New Issue

National Survey of Mental Health and Wellbeing of Adults

Users' Guide

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PREFACE

This publication presents detailed information on the 1997 National Survey of Mental Health and Wellbeing of Adults which collected information on the prevalence of selected mental disorders, associated disability and use of health services for Australian adults. It contains information about survey objectives, the development process, content of the survey, methods and procedures used in the collection of data, and available survey outputs. In addition, mental disorder diagnostic criteria, a data item list and other relevant information are included as Appendixes.

The survey was an initiative of, and funded by, the Commonwealth Department of Health and Aged Care (formerly the Department of Health and Family Services) as part of the National Mental Health Strategy.

Expert groups, comprising representatives from a range of eminent research, clinical and academic organisations, provided advice on the survey content and design. These included the World Health Organization (WHO) Training and Reference Centre for CIDI (The WHO Centre) at the University of New South Wales, the National Health and Medical Research Council Psychiatric Epidemiology Research Centre at the Australian National University, the National Drug and Alcohol Research Centre at the University of New South Wales, the Departments of Psychiatry at the Universities of Western Australia, Melbourne and Adelaide, along with the Australian Institute of Health and Welfare.

The Composite International Diagnostic Interview (CIDI), a standard questionnaire endorsed by the WHO, was selected as the basis for developing the diagnostic component of the survey. The WHO Centre in Australia provided a computer-based survey instrument incorporating the CIDI and specific modules to collect data on disability and health service use. A Technical Advisory Committee, comprising Professor Scott Henderson (Chair), Professor Gavin Andrews, Professor Wayne Hall, Professor Helen Herrman, Professor Assen Jablensky and Professor Robert Kosky, endorsed the validity of the survey instrument. The Australian Bureau of Statistics (ABS) tested the instrument under household survey conditions.

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*.

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LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
AHMAC NMHWG	Australian Health Ministers Advisory Council National Mental Health Working Group
AIHW	Australian Institute of Health and Welfare
BDQ	Brief Disability Questionnaire
CAI	Computer Assisted Interview
CD	Collector District
CIDI	Composite International Diagnostic Interview
DSM–IV	Diagnostic and Statistical Manual of Mental Disorders—fourth edition
EPQ	Eysenck Personality Questionnaire
GHQ–12	General Health Questionnaire–12 item scale
HFS	Commonwealth Department of Health and Family Services
ICD–10	International Classification of Diseases—10th revision
MCS	Mental Component Summary
MMSE	Mini–Mental State Examination
MOS	Medical Outcomes Study
NCAG	National Consumer Advisory Group
NCCSMHYP	National Collaborating Centres for the Survey of the Mental Health of Young People
NDARC	National Drug and Alcohol Research Centre
NHMRC PERC	National Health and Medical Research Council Psychiatric Epidemiology Research Centre
PCS	Physical Component Summary
RSE	Relative standard error
SE	Standard error
SEIFA	Social Economic Indexes For Areas
SF–12	Short Form–12
SMHWB	1997 National Survey of Mental Health and Wellbeing of Adults
SUDOR	Service Utilisation and Days Out of Role
WHO	World Health Organization
The WHO Centre	The World Health Organization Training and Reference Centre for CIDI in Australia
*	Relative standard error of between 25% and less than 50%
**	Relative standard error of 50% or more
. .	Not applicable

CHAPTER 1 BACKGROUND

INTRODUCTION

The designation of mental health by the Commonwealth Government and State Governments as one of the five National Health Priority Areas is in recognition of its social and public health importance. In addition to the pain and disability which may be suffered by individuals, mental illness may also burden their families considerably (Human Rights and Equal Opportunities Commission 1993).

Mental health relates to emotions, thoughts and behaviours. A person with good mental health is generally able to handle day-to-day events and obstacles, work towards important goals, and function effectively in society. However, even minor mental health problems may affect everyday activities to the extent that individuals cannot function as they would wish, or are expected to, within their family and community. Consultation with a health professional may lead to the diagnosis of a mental disorder.

A mental 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, p. 5).

THE NATIONAL MENTAL HEALTH STRATEGY

The economic and personal costs of mental illness are major social and public health issues. In 1992 the Commonwealth Government and State and Territory Governments of Australia endorsed the National Mental Health Strategy whereby they have made a commitment to improve the lives of people with mental illness and of the people who care for them. The strategy aims to:

- promote the mental health of the Australian community;
- where possible, prevent the development of mental health problems and mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental disorders.

The reforms being pursued through the strategy are aimed to assist people with a mental illness to have access to improved services and support.

In developing the strategy it was recognised that there was a lack of adequate mental health research due to the scarcity of data on the prevalence of mental disorders and the welfare of mentally ill people in the community.

In December 1994, a workshop commissioned by the then Commonwealth Department of Health and Family Services (HFS) recommended the conduct of a national survey of mental health and wellbeing. The survey was to comprise three components: an adult study; a child and adolescent study; and a study of low prevalence (psychotic) disorders, such as schizophrenia.

Subsequently, as part of the National Mental Health Strategy, HFS commissioned the Australian Bureau of Statistics (ABS) to conduct the adult component of the survey.

SURVEY OBJECTIVES AND CONTENT

The objectives of the 1997 National Survey of Mental Health and Wellbeing of Adults (SMHWB) were to provide information on the prevalence of selected major mental disorders, the level of disability associated with these disorders, and the health services used and help needed as a consequence of a mental health problem for Australians aged 18 years or more.

Results from the survey will assist monitoring initiatives of the National Mental Health Strategy and provide an Australian baseline against which future activity can be compared and evaluated.

Expert groups, comprising representatives from a range of eminent research, clinical and academic organisations, provided advice on the survey content and design (see Appendix 3 for a list of committees and members).

The range of major mental disorders included in the survey are those which the Technical Advisory Committee considered to have the highest rates of prevalence in the population and which were also able to be identified in an interviewer-based household survey.

On this basis, the mental disorders included in the SMHWB were:

- Anxiety disorders
  - Panic disorder
  - Agoraphobia
  - Social phobia
  - Generalised anxiety disorder
  - Obsessive-compulsive disorder
  - Post-traumatic stress disorder
- Affective (mood) disorders
  - Depression
  - Dysthymia
  - Mania
  - Hypomania
  - Bipolar (affective) disorder
- Substance use disorders (for alcohol and drugs)
  - Harmful use/abuse
  - Dependence

Other topics agreed by the Technical Advisory Committee included:

- chronic physical conditions;
- disability;
- health service use;
- perceived need for health services;
- other scales and measures; and
- a range of demographic and socioeconomic characteristics.

COMPOSITE INTERNATIONAL DIAGNOSTIC INTERVIEW

Measuring mental health in the community through household surveys is a complex task as mental disorder is usually determined through clinical diagnoses. For the SMHWB, the diagnostic component of the interview was administered through a modified version of the Composite International Diagnostic Interview (CIDI).

The CIDI was initially produced as part of a major joint project between the World Health Organization (WHO) and the United States Alcohol, Drug Abuse and Mental Health Administration during the 1980s. It is a comprehensive interview for adults which can be used to assess current and lifetime prevalence of mental disorders through the measurement of symptoms and their impact on day-to-day activities.

The Technical Advisory Committee chose the CIDI for the diagnostic component of the SMHWB because it:

- provides a fully structured modular diagnostic interview;
- is designed to be administered by lay interviewers;
- is a widely used instrument in epidemiological surveys; and
- is supported by a network of international centres overseen by a WHO steering committee.

The CIDI enables the diagnoses of mental disorders based on either:

- the International Classification of Diseases — 10th revision (ICD–10); or
- the Diagnostic and Statistical Manual of Mental Disorders — 4th revision (DSM–IV).

The World Health Organization Training and Reference Centre for CIDI (The WHO Centre) at the University of New South Wales was contracted by HFS to develop a computer-based interview to collect the survey data.

It should be noted that previous versions of the CIDI have been based on ICD–9.

ETHICS

The survey questions were approved by the Australian National University Ethics Committee, and consultations with the Privacy Commissioner continued throughout survey development.

