measures from existing New Zealand survey data.* Official Statistics Research Series, 2. [viewed 8/3/13]

Pitts, M. et al. (2006) Private Lives: *A report on the wellbeing of GLBTI Australians.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Pitts, M. et al. (2009) Health Service Use and Experiences of Transgender People. Australian and New Zealand Perspectives. *Gay & Lesbian Issues and Psychology Review*, 5(3): 167-176

Price Waterhouse Coopers (2011) *National LGBTI Health Alliance - Mental Health and Suicide Prevention Project Final Report.* Price Waterhouse Coopers. Sydney

Ray, N. (2006) *Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness.* National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless. New York

Rosenstreich, G. (2009) *Problems and Responses.* Presentation to the Gay, Lesbian, Bisexual, Transgender and Intersex People Mental Health Roundtable. Melbourne 17 December. www.lgbtihealth.org.au/Mental-Health [viewed 8/3/13]

Rosenstreich, G. (2010a) *Excluded from the table: LGBT health and wellbeing.* Health Voices, 6: 12-14

Rosenstreich, G. (2010b) *Inclusive Practice: Reducing Barriers to Sexuality, Sex and Gender Diversity.* Workshop presentation to the 4th Asia-Pacific Regional Conference of the International Association for Suicide Prevention. Brisbane www.lgbtihealth.org.au/sites/default/files/Rosenstreich-LGBTI-Inclusive-Suicide-Prevention-20101119.pdf [viewed 8/3/13]

Rosenstreich, G. et al. (2011) Primary Health Care and Equity: the case of LGBTI Australians Australian *Journal of Primary Health*. 17(4): 302-308

Rosenstreich, G. (2011) Discrimination, LGBTI Mental Health and Suicide. *Australian Journal on Psychosocial Rehabilitation*, newparadigm, Spring 2011: 16-19

Schutzmann, K. et al (2009) Psychological distress, self-harming behaviour, and suicidal tendencies in adults with disorders of sex development. *Archives of sexual behaviour*, 38(1): 16-33

Semp, D. (2006) *A public silence: A report on sexual orientation and public mental health services in New Zealand.* Unpublished paper. Psychology Department. University of Auckland

Senreich, E. (2011) The Substance Abuse Treatment Experiences of a Small Sample of Transgender Clients. *Journal of Social Work Practice in the Addictions*, 11(3): 295-299

Simply Trans (2007) Perth Inner City Youth Service. Perth. (Resource written by various trans people). www.glcs.org.au/pdf/Simply_Trans.pdf [viewed 11/4/11]

Smith, A. et al. (2003) Sex in Australia: Sexual Identity, Sexual Attraction and Sexual Experience Among a Representative Sample of Adults. *Australian and New Zealand Journal of Public Health*, 27(2): 138-145

Suicide Prevention Australia (2009) *Position Statement Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities,* SPA. Sydney

Wilkinson, R. and M. Marmot (eds)(2003) *Social Determinants of Health – The Solid Facts.* World Health Organisation. Geneva.

LGBTI
National LGBTI Health Alliance

Email: info@lgbtihealth.org.au
Fax: +61 (02) 8212 9013
Postal: PO Box 51 Newtown NSW 2042 Australia

www.lgbtihealth.org.au

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RA -5

This is the attachment marked 'RA-5' referred to in the witness statement of Ro Allen dated "2 July 2019" .

Human Rights Law Centre

End the Hate

Responding to prejudice motivated speech and violence against the LGBTI community

Human Rights Law Centre

Contact
Anna Brown and Lee Carnie
Human Rights Law Centre
Level 17, 461 Bourke Street
Melbourne VIC 3000

T: + 61 3 8636 4450
E: anna.brown@hrlc.org.au
lee.carnie@hrlc.org.au
W: www.hrlc.org.au

The Human Rights Law Centre protects and promotes human rights in Australia and in Australian activities overseas. We do this using an integrated strategic combination of legal action, advocacy, research and capacity building.

The HRLC is an independent, not-for-profit, non-government organisation and is a registered charity so all donations are tax deductible.

Follow us: @rightsagenda

Join us: www.facebook.com/pages/HumanRightsLawCentreHRLC

Cover photo: Levi Saunders

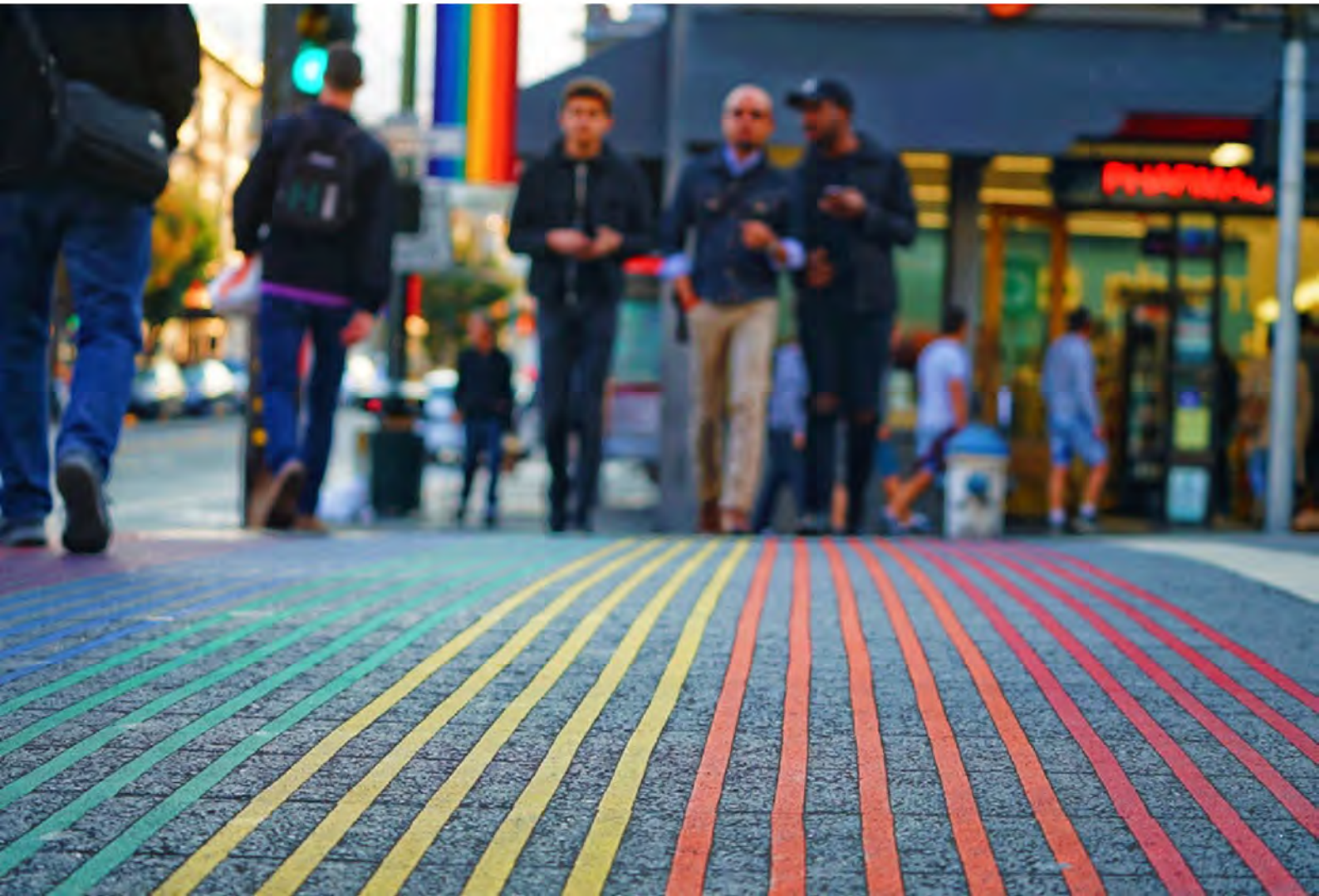
Acknowledgements
This report was researched and written by Anna Brown and Lee Carnie

The Human Rights Law Centre would like to thank the US Consulate General for funding this project.