CHAPTER 2 SURVEY DESIGN

OVERVIEW

The SMHWB was an initiative of, and funded by, HFS as part of the National Mental Health Strategy. The survey was designed to provide information on the prevalence of selected major mental disorders, the level of disability associated with these disorders, and health services used, and help needed, as a consequence of a mental health problem for Australians aged 18 years or more.

The survey was conducted in May–August 1997 requesting information from a representative sample of persons living in private dwellings in all States and Territories of Australia. Approximately 10,600 people aged 18 years or over participated in the survey, representing a response rate of 78%.

The SMHWB was conducted under the *Census and Statistics Act 1905* on a voluntary basis.

SURVEY DEVELOPMENT

The ABS tested the survey instrument developed by The WHO Centre (see page 7) under household survey conditions. The primary objectives of the testing program were to:

- assess the survey instrument's capacity to meet survey objectives, within budget constraints;
- assess the suitability of the proposed data content in the Australian context;
- ensure the compatibility of the survey instrument with the ABS computing environment;
- develop operational procedures to collect and process the data;
- assess respondent reaction to the proposed survey and, hence, determine likely response rates; and
- develop a suitable training package for ABS interviewers, ensuring they were knowledgeable about survey concepts and procedures, and familiar with the computerised survey instrument.

Three tests were undertaken during the development process:

- An initial test, using only part of the proposed questionnaire, was held in Brisbane in April–May 1995.
- A second test of the survey was undertaken in Sydney in August–September 1995.
- A dress rehearsal for the SMHWB was conducted in Sydney in November–December 1996. This involved a full test of field procedures and questionnaire content to ensure that these were operating efficiently and effectively.

Comprehensive reports describing test outcomes and recommendations were prepared after each test. These reports were presented to the Technical Advisory Committee which considered the recommendations and approved all amendments to the survey content.

SCOPE AND COVERAGE

Scope

The SMHWB covered urban and rural areas across all States and Territories of Australia, and included people aged 18 years or more who were usual residents of private dwellings. A private dwelling was defined as a house, flat, home unit, caravan, garage, tent or any other structure being used as a place of residence at the time of the survey.

Each household within private dwellings was included in the survey in its own right. A household comprises a group of persons usually living together in a dwelling who make regular provision to take meals together.

The survey scope excluded:

- special dwellings (such as hospitals, nursing homes, hotels and hostels etc.); and
- dwellings in remote and sparsely settled parts of Australia.

The following persons living in Australia, but not usually considered part of the Australian resident population, were excluded from the scope of the survey:

- diplomatic personnel of overseas governments and non-Australian members of their households;
- non-Australian service personnel stationed in Australia and their dependants; and
- overseas visitors whose usual place of residence is outside Australia.

Non-Australians (other than those above) working in Australia, or in Australia as students or settlers, and their dependants, were included in the survey scope.

Coverage

Coverage rules are designed to ensure that, as far as possible, persons within the scope of the survey have only one chance of being interviewed.

All usual residents in scope had a chance of being selected to complete the survey. One adult member (aged 18 years or more) of each household in each selected dwelling was randomly selected to complete the interview. If the selected person was away for the entire enumeration period, the survey was not completed for that household. Visitors present in selected dwellings at the time of the survey were not included.

SAMPLE DESIGN

The SMHWB was conducted throughout Australia using a stratified multistage area sample of private dwellings. The area-based selection ensured that all sections of the population living in private dwellings within the geographical scope of the survey were represented in the sample. Each State and Territory was stratified geographically and independent samples were selected from each stratum. Each stratum contained a number of Collection Districts (CDs) defined for the 1991 Population and Housing Census. A sample of CDs was selected from each stratum and then divided into a number of blocks. A sample of these blocks was selected for inclusion in the survey.

The sample was selected to ensure that each dwelling within a stratum had an equal and known probability of selection and was allocated across States by part of State (capital city, rest of State) proportionally to the number of persons aged 18 years and over living in private dwellings.

Within each selected block a list of all private dwellings was prepared and a systematic random sample of dwellings was selected. Within each household within the selected dwellings, the in-scope person (aged 18 or more) with the next birthday was chosen.

For the SMHWB a sample of approximately 15,500 private dwellings distributed across all States and Territories was initially selected. The sample design aimed to achieve completed interviews for 10,000 persons, enabling the survey to provide accurate national level estimates. Specifically, the aim was to achieve estimates for:

- prevalence rates of 10% with a relative standard error of about 6% at the Australian level; and
- prevalence rates of 30% with a relative standard error of about 3% at the Australian level.

The sample design was also considered sufficient to provide broad level estimates for the more populous States. The Australian Capital Territory Department of Health and Community Care funded an additional sample to enhance the reliability of Australian Capital Territory estimates. The Victorian Department of Human Services funded an additional sample to provide selected regional data for Victoria. The Health Department of Western Australia funded an additional survey to provide regional data for Western Australia. Data from the Victorian supplementary sample and the additional Western Australian survey are not included in the national estimates produced from the SMHWB.

SURVEY INSTRUMENT

The WHO Centre, contracted by HFS, developed a computer-based interview to collect the survey data. The diagnostic component of the interview was administered through a computer-assisted interview (CAI) version of the CIDI (see page 3).

Topics covered in the survey instrument included:

- Mental disorders and physical conditions:
  - selected ICD–10 and DSM–IV diagnoses of mental disorder
  - chronic physical conditions
  - psychosis (screening questions only)
  - personality disorders (screening questions only)
  - Mini-Mental State Examination (MMSE)
- Disability measures:
  - Brief Disability Questionnaire (BDQ)
  - Short–Form 12 (SF–12)
  - Service utilisation and days out of role (SUDOR)
- Health service utilisation and perceived health needs:
  - admissions to hospitals
  - consultations with health professionals
  - perceived need for health services
  - types of help received
  - barriers to help
- Other scales and measures:
  - General Health Questionnaire–12 item scale (GHQ–12)
  - Eysenck Personality Questionnaire (EPQ)—Neuroticism
  - Kessler Psychological Distress Scale–10
  - Delighted–Terrible Scale
  - suicidal thoughts and attempts
- Demographic and socioeconomic characteristics.

Survey topics are discussed in detail in chapters 3–7, and Appendixes 1–4.

Questionnaire availability

A paper copy of the computerised survey instrument developed by The WHO Centre is available from HFS. Please contact:

Director
Quality and Effectiveness Section
Mental Health Branch (MDP 37)
Commonwealth Department of Health and Aged Care
PO Box 9848
CANBERRA ACT 2601

Telephone: 02 6289 8070

SURVEY OPERATIONS

Interviewer training and support

Interviewers for the 1997 SMHWB were recruited from a pool of trained interviewers with previous experience on ABS household surveys. A group of ABS officers were trained by The WHO Centre to provide identical training to the interviewers in each State and Territory. All interviewers completed a comprehensive five-day training program covering CAI, field procedures, sensitivity training and question-by-question instructions. All phases of the training emphasised understanding of the survey concepts and definitions, and adherence to interview procedures to ensure data quality.

Initial approach

Where possible, households selected for the SMHWB were initially approached by mail informing them of their selection in the survey and advising them that an interviewer would call to arrange a suitable time to conduct the survey interview. A brochure, providing some background to the survey, information concerning the interview and a guarantee of confidentiality was included with the initial approach letter. For a small number of households where the ABS did not have an adequate postal address, this was not possible.

At the initial visit by the interviewer, a paper household form was completed from information provided by a responsible adult member of the household. This form collected details of the number of people in the household and basic demographic characteristics of each person. One adult member (aged 18 years or more) of each household was randomly selected, based on date of birth, to complete the interview.

Personal interview

At the beginning of the interview, interviewers sought to establish an appropriate setting which allowed them to use a notebook computer. Due to the length of the interview and the nature of the questions, which required concentration; and to avoid interruptions, interviewers requested that the interviews, if possible, take place in private. Proxy, interpreted or foreign language interviews were not conducted.