We acknowledge the generous expertise of organisations who contributed to this report, including the Anti-Violence Project, Australian Research Centre in Sex, Health and Society, CoHealth, Colin Biggers & Paisley Lawyers, GASP (City of Greater Geelong), Gay & Lesbian Health Victoria, Liberty Victoria, Intersex Human Rights Australia, Minus 18, Thorne Harbour Health, Transgender Victoria, Victoria Legal Aid, Victoria Police, Victorian Equal Opportunity & Human Rights Commission, Victorian Gay & Lesbian Rights Lobby, Victoria's Gender & Sexuality Commissioner, and the individuals who have told their stories.

ABN: 31 117 719 267

Contents



Executive Summary

All human beings are equal and should be treated with equal dignity and respect.

Yet the horrific hate crime at the Pulse night club in Orlando, USA in 2016 and the drastic spike in incidents of hate conduct during the marriage equality postal survey in Australia in 2017 remind us that more needs to be done to eradicate harmful prejudice in our community.

For decades, members of lesbian, gay, bisexual, trans and intersex (LGBTI) communities have been calling for an end to the hate speech and hate violence which targets people based on who they are or who they love.

The Australian Human Rights Commission has found that almost 75% of LGBTI people had experienced some type of bullying, harassment or violence on the basis of their sexual orientation, gender identity or sex characteristics.[1]

This report discusses three facets of hate which cause physical, psychological and emotional harm not only to individuals, but to members of the targeted group and other minority communities, and damage our community as a whole.

Hate crimes are unlawful actions which target marginalised and vulnerable members of our communities.

Hate speech is speech which expresses hatred of a group of people in our society.

Hate conduct is a broader category of prejudice motivated behaviour which includes hate crimes and hate speech, as well as potentially non-criminal activity such as harassment and bullying.

It is difficult to progress solutions on these issues without access to accurate data on the prevalence of hate speech and hate crime which targets LGBTI people. As a result, it remains under-researched, poorly understood and almost impossible to effectively respond to.

The Human Rights Law Centre calls on the Victorian Government to:

1. Legislation: Introduce a Hate Crimes Act to ensure all people are equally protected from hate crime, hate speech and hate conduct, including LGBTI Victorians.
2. Research and data collection: fund further research and improve data collection methods and policies of all government agencies, including Victoria Police, to ensure accurate information on the prevalence of prejudice motivated conduct is available.
3. Support for victims: Introduce adequately funded independent third party reporting to improve rates of incident reporting, and introduce specialist support programs for victims of LGBTI-related hate crime.

Background

Methodology

The Human Rights Law Centre initially convened an LGBTI Hate Crime Expert Roundtable with stakeholders and experts in the aftermath of the Pulse nightclub shooting in Orlando, USA in 2016. The purpose of the Expert Roundtable was to develop an updated understanding of the prevalence of and responses to prejudice motivated harassment and violence against LGBTI people in Victoria and to identify and implement improvements in line with international best practice.

Our focus was expanded following the marriage equality postal survey held between August and November 2017 to capture reported increases in rates of hate conduct and to identify the barriers which led to under-reporting and inaccurate data collection during this period. This report provides an overview of the contemporary understandings of existing barriers preventing effective responses to hate speech, hate crime and hate conduct.

> *"After the survey was announced, my world becomes hell. It was the hate and vitriol of the 1990s that I experienced, but this time our Prime Minister gave this hatred a name – respectful debate."*
>
> - Submission to Senate Inquiry into the postal survey

Previous research

Prejudice motivated crimes against LGBTI people have been considered in detail in previous reports, including:

- *With Respect: A Strategy for Reducing Homophobic Harassment in Victoria report* (2006) (**With Respect report**);
- *Coming Forward: The Underreporting of Heterosexist Violence and Same Sex Partner Abuse in Victoria* (2008) (**Coming Forward report**);
- *With Respect Awareness Project report* (2010); and
- *Review of Identity Motivated Hate Crime* undertaken by the Hon Justice Geoffrey Eames AM QC (2010) (**Eames Review**).[2]

There remains a poor understanding of the exact prevalence of hate conduct LGBTI people face, which impedes progress. Since 2010, Victoria has made significant advances in the protection of the rights of LGBT people. Despite this progress, the same types of harassment, abuse and violence identified in past reports, which are motivated by prejudice or hatred, still persist today.

Victoria's hate crime legislation[3] was introduced in 2010 to allow for heavier sentences to be imposed for crimes motivated by prejudice but has rarely been used. Reasons for this include under-reporting, failure to identify and record crimes as hate crimes by police, difficulties locating perpetrators, reluctance by prosecutors to raise the provision and the high threshold of proving prejudice motivation in court.

Defining hate conduct

Hate crime

Hate crimes, also known as prejudice-motivated crimes, are unlawful actions that target a victim because of their membership (or perceived membership) of a certain social group.[4]

A hate crime is comprised of two elements:
(a) a criminal offence; and
(b) prejudice motivation, also known as a 'bias motive'.

Hate crimes do not occur in a vacuum; they are a violent manifestation of prejudice which can be pervasive in the wider community. Specific laws that address hate crime are necessary to demonstrate our society's condemnation of crimes committed based on prejudice. Such laws would acknowledge that hate crimes have a greater impact and affect a broader community's sense of safety, while also recognising the increased culpability of the offender.

Hate speech

Hate speech, also known as vilification, is speech which expresses hatred of a group of people in our society. Vilification of people because of their sexual orientation, gender identity, sex characteristics or other protected attribute diminishes the dignity, self-worth and integration into our community of people from a diverse range of backgrounds.

If left unchecked, hate speech can embed discrimination and provide an 'authorising environment' for the escalation to violence.

Hate conduct

Hate conduct, also known as prejudice motivated conduct, is a broader category of prejudice motivated behaviour which includes non-criminal conduct that is motivated by hatred or prejudice based on a person's membership (or perceived membership) to a social group.

It is an umbrella term used to describe a range of behaviours from online bullying or street harassment, to public graffiti and offensive publications. It can include actions which are not deemed serious enough for criminal investigation but which have a significant detrimental impact on individual and community safety.

Melbourne vigil for Pulse nightclub shooting in Federation Square

Hate crimes have ripple effects that affect a much broader community than those directly affected.

On 12 June 2016, 49 people were killed and 58 others wounded in a mass shooting hate crime inside Pulse, a gay nightclub in Orlando, USA.

Following the attack, candlelight vigils were held across Australia and the world in memory and support of the victims of the massacre.

It also re-ignited discussions within LGBTI communities about how to tackle hate crime and its insidious effects.

"Stepping into a gay bar represents leaving behind what can be an intolerant and violent outside world, and entering a place where you can be whoever you are...

I think you can see by the numbers of people that have come out tonight that these issues have a ripple effect across the globe.

It affects all LGBTI people. We understand what it means. Maybe not to be shot at but certainly to have verbal and physical violence just as a threat under our skin all our lives."