Following the initial section of the survey, which covered demographics, respondents were informed that some of the remaining questions might be personal or sensitive and that they were under no obligation to answer. However, they were assured that their answers would be treated confidentially, and advised that their openness would be appreciated.

Sequencing through the interview was controlled by the computer instrument. When a respondent appeared to have difficulty providing meaningful answers to the initial section of the interview, the instrument skipped to the MMSE which provides a formal test of cognitive impairment (see page 17); if the respondent made more than 12 errors, the interview was terminated.

For questions with a range of possible responses, interviewers used prompt cards listing response categories. 'Don't know' responses to symptom questions were treated as 'no'.

Respondent support

A letter thanking respondents for their participation in the survey, and a brochure containing information about understanding mental illness and telephone numbers for further information were offered to all respondents.

SURVEY RESPONSE

Measures to maximise response

In an ideal situation, interviews would be conducted with all people selected in the sample. The ABS attempts to maximise response to avoid bias and reduce sampling variability. However, some non-response is unavoidable when people choose not to participate or cannot be contacted. Although participation in the SMHWB was voluntary, measures were taken to encourage respondent cooperation and maximise response, including:

- Distributing written information about the survey to selected households. ABS sent advance letters which gave notice that an ABS interviewer would call, provided a contact number for more information and included an information brochure.
- Making a concerted effort to contact the occupants of each selected dwelling. Interviewers made at least three call-backs in rural areas and at least five in urban areas before a dwelling was classified as 'non-contact'.
- Stressing the importance of the survey to the planning and provision of mental health services to meet Australia's needs.
- Stressing the importance of all selected individuals participating in the survey as they represented a number of others in that local area, in that State and in Australia.
- Stressing the confidentiality of all information collected under the *Census and Statistics Act 1905*. Under provisions of the Act, the ABS cannot release any information which is likely to enable the identification of individuals or households to any person, organisation or government authority.

Response rate

Initially, 15,531 private dwelling households were selected in the sample for the SMHWB. This reduced to an effective sample of 13,624 households after sample loss (all household members out of scope, vacant dwelling, dwelling under construction, etc.). As shown in the following table, there were 10,641 fully responding participants, giving a response rate of 78.1%.

RESPONSE

	no.	%
Effective sample	**13 624**	**100.0**
Response		
Fully responding	10 641	78.1
Non-response		
Refusal	1 477	10.8
Non-contact	558	4.1
Other(a)	948	7.0

(a) Comprises language problems, death or illness in the household, respondent away for entire enumeration period, interview terminated.

DATA PROCESSING

Internal edits

The survey instrument provided by The WHO Centre contained a range of internal edits for sequencing and consistency. The majority of these were determined by CIDI conventions. It is possible that modification of the CIDI for household survey conditions, and the incorporation of additional modules for the SMHWB may have introduced problems which have not yet been identified. In addition, the SMHWB is one of the first times that the CIDI has been run incorporating ICD–10. Since the release of the initial publication, it has emerged that the survey instrument did not correctly establish diagnoses of mania, hypomania, and therefore bipolar disorders (see Appendixes 1 and 2 for details).

Diagnostic scoring

Appendix 4 refers to sequencing respondents through the interview based on 'potential mental disorders'. However, precise ICD–10 and DSM–IV criteria were applied to respondent records after the completion of the survey. A separate scorer, provided by The WHO Centre, matched survey questions against the ICD–10 and DSM–IV criteria outlined in Appendixes 1 and 2 respectively and data items containing diagnoses were added to each record.

The scorer for ICD–10 and DSM–IV diagnoses was designed by the CIDI editorial committee for CIDI version 2.1, used in the SMHWB. It is important to note that, due to the complexity of introducing ICD–10 coding into the CIDI, three updates to the scorer have been written since the SMHWB. These have been posted on the WHO Internet site (http://www.who.int/msa/cidi), the latest in August 1998.

External edits

While the survey was in the field, checks for logical consistency and correct linking between household form and personal interview were carried out. Interviewers also documented queries arising from the interviews for later resolution. As interviews were completed, ABS office staff resolved interviewers' queries regarding interviews and technical issues associated with CAI. They also conducted a number of sequencing and logic checks. For example, interviewer keying errors were amended when possible, interviewer queries about CIDI conventions checked, and discrepancies between household forms and the CAI component of the interview checked and amended if necessary.

Occupation and family relationship

Occupation and family relationship were coded by the ABS. Occupation relates to the main job held by employed respondents at the time of their interview, or in the case of those who had previously been employed, the time when they last worked. Based on a description of the kind of work performed, occupation was coded to the four-digit (unit group) level of the Australian Standard Classification of Occupations (ABS 1986), current at the time of the survey. Family relationship was coded for each SMHWB respondent, in relation to all usual members of their household in order to establish household type.

CHAPTER 3 DISORDERS AND CONDITIONS

INTRODUCTION

This chapter provides information on the mental disorders and chronic physical conditions included in the SMHWB. The survey included questions to produce both ICD–10 and DSM–IV diagnoses of mental disorders. In addition, it included questions which screened for personality disorders and psychosis, the MMSE, and questions on selected physical conditions.

MENTAL DISORDER

The SMHWB provided CIDI diagnoses for selected major mental disorders according to both the ICD–10 and DSM–IV classifications. ICD–10 and DSM–IV estimates for the overall prevalence of mental disorder, as well as for specific disorders, therefore differ due to variations in the diagnostic criteria (see Appendixes 1 and 2). Disorders included in the SMHWB were chosen taking into consideration:

- disorders expected to affect more than 1% of the population;
- the capacity of the CIDI to diagnose specific mental disorders; and
- the limitations of a household survey in identifying specific mental disorders.

For this survey, the prevalence of mental disorders relates to any occurrence during the 12 months prior to interview. Output categories are limited according to the prevalence of individual disorders. In some cases disorders must be grouped together in order to obtain reliable prevalence estimates.

Probe questions

At certain points in the CIDI, respondents could be asked a series of probe questions about symptoms, problems or experiences in order to establish whether these were clinically significant and whether they were due to medication, drugs, alcohol or a physical illness/injury.

The questions on clinical significance assessed whether the symptoms were sufficiently severe for the person to seek professional help, or whether the symptoms interfered with his or her life or activities a lot. The symptoms were considered below clinical significance if the person did not tell a doctor or other health professional about the symptoms, did not take medication for them more than once and did not feel that they interfered with his or her life a lot. Such symptoms did not count towards a diagnosis of mental disorder. Some symptoms, however, are inherently of clinical significance because of their grave nature, e.g. a suicide attempt. In such cases, the clinical significance questions were not asked.

Further questions sought to establish whether symptoms were always the result of the person's use of medication, drugs or alcohol; or of physical illness or injury. If either of these explanations, or some combination of the two, explained all of the occurrences of the symptoms, they did not count towards a diagnosis of mental disorder.

Probe questions *continued*

If the respondent had told a doctor, a further set of questions was asked to determine from the doctor's diagnosis whether the symptoms were possible psychiatric symptoms.

Exclusions

The probe questions exclude symptoms on the grounds of psychoactive substance use (medication, drugs or alcohol), or physical illness/injury.

Some disorders are excluded by the presence of other mental disorder(s). For example, neurasthenia is not recorded in the presence of a depressive episode, hypomania, mania, bipolar affective disorder, panic disorder or generalised anxiety disorder. Not all exclusion criteria specified in the ICD–10 and DSM–IV were able to be addressed in the survey. Exclusion criteria are detailed in Appendixes 1 and 2.

Psychotic symptoms

For disorders involving mania or hypomania, the presence or absence of psychotic symptoms was measured by an item on delusions of grandiosity. For all other disorders, no attempt was made to assess the presence or absence of psychotic symptoms. In the following ICD–10 and DSM–IV categories, individuals were allocated to 'without psychotic symptoms/features' by default:

- F32.2 Severe depressive episode without psychotic symptoms (ICD–10)
- F33.2 Recurrent depressive disorder, severe without psychotic symptoms (ICD–10)
- 296.23 Major depressive disorder, single episode, severe without psychotic features (DSM–IV)
- 296.33 Major depressive disorder, recurrent, severe without psychotic features (DSM–IV)

ICD–10 DIAGNOSES OF MENTAL DISORDERS

The following ICD–10 diagnoses (each indicated by mnemonic and name) were covered by the SMHWB to support the output list on page 2.

Substance use disorders

- F10.1 Harmful use—alcohol
- F11.1 Harmful use—opioids
- F12.1 Harmful use—cannabinoids
- F13.1 Harmful use—sedatives or hypnotics
- F15.1 Harmful use—stimulants
- F10.2 Dependence syndrome—alcohol
- F11.2 Dependence syndrome—opioids
- F12.2 Dependence syndrome—cannabinoids
- F13.2 Dependence syndrome—sedatives or hypnotics
- F15.2 Dependence syndrome—stimulants

Affective disorders

- F30.0 Hypomania
- F30.1 Mania without psychotic symptoms
- F30.2 Mania with psychotic symptoms
- F31 Bipolar affective disorder
- F32.0 Mild depressive episode
- F32.1 Moderate depressive episode
- F32.2 Severe depressive episode without psychotic symptoms
- F32.00 Mild depressive episode without somatic syndrome
- F32.01 Mild depressive episode with somatic syndrome
- F32.10 Moderate depressive episode without somatic syndrome
- F32.11 Moderate depressive episode with somatic syndrome
- F33.00 Recurrent depressive disorder, mild without somatic syndrome
- F33.01 Recurrent depressive disorder, mild with somatic syndrome
- F33.10 Recurrent depressive disorder, moderate without somatic syndrome
- F33.11 Recurrent depressive disorder, moderate with somatic syndrome
- F33.2 Recurrent depressive disorder, severe without psychotic symptoms
- F34.1 Dysthymia

Anxiety disorders

- F40.0 Agoraphobia
- F40.00 Agoraphobia without panic disorder
- F40.01 Agoraphobia with panic disorder
- F40.1 Social phobia
- F41.0 Panic disorder
- F41.00 Panic disorder—moderate
- F41.01 Panic disorder—severe
- F41.1 Generalised anxiety disorder
- F42.0 Obsessive-compulsive disorder—predominantly obsessional thoughts or ruminations
- F42.1 Obsessive-compulsive disorder—predominantly compulsive acts
- F42.2 Obsessive-compulsive disorder—mixed obsessional thoughts and acts
- F43.1 Post-traumatic stress disorder

Neurasthenia

- F48.0 Neurasthenia

DSM–IV DIAGNOSES OF MENTAL DISORDERS

The following DSM–IV diagnoses (each indicated by mnemonic and name) were covered by the SMHWB to support the output list on page 2.

Substance-related disorders

- 305.00 Alcohol abuse
- 305.50 Opioid abuse
- 305.20 Cannabis abuse
- 305.40 Sedative abuse
- 305.70 Amphetamine abuse
- 303.90 Alcohol dependence
- 304.00 Opioid dependence
- 304.30 Cannabis dependence
- 304.10 Sedative dependence
- 304.40 Amphetamine dependence

Mood (affective) disorders

- 296.21 Major depressive disorder, single episode, mild
- 296.22 Major depressive disorder, single episode, moderate
- 296.23 Major depressive disorder, single episode, severe without psychotic features
- 296.31 Major depressive disorder, recurrent, mild
- 296.32 Major depressive disorder, recurrent, moderate
- 296.33 Major depressive disorder, recurrent, severe without psychotic features
- 300.4 Dysthymic disorder
- 296.01 Bipolar I disorder, single manic episode, mild
- 296.02 Bipolar I disorder, single manic episode, moderate
- 296.03 Bipolar I disorder, single manic episode, severe without psychotic symptoms
- 296.41 Bipolar I disorder, manic, mild
- 296.42 Bipolar I disorder, manic, moderate
- 296.43 Bipolar I disorder, manic, severe without psychotic symptoms
- 296.89 Bipolar II disorder

Anxiety disorders

- 300.01 Panic disorder without agoraphobia
- 300.21 Panic disorder with agoraphobia
- 300.22 Agoraphobia without history of panic disorder
- 300.23 Social phobia
- 300.3 Obsessive-compulsive disorder
- 309.81 Post-traumatic stress disorder
- 300.02 Generalised anxiety disorder

ONSET AND RECENCY

Questions on onset (first time) and recency (last time) were asked for each group of symptoms which may correspond to a diagnosis of mental disorder. With the exception of dysthymia, responses were categorised as:

- current (within last two weeks)
- two weeks to less than one month ago
- one month to less than six months ago
- six months to less than one year ago
- in the last 12 months (not sure when)
- more than one year ago

Duration

If the response to the question on either onset or recency was 'more than one year ago', the respondent was asked how old they were the (first or last) time they had the symptoms. The duration of the disorder was derived from these data.

Dysthymia, however, requires a duration of at least two years. Respondents who indicated that they had experienced symptoms of dysthymia in the 12 months prior to interview were asked their age of onset. Recency was defined as 'current' if they still had dysthymia; otherwise it was determined by comparing the month of interview with the month the most recent episode had ended.

PHYSICAL CONDITIONS

A subset of items from Belloc, Breslow and Hochstim (1971) was used as a measure of physical conditions in general. Respondents were asked about the presence of any of the following chronic (long-lasting) and current conditions:

- asthma
- chronic bronchitis
- anaemia
- high blood pressure
- heart trouble
- arthritis
- kidney disease
- diabetes
- cancer
- stomach or duodenal ulcer
- chronic gall bladder or liver trouble
- hernia or rupture

COMORBIDITY

Comorbidity refers to the occurrence of more than one disorder at the same time. The existence of some conditions predisposes individuals to others. For example, severe social phobia may cause depression and alcohol dependence. Further, the presence of mental and/or physical conditions in combination is likely to compound the difficulties people face. The SMHWB enables analysis of comorbidity, both in terms of the number of disorders, and combinations of different types.

PSYCHOSIS SCREENER

Psychoses are mental disorders in which people have strange ideas (e.g. that they are being spied on by aliens) or experiences (e.g. hearing voices when there is no one there). These strange ideas or experiences are unaffected by rational argument and are out of keeping with the views of any culture or group to which the person belongs. The survey included four items (from seven questions) designed to screen for the likely presence of psychosis. There is no standard output from these items, but output may be tailored to users' specifications (see page 68 for psychosis screener data items).

PERSONALITY DISORDERS SCREENER

The SMHWB included screening questions for nine ICD–10 personality disorders (listed below). It is important to note that these provide indicators of possible presence only. The screener included only two general criteria which apply to all personality disorders, plus those criteria relating to specific personality disorders that could be assessed as 'true' or 'false'. Most respondents were not required to answer all the questions in this section; respondents were only required to answer sufficient questions to determine whether the required number of criteria had been met. No probe questions were asked regarding symptoms of personality disorder. Screening questions for the following ICD–10 personality disorders were included:

- F60.0 Paranoid personality disorder
- F60.1 Schizoid personality disorder
- F60.2 Dissocial personality disorder
- F60.30 Emotionally unstable personality disorder—impulsive type
- F60.31 Emotionally unstable personality disorder—borderline type
- F60.4 Histrionic personality disorder
- F60.5 Anankastic personality disorder
- F60.6 Anxious (avoidant) personality disorder
- F60.7 Dependent personality disorder

Specific screening criteria for each of these disorders are presented in Appendix 3.

MINI-MENTAL STATE EXAMINATION

The MMSE was adapted by The WHO Centre from Folstein, Folstein and McHugh (1975) and included a number of questions and tasks to test orientation, registration, calculation and attention, recall, language and visual construction e.g. spelling 'world' backwards, naming objects and copying a drawing. The MMSE screens for the presence of cognitive impairment, but does not identify any particular organic mental disorders. The MMSE was asked of all respondents aged 65 years or over.