Victorian Gender & Sexuality Commissioner Ro Allen at the Melbourne vigil (2016)

Experiences of hate

"The most shocking finding of the study was that LGBTIQ respondents said that experiences of verbal and physical assaults more than doubled in the three months following the announcement of the postal survey compared with the prior six months.
They reported an increase of more than a third in depression, anxiety and stress during the same period. Almost 80% of LGBTIQ people and almost 60% of allies said they found the marriage equality debate considerably or extremely stressful."

The Australia Institute and National LGBTI Health Alliance
Study of nearly 10,000 LGBTIQ Australians, families and friends[5]

LGBTI experiences of hate conduct

The LGBTI community is diverse. The prevalence, experience and impact of prejudice motivated crime and incidents can affect individuals and groups in very different ways.

For example, available research does not fully explain anecdotal reports that transgender women of colour and people from culturally and linguistically diverse communities are disproportionately targeted by hate conduct.

There is very little available data on the experiences of hate conduct targeting by intersex people. In addition, the experience of a young intersex person is very different to the experiences of young LGBT people, who have access to more readily available information and specialist support services. [6]

The intersection of different aspects of identity can also have an impact on how LGBTI people experience prejudice motivated crime and incidents. For example, LGBTI experts have identified that:

- Aboriginal and Torres Strait Islander sistergirls and brotherboys may be targeted both because of their race and gender identity.
- Older LGBTI people are particularly vulnerable to being targeted, are less likely to have family supports and are more reluctant to report to police.
- LGBTI people living in rural, regional and remote Victoria are at risk of further marginalisation as a result of social isolation and a lack of LGBTI specific support services.

Starlady (pictured right) and two other members of the LGBTI community were assaulted and chased down the street in Melbourne on a Friday night in November 2016.

"I was screaming loudly for someone to call the police... There was a crowd of people around as well, and nobody said or did anything. It was sad. It's very different – you're being targeted because of your sex, gender identity, sexuality, race or religion.

Those crimes are very different and need to be handled differently by police, but they don't understand that."

Extract from Matthew Wade, *Star Observer*, 'Three LGBTI people assaulted in Melbourne' (7 November 2016).

Photo: Anna Cadden (Film: *Queen of the Desert*)

Danny Bryce-Maurice was bashed by four men while celebrating a friend's birthday in the St Kilda Botanical Gardens with his husband in January 2016.

"The verbal abuse started as soon as they noticed me

... *"faggot freak"* ...

"This is the men's toilet, not the ladies, f----ing faggot, get the f--- out of here!"

They started punching and kicking me repeatedly to the face, head, and finally my body.

It was relentless. I could not defend myself."

Extract from Liam Mannix, *The Age*, 'Four teenagers wanted for homophobic bashing in St Kilda' (3 February 2016)

A 15 year old boy was hospitalised after a violent attack in Alexandra Gardens in January 2016.

Police say the teen and a friend were making their way to the Midsumma festival at 5pm when he was approached by a man, believed to be known to him, and assaulted.

Numerous passers-by intervened, holding the man so the two teens could leave and report the matter to police.

The victim was treated at the Royal Children's Hospital.

Extract from Beau Donelly, *The Age*, 'Boy attacked at Midsumma Festival' (19 January 2016)

Brendan (pictured right) was attacked by a group of men in Smith Street in Collingwood after leaving a gay bar where he had been having a night out with friends in January 2018.

"He said a word that wasn't so nice ... [f---ing faggot] ... then there was one giant punch to my left eye.

I'm no longer going out at night by myself... it doesn't matter what part of the city I'm in, I'm always looking over my shoulder."

Brendan was beaten unconscious, and left with cracked ribs, his skull fractured in several places and lasting eye damage.

Extract from Tammy Mills & Daniella Miletic, *The Age*, 'Police seek witnesses after man bashed in homophobic assault in Collingwood' (9 April 2018).
9 News, '"I'm always looking behind my shoulder": Man brutally bashed in homophobic attack' (9 April 2018)

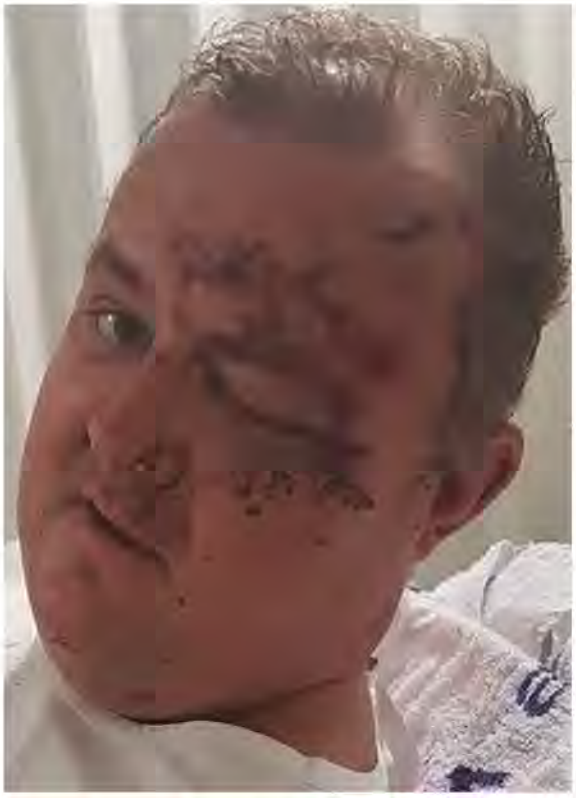


Photo: Victoria Police

Photo: Twitter

Elliott Harvey (pictured below left) was left blind in one eye after being violently attacked by three men after leaving a gig he was attending with friends in Brunswick in May 2017.

"I think they particularly disliked my hair cut, having my hair up in a fountain like this. All the things they said to me were pretty trivial, just homophobic insults.

It was cowardly really... I was on the ground when they punched my eye out.

It's drastically affected my life. I can't work because I can't drive, but also depth perception has a lot to do with walking through undulating forests. I can't really go surfing because of the glare. A lot of the things that make me happy are pretty sad right now."

Extract from Emily Woods & Melissa Cunningham, 'Two men arrested after Brunswick club attack that left victim blind in one eye' (7 July 2017)

Prevalence of LGBTI hate conduct

The prevalence of prejudice motivated conduct and crime directed at the LGBTI community is not fully understood, though research suggests that the LGBTI community experiences prejudice motivated conduct at a higher rate than the general population:

1. Numerous research studies conducted by Gay & Lesbian Health Victoria have outlined ongoing experiences of harassment and abuse on the basis of sexual identity and gender identity, with a close nexus established between incidents of harassment and abuse and both acute and ongoing psychological harm.[7]

2. Only a small amount of research details the experiences of intersex people. However, the available research shows that many intersex young people had experienced bullying and discrimination, including physical violence in schools, based on a known variation or more commonly on the basis of physical traits.[8]

3. Results from 2012's Private Lives 2, the second national survey of the health and wellbeing of LGBT Australians, found that trans people report higher rates of abuse (including higher rates of sexual assault against trans women) and that a significant percentage of respondents would hide their sexual orientation or gender identity out of fear of experiencing violence or discrimination.[9]

4. The Australian Human Rights Commission has reported that 6 in 10 LGBTI people experienced verbal homophobic abuse and 1 in 5 experienced physical abuse in a 12 month period.[10]

5. LGBTI community advocates at the Expert Roundtable discussed the high prevalence of harassment perpetrated in public spaces. LGBTI community advocates also noted that somewhere between 9% and 24% of harassment occurs in the home. This statistic includes family violence which is perpetrated by family members, but which is not always recognised by victims as such.[11]

6. One study found that 50.4% of LGBTIQ+ participants experience public harassment on a weekly or monthly basis, with common experiences including staring (65.1%), verbal comments (63%), horn honking (62.3%), wolf whistling (41.4%) and unwanted conversation (42.5%), with 31.5% of experiences targeting gender identity and 29.1% targeting sexual orientation.[12]

As the majority of prejudice motivated conduct is not reported to police (and therefore not recorded as a prejudice motivated crime or incident), the exact prevalence of this type of behaviour remains unclear.

Photo: Scott Webb, Pexels.

2017 Postal survey

Photo: The Human Rights Law Centre's Anna Brown speaking to reporters outside the High Court following the unsuccessful legal challenge to the postal survey on 9 August 2018.

> *"I will personally hunt you down and break your head. You ---- piece of shit faggit [sic]-----. I voted no because you are all a bunch of f----- perverted paedophile mother----. I hope you all die due to aids. Phags. [sic]"*
>
> Message sent to the Equality Campaign (2017)

In late 2017, the Australian Government announced a non-compulsory postal survey to be conducted by the Australian Bureau of Statistics on whether the law should be changed to allow same-sex couples to marry.

During this period and in the subsequent months, LGBTIQ Australians reported an increase in hate speech and hate conduct.[13] Specialist mental health services also reported a corresponding spike by up to 40% in people seeking counselling and support.[14]

In February 2018, a Senate Committee released a report recommending that questions of human rights for minority groups should not be resolved by a public vote.[15]

The Senate Committee received evidence from a large number of people about offensive and misleading behaviour and material. It acknowledged that the postal survey was 'deeply distressing to the LGBTIQ community and highly divisive within the community more broadly'.[16]

The Federal Parliament passed the Marriage Law Survey (Additional Safeguards) Act 2017 in late 2017, 36 days after the postal survey period commenced.

This was the first time in Australia that LGBTI people were protected from hate speech at a federal level. However, the Senate Committee confirmed that the legislation proved insufficient to curb much of the offensive material distributed by mail and throughout social media.[17]

Thalia Black, a 16 year old trans woman, was physically assaulted by a man in Hobart in another instance of transphobic hate violence during the postal survey in September 2017.

"He came up and started to say really horrible things. I just tried to laugh it off because I've dealt with this all my life.

The next thing I know he has his hands around my throat and started squeezing. I was really scared, I don't feel as safe as I used to ... I'm wondering if I'm going to get be attacked again."

Extract from Patrick Billing, *The Mercury*, 'Sixteen-year-old Thalia Black alleges she was attacked by a man in Hobart's Elizabeth Mall' (25 September 2017)

A 26 year old woman was punched in the face as she walked her dog in Gippsland while wearing a t-shirt showing a rainbow with the words "Born fabulous, not straight", in a homophobic attack in November 2017.

"As a woman, I should be able to go for a walk around the lake at any time of the day or night, wearing whatever I want, and feel safe.

Regardless of sexual preference, gender or religion, we should all have that right. I simply wanted my attackers to be found and brought to justice."

Extract from *The Gippsland Times*, '"Homophobic" assault in Sale' (3 November 2017)

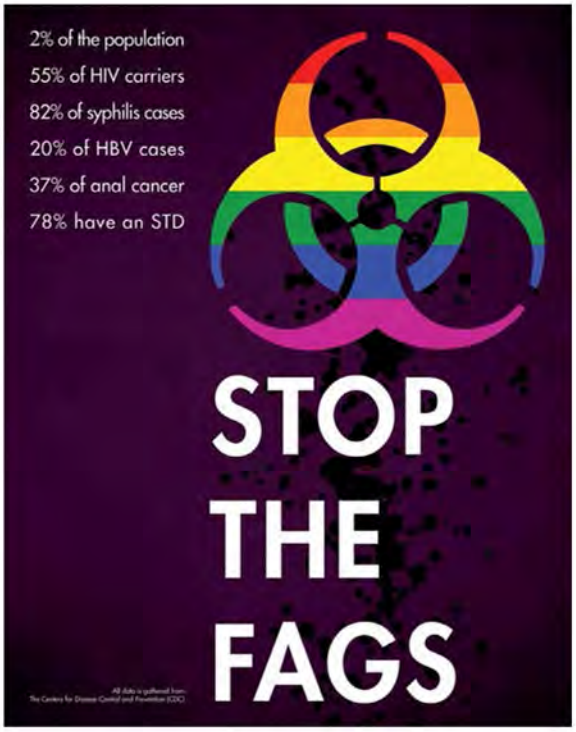
Examples of hate conduct

19 year-old Sean was punched in the head while waiting for a bus, by a man in Brisbane in September 2017.

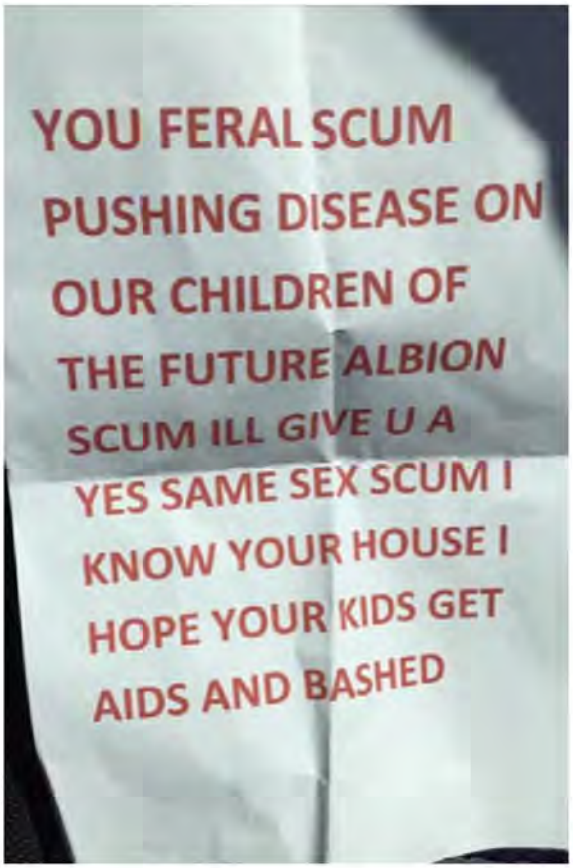
According to a Facebook post on "Bulimba 4 Marriage Equality", the attacker was tearing down rainbow flags put up by local 'Yes' campaigners and yelling slurs about gay people.

The man then directed slurs at Sean, who responded. The attacker then asked Sean if he had called him a "homophobe" and then punched Sean in the face after he answered in the affirmative.

Extract from Michael McKenna & Remy Varga, *The Australian*, "Kevin Rudd's godson 'victim of same-sex marriage attack' "(13 September 2017)



Examples of 'No' posters



Examples of hate conduct

Bonnie Hart, an intersex advocate in Brisbane, was targeted by vandals who spray-painted a swastika on her garage after she hung a rainbow flag from her home.

"My sister and I both burst into tears. It was very triggering. We were born biologically between male and female and we have had a lot of stigmatisation as a result of that, as well as medical treatments and surgeries when we were younger that we didn't want.