The MMSE has a maximum score of 30 points. A score of 23 or less is generally accepted as indicating the presence of cognitive impairment. The severity of cognitive impairment may be classified as:

- no cognitive impairment (24–30)
- mild cognitive impairment (18–23)
- severe cognitive impairment (17 or less)

Where respondents could not complete tasks due to physical impediments, their MMSE score was pro rated.

CHAPTER 4 DISABILITY

INTRODUCTION

The survey used a number of different measures of disability: BDQ, SF–12 and SUDOR. These were selected by the Technical Advisory Committee to allow comparison with previous Australian research as well as with overseas studies. Their use in the SMHWB will allow them to be compared on the same, large population. The disability items used in this survey differ from those used in the ABS Survey of Disability, Ageing and Carers, which is based on the WHO International Classification of Impairments, Disabilities and Handicaps, and takes into account physical, intellectual and social functioning.

BRIEF DISABILITY QUESTIONNAIRE

The BDQ is a standard questionnaire containing eight questions designed to measure general levels of disability. The eight-item scale emphasises physical aspects of disability. Respondents are asked whether they are limited because of health problems in a number of activities such as running or sports; carrying groceries; climbing stairs; bending, lifting or stooping; walking long distances and bathing or using the toilet. They are also asked whether they had decreased motivation or personal efficiency, or a deterioration in their social relations. The items in the BDQ refer to the four weeks prior to the interview.

According to the internationally accepted Medical Outcomes Study (MOS) method of scoring the BDQ (scale of 0–16), a high score indicates that the respondent has been limited in their activities by health problems. Disability status may be measured by the following BDQ scores:

- none (score of 0–2)
- mild (3–4)
- moderate (5–9)
- severe (10 or more)

The BDQ also includes two measures of days spent out of role:

- number of days in the four weeks prior to interview on which respondents were unable to carry out usual daily activities fully; and
- number of days in the four weeks prior to interview on which respondents stayed in bed most of the day because of illness or injury.

In an attempt to link BDQ score with specific conditions or symptoms, respondents who indicated they had some level of disability according to the BDQ, and had reported more than one physical condition or set of symptoms that indicated a potential mental disorder (see Appendix 4), were asked to identify their main problem (the condition or set of symptoms which troubled them the most). Respondents were also asked to rate their disability in terms of the limitations due to their main problem: not at all, sometimes or a little, moderate or definitely.

SHORT FORM–12

The SF–12 (containing 12 questions) is a standard international instrument which provides a generic measure of health status. It may also be considered as a measure of disability because it addresses limitations due to physical and mental health.

The SF–12 measures disability across eight dimensions. Two questions were asked for each of the following dimensions:

- physical functioning
- role limitations due to physical health problems
- role limitations due to emotional problems
- mental health

One question was asked for each of the following dimensions:

- bodily pain
- general health
- vitality
- social functioning

For this survey, most questions in the scale refer to the four weeks prior to the interview.

From these questions the Physical Component Summary (PCS) and the Mental Component Summary (MCS) are derived. The PCS focuses mainly on limitations in physical functioning, role limitations due to physical health problems, bodily pain and general health. The MCS focuses mainly on role limitations due to emotional problems, social functioning, mental health and vitality. The PCS and MCS scores are derived using norm-based methods outlined in Ware, Kosinski and Keller (1995). A lower score indicates a greater degree of disability.

SERVICE UTILISATION AND DAYS OUT OF ROLE

This module included three questions on:

- the number of visits to doctors or other health professionals;
- the number of days when respondents were totally unable to work or carry out normal activities; and
- the number of days when they had to cut down on what they did, or did not get as much done as usual.

SUDOR questions referred to the four weeks prior to interview and appeared throughout the interview. In the first instance, respondents were asked these questions about their health in general. In addition, respondents who reported physical conditions were asked SUDOR questions regarding their reported physical condition(s) in totality. Respondents with symptoms indicating a potential mental disorder (see Appendix 4) were also asked SUDOR questions. Symptoms relating to panic disorder, agoraphobia, social phobia and generalised anxiety disorder were grouped together, as were symptoms of depression and dysthymia. SUDOR questions were not asked in relation to the MMSE, or psychosis screener.

CHAPTER 5 HEALTH SERVICE UTILISATION AND PERCEIVED HEALTH NEEDS

INTRODUCTION

The survey was designed to collect information on health service utilisation by all respondents in the 12 months prior to interview. While respondents were asked whether their health service contacts were related to a mental health problem, it is not possible to directly link them with specific mental disorders. A mental health problem, in this context, may relate to stress, worry, sadness, or to any mental health problem identified as such by the respondent, regardless of whether or not the respondent met criteria for a mental disorder. Hence, while it is possible to analyse the service utilisation of those with mental disorders or those with a potential mental disorder (see Appendix 4), it is not possible to directly link service use to specific mental disorders.

CONSULTATIONS WITH HEALTH PROFESSIONALS

Admissions to hospital

Respondents were asked about the number of admissions to general hospitals and, in particular, about the number of admissions for nerves or mental problems. Respondents were also asked about the number of admissions to psychiatric hospitals and drug and alcohol rehabilitation centres. For each type of admission, respondents were asked to identify whether they were in a public or a private bed; and the total number of nights spent in the hospital or unit.

Health professionals

Information was also collected on consultations with the following health professionals (apart from any occurring during hospital admissions):

- general practitioner
- radiologist
- pathologist
- physician or other medical specialist
- surgical specialist or gynaecologist
- psychiatrist
- psychologist
- social worker or welfare officer
- drug and alcohol counsellor
- other counsellor
- nurse
- mental health team
- chemist for professional advice
- ambulance officer
- other health professional

Health professionals *continued*

Respondents were asked to identify the number of consultations with each group of professionals as well as where the consultations mainly took place according to the following categories:

- in health professional's rooms
- at home
- at a community health clinic
- at a drug and alcohol service
- as a hospital outpatient (including accident or emergency)

Those who reported consultations with health professionals were asked to identify how many of their consultations were related to mental health problems such as stress, anxiety, depression, or dependence on drugs or alcohol. Some respondents may have considered they had a mental health problem prior to using services, whereas others may have been informed by, or realised following consultation with, a health professional.

PERCEIVED NEED FOR HEALTH SERVICES

Respondents who used services for mental health problems

Respondents who used services for mental health problems (i.e. were admitted to a general hospital for nerves or mental problems, a psychiatric hospital or a drug and alcohol unit; or who consulted a health professional for a mental problem) were asked to identify the types of help they received from the following list:

- information;
- medication;
- counselling;
- social intervention to help sort out practical issues, such as housing or financial problems; and
- skills training to improve their ability to work, to look after themselves or to use their time.

For each type of help they received, respondents were asked if they received as much help as they needed and if not, they were asked to choose the main reason from the following:

- I preferred to manage myself.
- I didn't think anything more could help.
- I didn't know how or where to get more help.
- I was afraid to ask for more help, or of what others would think of me if I did.
- I couldn't afford the money.
- I asked but didn't get the help.
- I got help from another source.

Respondents who used services for mental health problems *continued*

For each type of help they did not receive, respondents were asked whether they felt they needed it, and if so, the main reason why they did not receive it (from the list of reasons above).

Respondents who did not use services for mental health problems

Respondents who had not used services for mental health problems but who had symptoms that indicated a potential mental disorder (see Appendix 4) were asked whether they felt they needed each of the five types of help (listed previously) and the main reason why they did not seek it (from the list of reasons above).

Perceived need

For each type of help, respondents who used services for mental health problems were classified to one of the categories below. Similarly, respondents who had not used services for mental health problems but who had symptoms that indicated the likely presence of mental disorder (see Appendix 4) were also classified to one of the following categories:

- no (perceived) need—those who were not receiving help and felt that they had no need of 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.

CHAPTER 6 OTHER SCALES AND MEASURES

INTRODUCTION

A range of other scales and measures were included in the SMHWB to provide general assessments of mental health and to allow for research into what measures might best be included in future surveys. These measures have been used in previous Australian studies and overseas surveys and will be explored as possible predictors of disability, service use and perceived need. Previous use of these measures indicates a range of possible outputs from each and, hence, outputs can be provided to specification.