Bonnie is my younger sister and I was so afraid it would traumatise her, seeing the swastika... To us, it was a hate crime." (Phoebe Hart)

Extract from Melissa Davey, *The Guardian*, "Rocks thrown through windows amid spate of homophobic attacks" (26 September 2017)

Impact of hate conduct

Impact on the individual

Victims of hate conduct can experience significant physical, psychological and emotional harm, as well as long-term repercussions on their sense of identity, self-worth and feelings of safety and belonging in the community or in public.

Impact on the target community

Members of a target group can feel threatened and vulnerable to victimisation when they are aware of individual incidents of prejudice motivated speech, conduct and crime, which has a broader impact on the entire group to which the victim belongs.

Impact on other minority groups

Other vulnerable and minority groups can also experience this threat to personal safety and community cohesion, particularly where the prejudice motivation is based on an ideology, doctrine or sentiment which has a negative view of a number of minority groups in society.

Impact on the broader community

In diverse and accepting communities, hate conduct diminishes our community as a whole. Instead of encouraging people to live together on an equal footing, the deliberate targeting of individuals within our community undermines our fundamental rights to live safely and be treated equally.

Visibility is a key factor in experiences of public harassment. The cumulative impact of experiencing public harassment causes a broad range of harms, including emotional and psychological impacts, physical impacts, social exclusion and identity expression.

People from LGBTI communities may also have less support from family to recover from incidents of violence and are more likely to experience mental health issues as a result of previous experiences of bullying, marginalisation, exclusion and prejudice motivated conduct.[18]

Hate conduct and bullying has a significant impact on the mental health of LGBTI people.

For example, in 2017, Trans Pathways [19] - the largest ever survey into the mental health of trans young people in Australia - found that:

- nearly 90% had been rejected by their friends or peers;
- almost 70% had experienced discrimination;
- almost 80% had experienced bullying in educational institutions;
- almost 80% of young trans people had self-harmed and almost half had attempted suicide, as a result of their experiences of discrimination, violence and bullying;
- almost two thirds had felt a lack of family support; and
- 1 in 5 young trans people had encountered unstable accommodation, including homelessness.

Barriers to reporting

Summary of barriers

People who experience prejudice motivated conduct face distinct barriers when it comes to reporting these incidents and crimes to police.

People from LGBTI communities are less likely to report violence, seek support or identify experiences of non-physical harassment and abuse as a prejudice motivated crime, partly because of a fear of being outed as well as actual or perceived discrimination.

Under-reporting of crime or incidents to police occurs for a variety of reasons, including a lack of trust in reporting to police, a lack of awareness about available offences, an inability to identify perpetrators, fears reporting will exacerbate bullying, cause victimisation or escalate the behaviour, and barriers caused by the significant psychological trauma and ongoing mental health impacts of being a victim of crime.

Persistent reasons for LGBTI people not reporting LGBTI-related hate conduct identified in Gay & Lesbian Health Victoria's (GLHV) Coming Forward Report remain, including the belief that their complaint will not be taken seriously (e.g. family violence), shame (e.g. offences at beats), lack of confidence in police responses, inconsistency in police responses and 'self-triaging' by a victim.

Key feedback provided from LGBTI stakeholders and organisations, academics, government officials and Victoria Police about barriers to reporting included:

- LGBTI community members are often unaware of the range of police responses available for public harassment and family violence.
- Many trans and gender diverse people who have experienced harassment and hate crime anticipate or expect it to happen again, have strong responses to triggering events and change their behaviour to avoid reminders of the experience (including not reporting an event).
- Young people are more likely to experience online bullying by multiple perpetrators where the cumulative impact leads to school disengagement and barriers to reporting include no contact with or support from their family.
- Under-reporting of LGBTI family violence is perpetuated by gendered models for understanding family violence which do not apply to same-sex relationships.
- LGBTI Liaison Officers (GLLOs) have made a significant impact in building LGBTI confidence in police and this network continues to grow. However, access to GLLOs is limited, particularly in rural and regional Victoria.

LGBTIQ+ community perceptions of police

The Victorian Gay & Lesbian Rights Lobby's *Community Survey 2017: Perceptions and Experiences of Victoria Police* surveyed 274 adults aged 18 to 49 about their perceptions of and experiences with Victoria Police.

The survey found that most respondents would report a LGBTI-related crime to the police. Tellingly, trans and gender diverse people were less likely to feel safe discussing or reporting a crime related to their gender identity with the police. The responses revealed positive experiences:

"My private and public dealings with police have always been excellent. No complaints but plenty of praise for what they do. Thanks.

My partner and I were preparing signed statements to support my partner visa and felt comforted/less stressed when we spoke with a police officer to help us legitimise the documents. He gave us words of encouragement and support that helped calm our nerves."

However, there were also a number of reports of negative experiences, with 1 in 3 negative responses being reported by trans and gender diverse people. For example:

"I was assaulted in my own home, the guy taking my statement acted like I was wasting his time. After that, I got a very general information letter, and never heard from them again!

Tried to report verbal abuse when walking in Brunswick. The cop asked how they knew we were gay. I said because I was holding hands with my partner. The cop replied, well there's your problem and laughed. It was pathetic."

In May 2018, La Trobe University released the *Policing for same sex attracted and sex and gender diverse (SSASGD) young Victorians* report in collaboration with Victoria Police.[20]

76 young SSASGD people were interviewed. Almost 95% of young people surveyed had experienced some form of targeted abuse, with just under 90% reporting currently experiencing mental health issues.

The majority of respondents (58.3%) disagreed that police officers understand the issues facing SSASGD young people, with responses revealing a lack of trust and confidence in Victoria Police. 1 in 2 young SSASGD people surveyed said they were unlikely to report hate crime to the police in the future, with 60% identifying perceived prejudice within Victoria Police as a major disincentive to reporting.

Again, trans and gender diverse people were more likely to report negative experiences with Victoria Police, such as perceived over-policing or discrimination.

On a positive note, 43% of respondents were aware of GGLOs and 68% said that they would prefer reporting a crime to GLLOs in the future.

The SSASGD young people interviewed recommended that Victoria Police focus on:

- cultural change, education and training;
- recruiting more LGBTIQ+ people to Victoria Police;
- promoting and expanding the role of GLLOs; and
- technology-related reported options (e.g. phone apps or online chat).

Victoria Police perceptions of LGBTIQ+ communities

La Trobe University's 2018 report also featured interviews with 361 police officers – the largest sample of the attitudes and perceptions of Victoria Police about LGBTIQ+ inclusion to date.

Approximately half of the police respondents had contact with an SSASGD young person in their current role, but police officers reported generally low levels of knowledge about the needs of SSASGD young people.

Respondents accurately identified that SSASGD young people would be more comfortable reporting LGBTI-related hate crime to GLLOs. General members consistently viewed GLLOs as being more knowledgeable about the needs of LGBTIQ+ communities, but 78.6% had never consulted a GLLO on an issue related to LGBTIQ+ communities.

When it came to training, almost 60% of police officers surveyed said they had not received any training on LGBTIQ+ communities, and 10.8% were unsure or could not remember if they had received relevant training.

The small number of police officers who had received training on LGBTIQ+ issues reported that it was highly beneficial.

Victoria Police have committed to implementing the recommendations from the 2018 La Trobe report, which focus on:

- senior leadership promoting great LGBTIQ+ inclusive practice, including through policies and procedures and visibility;
- capacity building through training and community engagement, particularly a mandatory LGBTIQ training package for new GLLOs;
- strengthening and developing the role of GLLOs within Victoria Police; and
- considering ways to address SSASGD young people's perceptions of police.

Assisting victims of hate crime

In June 2016, James*, a gay man living in inner city Melbourne was subjected to ongoing threats and harassment from a neighbour. Decades earlier, James was walking through a park near a beat, and was beaten and stabbed by a stranger who used homophobic slurs as he attacked him. He did not report this incident to the police out of fear of being outed.

James' recent experience of ongoing homophobic harassment and threats to his safety triggered his past experience of crime. He no longer felt safe in his own home and moved to stay with a family member in rural Victoria.

James attended a local country police station to report the threats and harassment, but was told by the duty police officer that he would need to report at the police station closest to where the incidents occurred.

James contacted Greg Adkins from the Anti-Violence Project (pictured below) who made an informal third party report to a GLLO at Victoria Police. The GLLO promptly followed up with the country police station to ensure the incident was reported and appropriate training and protocols were followed in the future.

* Not his real name.

Photo: Greg Adkins, Anti-Violence Project - Simon Dwyer/Fairfax Syndication

Prevention strategies

Police responses

Victoria Police initiated a Prejudice Motivated Crime Strategy in 2011 and over time has implemented a range of policies aimed at improving police officers' responses to LGBTI community members, including LGBTI Liaison Officers (GLLOs), LGBTI specific content in training curriculum and regular consultation with LGBTI community members through consultative mechanisms.

Data collection

The lack of accurate, comprehensive and disaggregated data about LGBTI people and hate conduct makes it very difficult to fully understand the issue and to form responses to deal with it effectively.

Significant under-reporting of incidents to police also means that the data does not fully capture incidents of prejudice motivated crime affecting LGBTI people in Victoria.

There are also practical information technology and system constraints that limit how data can be collected. Victoria Police are in the process of reviewing their current reporting and recording processes including database restraints.

There remain gaps in our knowledge about both the numbers of LGBTI-related prejudice motivated crimes and outcomes from reporting these crimes. There are a range of reasons for inaccurate data collection, including:

- Confirming that crime is prejudice motivated is difficult – it is inherently difficult to prove a person's motivation.
- Database constraints can lead to situations where data is not accurately recorded and negative experiences for victims of crime (e.g. a gender diverse person being asked whether they identify as 'male' or 'female').
- Inconsistent entry in the LEAP database can affect hate crime statistics.
- Intersectionality of data (e.g. where a person experiences prejudice on the basis of their race and sexuality) may not always be recorded.
- The sheer volume of information stored by police makes data analysis a very difficult task.

More violent forms of harassment rest on a background of everyday LGBTI harassment. Individual-based remedies are ineffective at producing a broader systemic cultural change to prevent prejudice motivated conduct against LGBTI people.

Challenges & opportunities

Third party reporting

LGBTI community organisations have advocated that LGBTI people are more likely to speak to people with specific LGBTI experience and knowledge in the issues affecting them. In addition, LGBTI victims of prejudice motivated crime will not report incidents unless they have confidence in the people they turn to for help (including friends, family, NGOs, support workers and police).

GLLOs can be used as a 'soft contact point' or first point of referral for reporting to Victoria Police, but not all LGBTI community organisations report to GLLOs.

International examples

- The UK and Scotland have introduced third party reporting - organisations that have agreed to make reports to the police on behalf of victims who do not want to make direct reports.
- Belgium uses apps to report certain crimes.
- New Zealand's AUROR third party reporting program requires petrol stations to report incidents of violence and is currently being tested with retailers.

Reporting racisim trial

The Victorian Equal Opportunity and Human Rights Commission has shared key learnings from a Reporting Racism trial[21] - an online platform for victims and bystanders to report incidents of racially motivated violence anonymously, focusing on Aboriginal and Torres Strait Islander victims of race-related hate crime. The majority of online reports were made by the person who experienced racism, but some were made by witnesses.

Key difficulties included:

- Retention of volunteers to run the program was challenging due to exposure to details of traumatic incidents and vicarious trauma, despite formal training provided to volunteers.
- Only 25% of reports were referred to Victoria Police, but the people who reported as part of the trial were sceptical about who the information would be passed on to (even though confidentiality was guaranteed).
- Many victims of racism felt there was no value in reporting the crime as there would likely be no outcome or change as a consequence of reporting.
- Additional resources were required.

International best practice

The International Covenant on Civil and Political Rights safeguards the right of all people to non-discrimination and equality, as do other international human rights instruments and treaties.

Yet every single day, LGBTI people around the world are targeted as victims of hate-fueled violence. Criminalising hate conduct is increasingly internationally accepted as a way to effectively deal with targeted violence. [22]

In July 2018, the UN Independent Expert on Sexual Orientation and Gender Identity recommended that all countries enact hate crime legislation with aggravated sentencing clauses , to adopt hate speech legislation, and to hold perpetrators to account – including political or religious leaders.[23]

The ODIHR's *Hate Crime Laws: A Practical Guide* highlights the importance of hate crime laws to:

- send an important symbolic acknowledgement that hate crime is taken seriously;
- increase public awareness;
- mandate law enforcement agencies to focus efforts on determining motive;
- ensure victims can see that the law is properly applied, and to argue their case where proper procedures are not followed; and
- facilitate more accurate data collection on hate crime.[24]

(a) Substantive offence

Some countries have chosen to introduce a substantive, separate 'hate crime' offence (e.g. the Czech Republic). A substantive offence usually has greater visibility, makes it easier to collect hate crime data and fulfils an important symbolic function. However, police investigators and prosecutors may feel more reluctant to use a specific hate crime offence where the prejudice motivation is built into the offence, particularly without sufficient training on indicators of motive.

(b) Aggravated sentencing clause

Most jurisdictions have introduced aggravated sentencing clauses which increase the penalty for any criminal offence which was motivated by prejudice (e.g. Victoria). While aggravated sentencing clauses are easier to incorporate into existing criminal laws and apply to a wide range of crimes, courts may decide not to apply the sentencing provision and the application of the clause may not be on the public record (which reduces its symbolic impact).

(c) Combination of both substantive offence and aggravated sentencing clause

Countries can adopt a range of provisions – including both a substantive offence and an aggravated sentencing clause – as the US and UK have done. However, for legislation to be effective, it needs to be supported by guidelines (including detailed lists of hate crime indicators), policies, information, resources and training to ensure police officers identify hate crimes in practice.

Legislative responses

Hate conduct, hate speech and hate crimes require tailored responses in recognition of their discriminatory nature and significant impact on a person's sense of safety.

The serious psychological consequences differ in each case, and should not be underestimated.

There is concern that existing laws and policies may not effectively deter or combat prejudice motivated crime in practice. In addition, current legal protections against prejudice motivated crime and the limited protection provided by sentencing provisions cannot provide effective early intervention or general deterrence of crimes that target the LGBTI community.

Sentencing Act 1991 (Vic)

The Sentencing Act 1991 (Vic) requires a court to consider whether a crime was motivated by hatred or prejudice towards a particular group of people in sentencing an offender. In practice, very few cases in Victoria have applied this section, and generally it has been considered in relation to racial prejudice.

Proving prejudice motivation in the courts is difficult as prosecutors have not always raised the provision as a consideration in sentencing and there has been judicial reluctance to find that a crime was motivated by hate or prejudice. [24] This is partly the case where there are multiple or complex motivations involved, difficulties in establishing proof 'beyond reasonable doubt' and where courts hold the view that prejudice was the motivation only in the absence of an alternative motive.[25]

Equal Opportunity Act 2010 (Vic)

The Equal Opportunity Act 2010 (Vic) (EOA) provides protections from unlawful discrimination, harassment and victimisation on the basis of various attributes in specific areas of public life.[26]

The EOA makes it unlawful to discriminate against people on the basis of their sex, sexual orientation or gender identity unless an exemption applies.