GENERAL HEALTH QUESTIONNAIRE–12 ITEM SCALE

The GHQ–12 is a general measure of health and wellbeing, which was designed to detect psychological impairment among respondents in community settings. It does not make clinical diagnoses. For each of the 12 items, respondents are required to choose one of four responses which indicate their current state of mind relative to how they usually are. There are two methods of scoring the GHQ–12:

- The GHQ method of scoring treats the four-point response scale as a bimodal scale and a score of zero or 1 is allocated to each item (zero for either of the first two responses, and 1 for either of the second two responses). Therefore, scores range from zero to 12.
- Likert scoring treats the four-point response scale as a multiple response scale and a score of zero to three is allocated to each item, producing a total scale score in the range of zero to 36.

EYSENCK PERSONALITY QUESTIONNAIRE—NEUROTICISM

This scale measures the extent to which respondents view themselves as being sensitive or emotional. It consists of 12 items scored as 'yes' or 'no'. Each 'yes' response is scored '1' and hence the scale as a whole is scored from zero to 12, with a higher score indicating greater neuroticism.

KESSLER PSYCHOLOGICAL DISTRESS SCALE–10

The Kessler Psychological Distress Scale–10 is a 10-item scale of current psychological distress which asks about negative emotional states in the four weeks prior to interview. For example, respondents were asked how often they felt nervous, hopeless, and depressed. They chose from the following responses:

- all of the time
- most of the time
- some of the time
- a little of the time
- none of the time

Each item was scored from 1 for 'all of the time' to 5 for 'none of the time'. Hence, the maximum possible score is 50 and the minimum possible score is 10, with high scores indicating low levels of distress and low scores indicating high levels of distress.

DELIGHTED–TERRIBLE SCALE

The Delighted–Terrible Scale seeks an overall rating from the respondent regarding their life as a whole. There are seven response options:

- delighted
- pleased
- mostly satisfied
- mixed
- mostly dissatisfied
- unhappy
- terrible

SUICIDAL THOUGHTS AND ATTEMPTS

The survey included a number of questions about suicide. From these it is possible to ascertain for all respondents:

- whether they had attempted suicide in the 12 months prior to interview; and
- whether they had ever attempted suicide.

CHAPTER 7 POPULATION CHARACTERISTICS

INTRODUCTION

In addition to the specific health information collected, the SMHWB obtained a range of information describing demographic and socioeconomic characteristics. These characteristics can be linked with the health data obtained in the survey to analyse the prevalence of mental disorder and physical conditions, disability and health service utilisation for particular groups in the community. Explanatory notes on education, employment, income and housing, and geographic classifications are presented in this chapter. Appendix 6 includes a full listing of population characteristics.

EDUCATION

Current post-school study

Respondents, other than those still at school, were asked whether they were currently studying at a TAFE college, university, or other educational institution, and whether this study was as a full or part-time student.

Post-school educational qualification

This was collected for persons not attending school. The highest educational qualification items comprised a slightly abridged version of the standard ABS questions with bachelor degree and higher qualifications being collected as one category. Respondents were asked whether they had obtained a qualification since leaving school and the highest qualification completed. Information about duration of study to complete the course, and additional information about reported nursing and teaching qualifications was collected to enable more accurate classification as follows:

- Bachelor degree or higher
- Undergraduate Diploma
- Associate Diploma
- Skilled Vocational Qualification
- Basic Vocational Qualification

Information relating to field of study is not available from this survey.

EMPLOYMENT

The labour force questions used in the survey were based on the standard ABS minimum question set. However, the questions to determine whether the respondent actively looked for work, and duration of unemployment did not conform exactly to ABS standards.

Labour force status

Persons were classified as either employed, unemployed or not in the labour force. Employed persons were those who reported that in the preceding week they had worked in a job, business or farm for one hour or more, or who had a job but were absent during that week. Unemployed persons were those who were not employed in the reference week, but actively looked for work at some time during the previous four weeks and were available to start. It is important to note that the question used to assess whether respondents actively looked for work differed from the standard ABS module; a prompt card was used rather than a series of questions. Persons who were neither employed nor unemployed as defined above were classified as not being in the labour force.

Occupation

Occupation relates to the main job held by employed respondents at the time of their interview, or in the case of those who had previously been employed, the time when they last worked. Based on a description of the kind of work performed, occupation was coded to the four-digit (unit group) level of the Australian Standard Classification of Occupations (ABS 1986), current at the time of the survey. For output purposes occupation is classified to the nine major groups:

- managers and administrators
- professionals
- associate professionals
- tradespersons and related workers
- advanced clerical and service workers
- intermediate clerical, sales and service workers
- intermediate production and transport workers
- elementary clerical, sales and service workers
- labourers and related workers

Hours worked

Employed persons were asked how many hours they usually worked (in all jobs) per week, including paid or unpaid overtime.

Full-time/part-time status

Employed persons were classified as full-time workers if they usually work 35 hours or more per week. Persons who usually work less than 35 hours per week were classified as part-time.

Duration of unemployment

For unemployed persons, this refers to the period of time since they began looking for work. For persons who began looking for work while still employed, this refers to the period since they last worked full-time for two weeks or more. Long-term unemployment is defined as unemployment for a period of 52 weeks or more.

It is important to note that the SMHWB asked respondents to nominate the number of weeks they had been looking for work, and the number of weeks since they last worked full-time for two weeks or more. The standard ABS approach compares the date the respondent began looking for work, or last worked full-time for two weeks or more, with the end of the reference week, to derive the number of weeks they have been unemployed.

INCOME AND HOUSING

The following income items are based on, but again do not precisely match ABS standards.

Main source of income

Respondents were asked to nominate their main source of income from the following list:

- wage or salary
- any government pension or allowance or benefit
- child support
- superannuation or annuity
- own business or share in a partnership
- rental investment
- dividends or interest
- other

Disability Support Pension

Respondents who nominated 'any government pension or allowance or benefit' as their main source of income were asked whether they received the Disability Support Pension. The Disability Support Pension is paid to persons unable to work because of a long-term or permanent disability.

GEOGRAPHIC CLASSIFICATIONS

Geographic information available from the SMHWB relates to the location of the dwelling at which each respondent was enumerated. As a result of scope and coverage rules (see chapter 2) all respondents were surveyed at their usual place of residence.

Two standard classifications of geographic area are available for use in output from this survey:

- Part of State:
  - capital city Statistical Division for each State or Territory
  - rest of State (covers the remaining areas)
- Department of Primary Industries and Energy Remote, Rural and Metropolitan Areas classification:
  - capital city/other metropolitan with a population more than 100,000
  - large/small rural centres with a population between 10,000–100,000
  - other rural areas with a population less than 10,000

Socio-Economic Indexes for Areas

The five Socio-Economic Indexes for Areas (SEIFA) indexes were derived from the 1991 Census:

- Urban Index of Relative Socio-Economic Advantage
- Rural Index of Relative Socio-Economic Advantage
- Index of Relative Socio-Economic Disadvantage
- Index of Economic Resources
- Index of Education and Occupation

Each person on the file was allocated index scores, based on the CD in which they were enumerated. The scores were grouped by deciles. The deciles relate to the area in which the person was enumerated, not to the socio-economic characteristics of the individual. A high decile score for the Index of Relative Social Disadvantage, for example, suggests that the area has fewer families of low income and fewer people with little training and working in unskilled occupations, whereas a low score suggests that the area has more families and people of this type.

CHAPTER 8 INTERPRETATION OF RESULTS

DATA QUALITY

Although care was taken to ensure that the results of this survey are as accurate as possible, there are certain factors which affect the reliability of the results and for which no adequate adjustments can be made. One such factor is known as sampling variability. Other factors are collectively referred to as non-sampling errors. These factors, which are discussed below, should be kept in mind when interpreting results of the survey.