Generally public activity on the street is not within the scope of the EOA. The With Respect report recommended amending the EOA to include broad anti-harassment provisions to target 'conduct that offends, humiliates, intimidates, insults or ridicules another person' based on protected attributes, with limited exceptions.[27]

Racial and Religious Tolerance Act 2001 (Vic)

The Racial and Religious Tolerance Act 2001 (Vic) (RRTA) was enacted to prevent racial and religious vilification which denigrates groups of people because of their racial or religious practices or beliefs.[28]

The RRTA provides that a person must not engage in conduct which 'incites hatred against, serious contempt for, or revulsion or severe ridicule of' a class of persons on the basis of their actual or perceived race or religion. There are also provisions which make it an offence to intentionally engage in conduct which is likely to incite hatred against a person because of their actual or perceived race or religion, or which threatens physical harm, or incites others to threaten physical harm, for this reason.

Currently, the protections in the RRTA are limited to race and religion and do not extend to perceived or actual sexual orientation, gender identity or sex characteristics.

In 2010, the former Attorney-General Rob Hulls commissioned retired judge, Geoffrey Eames, to inquire into whether existing civil and criminal laws adequately deal with conduct motivated by hatred or prejudice because of an identity characteristic of the victim. The final report is yet to be released by the Victorian Government.

Photo: Adam Marcucci

Protections from hate speech

All states and territories prohibit hate speech on the basis of race but not all provide protections for LGBTI people.

Victoria does not have specific laws which outlaw hate speech on the basis of sexual orientation, gender identity or sex characteristics. Inadequate protections from hate speech targeting LGBTI people sends the message that intolerance and prejudice are not taken seriously.

Anti-vilification laws necessarily restrict some people's right to free speech to protect the rights of other people to be free from discrimination and to prevent threats to their physical safety.

Criminal sanctions for vilification have a high threshold to appropriately deter discriminatory speech and conduct that damages community cohesion and safety. This allows for the expression of information or ideas that are offensive, unpopular, shocking or disturbing – but nonetheless lawful – to adequately protect free speech in a democratic society.

In addition, vilification laws typically include reasonable exemptions for fair media reporting, privileged communications, and public acts done reasonably and in good faith for academic, artistic, religious instruction, scientific or research purposes or other purposes in the public interest, including discussion or debate.

Existing protections from hate speech in Australia[29]

	Federal	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Lesbian	✗	✓	✓	✗	✓	✗	✓	✗	✗
Gay	✗	✓	✓	✗	✓	✗	✓	✗	✗
Bisexual	✗	✓	✗	✗	✓	✗	✓	✗	✗
Trans	✗	✓	✓	✗	✓	✗	✓	✗	✗
Intersex	✗	✓	✗	✗	✗	✗	✓	✗	✗

Crimes Act 1958 (Vic)

Currently, there is no standalone substantive offence of 'hate crime' under which an offender can be charged in Victoria. The majority of serious crimes are contained in the *Crimes Act 1958* (Vic) and can be used to charge offenders for LGBTI prejudice motivated crime.[30]

For example, the definition of stalking to include bullying behaviour empowers police officers to charge offenders for threats, 'abusive or offensive' words or acts, and any other behaviour reasonably expected to cause physical or mental harm (including self-harm) or to make someone afraid for their safety. This provision can be used to charge individuals for LGBTI prejudice motivated abuse or harassment which may not satisfy the thresholds for other offences.

Personal Safety Intervention Orders Act 2010 (Vic)

The Personal Safety Intervention Orders Act 2010 (Vic) was enacted to protect the safety of victims of assault, sexual assault, harassment, property damage or interference with property, stalking and serious threats.[31]

There are provisions in the Act which can be used to combat LGBTI prejudice motivated crime. For example, the definition of stalking is the same as under the *Crimes Act 1958* (Vic) and includes threats, abusive or offensive words or acts and other acts which cause harm and fears for personal safety. The Act also provides that harassment includes a course of conduct that is 'demeaning, derogatory or intimidating'.

Summary Offences Act 1966 (Vic)

There are also provisions within the *Summary Offences Act 1966* (Vic) which regulate relatively minor crimes. For example, section 17 of the Act makes it unlawful for a person to engage in obscene, indecent, threatening language or behaviour in a public place. The penalty for this crime is generally a fine issued by Victoria Police. In addition, public transport authorised officers can also issue infringement notices / fines for offensive language on public transport under equivalent public transport laws and regulations.

Although this definition does not explicitly relate to the LGBTI community, this provision empowers police officers to fine or charge an individual for using 'profane indecent or obscene language or threatening abusive or insulting words', which would apply to prejudice motivated language relating to a person's sexual orientation, gender identity or sex *characteristics*.

Recommendations for reform

Hate speech, hate conduct and hate crime all require coordinated, holistic and collaborative responses. Our communities need multiple reporting and recording tools to reflect the different needs of the victim (e.g. around privacy or capability such as computer literacy).

There are a number of steps which can be taken to reduce the incidence of prejudice motivated crime into the future. In addition, outstanding recommendations from previous With Respect, Coming Forward and With Respect Awareness Project reports should be fully implemented.[32]

Recommendation 1

The Victorian Government should:

1.1 Fund broad public awareness campaigns and strategies to change deep-seated negative attitudes to LGBTI people (e.g. No To Homophobia campaign).

1.2 Fund independent third party reporting centres for LGBTI community members at multiple sites across Victoria to report prejudice motivated conduct, as seen in New York, and work in partnership with police to improve reporting rates and support for victims.

1.3 Develop a best practice community based third party reporting form, incident capture system, mobile website or app to assist LGBTI and other community organisations to collect all relevant information and assist with third party reporting to police where requested.

1.4 Ensure specialist support for LGBTI young people experiencing prejudice motivated online bullying is available through existing mental health support services.

1.5 Fund longitudinal research into the cumulative impact of prejudice motivated conduct on health outcomes for the LGBTI community.

1.6 Fund further research and improve data collection methods and policies of all government agencies, including Victoria Police, to ensure accurate information on the prevalence of prejudice motivated conduct is available.

1.7 Implement recommendations 166 to 169 arising from the Royal Commission into Family Violence.

Community resources and support

Education about support for LGBTI victims of prejudice motivated conduct and crime is important for rebuilding a sense of community safety and ensuring individuals are fully supported to recover from incidents of prejudice motivated crime.

Resources and information for the LGBTI community will provide a sound basis for identification and reporting of prejudice motivated conduct in all its forms across the community.

Recommendation 2

The Victorian Government should fund the following recommendations to be implemented by LGBTI and community organisations:

2.1 Develop educational resources for LGBTI people about the mental health impact of experiencing prejudice motivated incidents and harassments (including 'on the street' or online harassment which do not constitute criminal offences) and mental health supports available.

2.2 Develop and distribute an information resource through LGBTI community networks which provides information to LGBTI victims of prejudice motivated crime about what conduct constitutes an offence and how they can access LGBTI specific support as a victim of crime.

2.3 Develop and distribute a protocol for referring informal reports from LGBTI and other community organisations, developed in partnership with Victoria Police, with guidelines on information which should be provided and relevant contact details.

2.4 Consider developing an online reporting tool to report 'on the street' or online harassment to ensure these incidents are reported and clustering or increases in prejudice motivated incidents reported to Victoria Police.