Sampling error

Sampling error refers to the difference between an estimate derived from a sample survey and the value that would be obtained if the whole population was enumerated. Factors which affect the sampling error include:

- Sample size—the larger the sample on which an estimate is based, the smaller will be the sampling error.
- Sample design—there are many different methods which could have been used to obtain a sample. The final design attempted to make national estimates as accurate as possible within cost and operational constraints (see chapter 2).
- Population variability—this refers to the extent to which people differ on the particular characteristic being measured. The smaller the population variability of a particular characteristic, the more likely it is that the population will be well represented by the sample and, therefore, the smaller the sampling error. Conversely, the more variable the characteristic, the greater the sampling error.

Standard error

One measure of sampling variability is 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 persons had been included in the survey, and about 19 chances in 20 that the difference will be less than two SEs.

The relative standard error (RSE) is the SE expressed as a percentage of the estimate to which it relates. Very small estimates generally have a high RSE and this makes them unsuitable for most uses. Only estimates with RSE less than 25% are considered sufficiently reliable for most purposes. However, estimates with an RSE between 25% and 50% are included in ABS publications of results from this survey, preceded by the symbol * as a caution to indicate that they are subject to high RSEs. Estimates with a RSE greater than 50% are preceded by the symbols ** as a caution to indicate that they are subject to high RSEs and should not be regarded as reliable. See Appendix 7 for more information on SEs.

Non-sampling error

Non-sampling errors are not due to sampling variability, but to other inaccuracies such as errors in response and recording errors. These errors may occur in any collection whether a census or a sample survey.

The main sources of non-sampling error are:

- errors related to scope and coverage;
- response errors such as incorrect interpretation of the wording of questions and inability to recall the required information;
- non-response bias, because the mental health and other characteristics of non-responding people may differ from responding people; and
- processing errors such as mistakes in the recording or coding of the data obtained.

Each of these sources of error is discussed in the following paragraphs.

Errors related to scope and coverage

Some dwellings may have been inadvertently included or excluded from the SMHWB for reasons such as the distinctions between whether they were private or non-private dwellings may have been unclear. All efforts were made to overcome such situations by constant updating of lists as sample dwellings were selected.

Some persons may have been inadvertently included or excluded because of difficulties in applying the coverage rules concerning household visitors or scope rules concerning persons excluded from the survey. Particular attention was paid to the design of the household form and interviewer training to ensure that such cases were kept to a minimum.

Response errors

In this survey, response errors may have arisen from three main sources: deficiencies in questionnaire design and methodology; deficiencies in interviewing technique; and inaccurate reporting by the respondent.

Errors may be caused by misleading or ambiguous questions, by inadequate or inconsistent definitions of terminology used, or by poor overall design of the interview causing questions to be missed. The diagnostic component of the instrument, the CIDI, has been thoroughly tested, is internationally recognised and is endorsed by the WHO. Further, in order to overcome any questionnaire design problems in the survey as a whole, individual questions and the overall interview procedure were thoroughly tested before being endorsed by the Technical Advisory Committee for use in the survey.

Lack of uniformity in interviewing techniques may result in non-sampling errors. Thorough training programs were used to achieve and maintain uniform interviewing practices. The use of a computer-assisted interview, specially designed to be used by non-clinical interviewers, should have further reduced interviewer variability in this survey.

In addition, inaccurate reporting by respondents may occur due to misunderstanding of questions, inability to recall the required information or unwillingness to reveal all details.

Non-response bias

Non-response may occur when people cannot or do not wish to cooperate, or cannot be contacted.

Non-response can introduce a bias to the results obtained in that non-respondents may have different characteristics and behaviour patterns in relation to their health from those persons who responded to the survey. The magnitude of the bias depends on the extent of the differences and the level of non-response.

As it was not possible to accurately quantify the nature and extent of the differences between respondents and non-respondents in this survey, every effort was made to reduce the level of non-response.

Processing errors

Processing errors may occur at any stage between initial collection of the data and final compilation of statistics. Specifically, in this survey, processing errors may have occurred at the following stages in the processing system:

- Clerical checking and coding—errors may have occurred during checking of interviews for completeness and during coding of various items such as occupation by office processors.
- Data transmission—errors may have occurred during the transmission of data from the field to the office.
- Editing—computer editing programs may have failed to detect errors which could reasonably have been corrected.
- Manipulation of data—errors may have occurred during various stages of computer processing involving the manipulation of raw data to produce the final survey data files (e.g. during the estimation procedure or weighting of the data file or in the course of deriving new data items from raw survey data).

A number of steps were taken to minimise errors at various stages of processing:

- Coding—staff engaged in coding were trained in the various classifications and procedures used according to detailed coding instructions.
- Computer editing—edits were devised to ensure that logical sequences were followed in the interview, that necessary items were present and that specific values lay within certain ranges. These edits were designed to detect reporting errors, incorrect relationships between data items or missing data items. For details on internal edits and diagnostic scoring see page 10.
- Data file checks—at various stages during processing (such as after computer editing and subsequent amendments, weighting of the file and derivation of new data items) tabulations were obtained from the data file showing the distribution of persons for different characteristics. These were used as checks on the contents of the data file, to identify unusual values which may have significantly affected estimates and illogical relationships not previously identified by edits. Mental health experts from the Data Analysis sub-committee (see Appendix 5) met to validate results before data were cleared for output.

METHODOLOGICAL ISSUES

Information recorded in this survey is essentially 'as reported' by respondents, and hence may differ from that which might be obtained from other sources or via other methodologies. There may also be some instances of under-reporting as a consequence of respondents being unwilling to talk about particular experiences, behaviours or conditions at an interview. Results of previous surveys of alcohol and illegal drug consumption suggest a tendency for respondents to under-report consumption levels.

Conditions and disorders

The CIDI is a structured interview for diagnosis of mental disorder for research purposes. Since the CIDI has no facility for subjective interpretation, it can inform a clinician's diagnosis but not replace it. Therefore, estimates of mental disorder produced by the SMHWB are not equivalent to clinical diagnoses, but closely match ICD–10 and DSM–IV criteria (see Appendixes 1 and 2). The prevalence of mania, hypomania and bipolar disorders is likely to be underestimated due to a problem in the survey instrument (see Appendixes 1 and 2 for details).

Reported information on physical conditions was not medically verified, and was not necessarily based on diagnosis by a medical practitioner.

Further, the survey collected information on a range of mental disorders but did not attempt to identify all disorders. The interview also incorporated additional CIDI modules which provided a set of screening questions for personality disorders and psychoses (see chapter 3). These modules did not collect sufficient information to determine whether the criteria for a diagnosis were met. In addition, the exclusion from the survey of people living in special dwellings (e.g. hostels, boarding houses and institutions) and homeless people will have affected results. For these reasons, the SMHWB may underestimate the extent of mental disorder in Australia.

Population characteristics

The questions used in the SMHWB to collect data on labour force status, education and income are not precisely the same as those used in other ABS surveys. The classification for household type also differs from the ABS standard (see chapter 7). As such, these data items are not exactly comparable with those in other ABS surveys, but they do provide an indication of an individual's status and they are sufficient to associate with mental health status.

Comparisons with other surveys and studies

The SMHWB is the most comprehensive data collection of its kind ever attempted in Australia. The inclusion of the CIDI with a range of other internationally accepted scales and measures (see chapter 6), as well as ABS demographic and socioeconomic variables (see chapter 7), means that comparisons with other similar surveys and studies is possible. However, it is important to note specific methodologies and content before making comparisons. For example, the Epidemiologic Catchment Area study conducted in the United States of America, and the Office of Population Censuses and Surveys—Surveys of Psychiatric Morbidity in Great Britain both collected data on specific mental disorders but the methodologies employed differed from those used in the SMHWB. It is also important to note that previous versions of the CIDI are based on ICD–9.

OTHER FACTORS AFFECTING ESTIMATES

In addition to data quality and methodological issues, a number of other factors should be considered when interpreting the results of this survey.

Sampling variability

It is important to bear in mind that survey estimates are derived from a sample of the population and are, therefore, subject to sampling variability. Consideration should be given to whether estimates are sufficiently reliable for proposed uses. Sampling variability and its implications for data reliability are discussed in the section on Data Quality, page 29.