Recommendation 3

Victoria Police should, in collaboration with relevant agencies and LGBTI community organisations:

3.1 Make training and information on LGBTI-related prejudice motivated crime available to all members of Victoria Police, particularly for police officers at stations in rural and regional areas without a dedicated GLLO.

3.2 Ensure databases can record sex and gender outside 'male' and 'female' categories for gender diverse people and allow for additional categories to be recorded as an attribute for prejudice motivated conduct.

3.3 Develop an information resource or short guide for police officers when entering data relating to LGBTI-related prejudice motivated conduct (e.g. including brief information on gender identity, including the key information which must be entered and consistent codes for ensuring data integrity).

3.4 Ensure databases can cross-reference and disaggregate data relating to prejudice motivated crime (e.g. allowing for multiple motivations to be recorded, and identifying features of the victim to be collected).

3.5 Implement the recommendations from La Trobe University's *2018 Policing for same sex attracted and sex and gender diverse (SSASGD) young Victorians* report.

3.6 Strengthen the role of GLLOs within Victoria Police and take further steps to promote LGBTIQ+ inclusive practice within the organisation.

Justice reform

Recommendation 4

The Victorian Government should:

4.1 Introduce a Hate Crimes Act which introduces a substantive hate crime offence, and protections from vilification (i.e. hate speech) and public harassment (i.e. hate conduct) on the basis of sexual orientation, gender identity and sex characteristics.

4.2 Publicly release the findings of the Eames Review.

4.3 Re-introduce greater enforcement powers to VEOHRC which were removed in 2011, in recognition of the fact that a significant barrier to the reduction of discrimination against LGBTI people is the reliance on individuals to enforce the law.

4.4 Conduct a review into the following:
(a) amending privacy legislation that restricts the exchange of information between different agencies, bodies and organisations to allow appropriate data sharing between agencies to provide a specialised response;
(b) lowering the standard of proof for prejudice motivation in serious criminal offences; and
(c) a new offence for prejudice motivated public threats or violence.

4.5 Develop best practice guidelines for information collection relating to prejudice motivated crime.

Recommendation 5

The Judicial College of Victoria should:

5.1 Update Victorian Court Bench Books to include information about prejudice motivated conduct based on sexual orientation, gender identity and sex characteristics.

5.2 Provide training to judicial officers to raise awareness and encourage consistent application of section 5(2)(daaa) of the Sentencing Act 1991 (Vic) and the experiences of LGBTI victims of prejudice motivated conduct.

1 Australian Human Rights Commission, *Resilient Individuals: Sexual Orientation, Gender Identity & Intersex Rights: National Consultation Report* (2015).

2 See Joint Working Group of the Attorney-General's and Health Minister's Advisory Committees on Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Issues, *With respect: A strategy for reducing homophobic harassment in Victoria - A discussion paper for the consideration of the Victorian Attorney General* (2006); William Leonard, Anne Mitchell, Marian Pitts and Sunil Patel (2008) 'Coming forward: The underreporting of heterosexist violence and same sex partner abuse in Victoria', *Australian Research Centre in Sex, Health & Society* (La Trobe University); {also} Foundation, With Respect Awareness Project (June 2010). The Eames Review's report has not been publicly released.

3 *Sentencing Act 1991* (Vic) s 5(daaa).

4 See OSCE Office for Democratic Institutions and Human Rights (ODIHR), *Hate Crime Laws: A Practical Guide* (2009).

5 Saan Ecker & Ebony Bennett, The Australia Institute and National LGBTI Health Alliance, *Preliminary results of the Coping with marriage equality debate survey: Investigating the stress impacts associated with the Australian marriage equality debate during the lead up to the postal survey results announcement* (December 2017).

6 See also, Intersex Human Rights Australia, *New publication "Intersex: Stories and Statistics from Australia"* (February 2016).

7 See e.g. Lynne Hillier, Tiffany Jones, Marisa Monagle, Naomi Overton, Luke Gahan, Jennifer Blackman and Anne Mitchell (2010) 'Writing Themselves In 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people', *The Australian Research Centre in Sex, Health & Society* (La Trobe University); above n 2.

8 Tiffany Jones, *'The needs of students with intersex variations'* 16(6) Sex Education (2016). See also, Intersex Human Rights Australia website, 'New publication "Intersex: Stories and Statistics from Australia"' (2016) Phoebe Hart – Hartflicker Moving Pictures, 'Orchids: My Intersex Adventure' (2010).

9 William Leonard, Marian Pitts, Anne Mitchell, Anthony Lyons, Anthony Smith, Sunil Patel, Murray Couch and Anna Barrett (2012) 'Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians', *The Australian Research Centre in Sex, Health & Society* (La Trobe University).

10 Australian Human Rights Commission, *Face the Facts: Lesbian, Gay, Bisexual, Trans and Intersex People* (2012).

11 We note that the Victorian Government and multiple Government agencies are currently working on implementing the recommendations from the Royal Commission into Family Violence. This report focuses on prejudice motivated crime that is not family violence, in recognition that multiple campaigns and strategies are currently underway to tackle family violence in Victoria, including in LGBTIQ communities. See State of Victoria, *Royal Commission into Family Violence: Report and recommendations* (2014-2016) Vol V, 145.

12 Bianca Fileborn, Australian Research Centre in Sex, Health & Society, *LGBTIQ+ experiences of public harassment* (August 2016).

13 Senate Finance and Public Administration References Committee, *Arrangements for the postal survey* (February 2018) 27.

14 - 17 Ibid.

18 Above n 8. See also, National LGBTI Health Alliance, The Statistics at a Glance (July 2016) https://lgbtihealth.org.au/wp-content/uploads/2016/07/SNAPSHOT-Mental-Health-and-Suicide-Prevention-Outcomes-for-LGBTI-people-and-communities.pdf.

19 Penelope Strauss, Angus Cook, Sam Winter, Vanessa Watson, Danie Wright Toussaint & Ashleigh Lin, Telethon Kids Institute, *Trans Pathways: The mental health experiences and care pathways of trans young people* (2017).

20 William Leonard and Bianca Fileborn, *Policing for SSASGD young Victorians* (2018) La Trobe University: GLHV; ARCSHS.

21 Kate Lahiff, Victorian Equal Opportunity & Human Rights Commission, *Reporting Racism Trial* (August 2016).

22, 24 *Sentencing Act 1991* (Vic) s 5(daaa). See e.g. *Clinton Rintoull v R* [2011] VSCA 245; *DPP v RSP* [2010] VSC 128; *Ian Lionel Gosland v R* [2013] VSCA 269.

23 UN Human Rights Council, 'Report of Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity' (11 May 2018) (UN Doc A/HRC/38/43).

25 Office for Democratic Institutions and Human Rights, *Hate Crime Laws: A Practical Guide* (2009).

26 *Equal Opportunity Act 2010* (Vic) Part 3.

27 Above n 2.

28 *Racial and Religious Tolerance Act 2001* (Vic) s 7 – 9, 24.

29 *Discrimination Act 1991* (ACT), *Anti-Discrimination Act 1977* (NSW), *Anti-Discrimination Act 1996* (NT), *Anti-Discrimination Act 1991* (Qld), *Equal Opportunity Act 1984* (SA), *Anti-Discrimination Act 1998* (Tas), *Equal Opportunity Act 2010* (Vic), *Equal Opportunity Act 1984* (WA).

30 *Crimes Act 1958* (Vic) s 21A.

31 *Personal Safety Intervention Orders Act 2010* (Vic) s 7.

32 Above n.2.

Human Rights
Law Centre

HRLC.ORG.AU