Scope and coverage

The scope and coverage rules of the survey (see chapter 2) define the boundaries of the population to which the estimates relate. The most important aspect of scope and coverage affecting the interpretation of estimates from this survey is that people in non-private dwellings (such as hostels, boarding houses and institutions) were excluded from the survey. As a result, survey estimates should be seen as relating to the population of Australians who live in private dwellings.

Concepts and definitions

Although many modules within the survey are internationally endorsed standards, it remains important to consider the scope of each topic and the concepts and definitions associated with individual pieces of information when interpreting survey results.

Wording of questions

Although some wording was Australianised, wording and prompts were largely determined by the CIDI and other international modules. However, to enable accurate interpretation of survey results, it is essential to bear in mind the precise wording of questions used to collect information and, in particular, those questions which used a series of 'running prompts' or a prompt card. As indicated previously, the paper copy of the survey instrument is available (see page 7).

Collection period

It is important to bear in mind the survey collection period (May–August 1997) when considering the results, or when comparing them with data from other sources collected at different times.

ESTIMATION PROCEDURES

The survey was conducted over a four-month period from May–August 1997. The estimation procedures developed for this survey ensure that survey estimates of the Australian population conform to independent estimates of the Australian population for the June quarter of 1997 at State by part of State (i.e. capital city, remainder of State), age and sex level.

Benchmarks

The benchmark used in the survey was the population estimate of persons living in private dwellings adjusted to exclude persons living in remote and sparsely settled parts of Australia. The benchmarks were classified by State, part of State (capital city, rest of State), age and sex. Initially the age groupings used were 18–19 year olds, five-year age groups for 20–74 year olds and all people aged 75 years and over. However, in some cases these groupings were collapsed due to small numbers of respondents.

Weights

Expansion factors or 'weights' were added to respondents' records to enable the data provided by these persons to be expanded to provide estimates relating to the whole population within the scope of the survey.

In essence, weights are an indication of the number of people in the Australian population who individual respondents represent. Weights are allocated to each respondent according to his/her State or Territory of usual residence, part of State, age and sex, and the probability of selection. This takes into account aspects of non-response, affected by State, part of State, age and sex.

CHAPTER 9 SURVEY OUTPUTS

DATA AVAILABILITY

Results from the 1997 SMHWB are available in the form of:

- publications;
- confidentialised unit record files, available on CD-ROM;
- tables produced on request to meet specific information requirements from the survey; and
- consultancy services.

Publications

Selected results of the 1997 SMHWB are, and the later Western Australian survey will be, presented in the following ABS publications:

- *Mental Health and Wellbeing: Profile of Adults, Australia, 1997* (Cat. no. 4326.0) released March 1998.
- *Mental Health and Wellbeing: Profile of Adults, Western Australia, 1997–98* (Cat. no. 4326.5) expected to be released in February 1999.

Confidentialised unit record files

For users who wish to produce their own tabulations and manipulations of survey data, a computer file containing unidentified records from the survey can be purchased, subject to conditions outlined in the ABS publication *Information Paper: Mental Health and Wellbeing of Adults, Australia, Confidentialised Unit Record File, 1997* (Cat. no. 4329.0). The data are released subject to the signing of an undertaking and the approval of the Australian Statistician.

A copy of the undertaking is available from:

Director
Health Section (W31c)
Australian Bureau of Statistics
PO Box 10
BELCONNEN ACT 2616

To protect the confidentiality of individual persons some data items have been removed from particular records and the level of detail for some items has been reduced.

Special data services

Subject to confidentiality and sampling variability constraints, tabulations can be produced from the survey incorporating data items, populations and geographic areas selected to meet individual requirements.

Listings of output data items from the survey which can be used in specifications of tables are available from Appendix 6 of this publication.

All requests for special tabulations are costed according to current ABS pricing policy. Special tabulations are available in the following formats:

- printed tables sent by post or facsimile; and
- electronic data files on floppy disk or email attachments.

Consultancy services

In addition to standard products and special data services, the ABS can undertake to analyse and report on particular survey topics for clients on a consultancy basis. This service is of particular use to those clients who may not have resources or facilities to undertake analysis of survey data from the confidentialised unit record file.

Data quality

This publication provides details of the concepts and definitions used in the survey, the level of information collected and outputs available. It should be noted that output categories are limited according to the prevalence of individual disorders. In some cases disorders must be grouped together in order to obtain reliable prevalence estimates.

APPENDIX 1 ICD–10 DIAGNOSES

INTRODUCTION

This Appendix presents descriptions of the CIDI diagnostic criteria according to the ICD–10. Note that not all exclusions specified in the ICD–10 were able to be addressed in the SMHWB. Therefore the definitions set out below differ in some cases from the ICD–10.

SUBSTANCE 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. Additional questions about the use of specific drugs were only asked if the person: used that drug more than five times; used it without a prescription; or, if the drug was prescribed, overused it.

Harmful use (F1x.1)

A pattern of use of psychoactive substances causing damage to physical or mental health. A diagnosis was achieved if recurrent and significant adverse consequences related to psychoactive substance use occurred in the 12 months prior to interview. Harmful patterns may lead to disability and are often associated with adverse social consequences. Harmful use should not be diagnosed if dependence syndrome is present.

This survey collected information on:

- Harmful use—alcohol (F10.1)
- Harmful use—opioids (F11.1)
- Harmful use—cannabinoids (F12.1)
- Harmful use—sedatives or hypnotics (F13.1)
- Harmful use—stimulants (F15.1)

Dependence syndrome (F1x.2)

A maladaptive pattern of substance use in which the use of the substance 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. A diagnosis was 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
- tolerance
- neglect of alternative interests because of substance use
- continued use despite knowing it is causing significant problems

This survey collected information on:

- Dependence syndrome—alcohol (F10.2)
- Dependence syndrome—opioids (F11.2)
- Dependence syndrome—cannabinoids (F12.2)
- Dependence syndrome—sedatives or hypnotics (F13.2)
- Dependence syndrome—stimulants (F15.2)

AFFECTIVE DISORDERS

Hypomania (F30.0)

A lesser degree of mania, 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. At least three of the following 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

Hypomania is not accompanied by psychotic symptoms, such as delusions of grandiosity, and the episode does not meet the criteria for mania, bipolar affective disorder or a depressive episode.

Mania without psychotic symptoms (F30.1)

Mood is elevated, expansive or irritable out of keeping with the person's circumstances leading to severe disruption with daily living. The episode lasts for at least seven days 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

There are no psychotic symptoms.

Mania with psychotic symptoms (F30.2)

The episode meets the criteria for mania (above) but psychotic symptoms are present.

Bipolar affective disorder (F31)

Characterised by two or more 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). For this survey, a diagnosis of bipolar affective disorder was given if the person met criteria for mania or hypomania and had more than one episode of hypomania or mania, or if the person met criteria for mania or hypomania and also for a depressive episode. The survey does not allow differentiation according to the type of the current episode.

Note

Due to a problem in the instrument identified since the release of the initial publication, responses from those who indicated that they had not been abnormally happy or excited, but had been unusually irritable, were not coded to the computer file during the CAI. As a result, the survey does not provide a prevalence rate for hypomania, mania and therefore, bipolar affective disorder. Therefore it is likely that published data slightly underestimate the prevalence of affective disorders.

Depressive episode (F32)

A depressive episode lasts for at least two weeks and is only diagnosed if the person has never had a hypomanic or manic episode.

At least two of the following are present:
- depressed mood
- loss of interest in activities
- lack of energy or increased fatigue

Additional symptoms from the following list must be present, to give a total of at least four:
- loss of confidence or self esteem
- feelings of worthlessness or 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 the following disorders based on the number of symptoms the person experienced:
- Mild depressive episode (F32.0)—two symptoms from the first list, and an additional symptom or symptoms from the second list above to give a total of at least four.
- Moderate depressive episode (F32.1)—two symptoms from the first list, and additional symptoms from the second list above to give a total of at least six.
- Severe depressive episode without psychotic symptoms (F32.2)—all three symptoms from the first list and additional symptoms from the second list above to give a total of at least eight.

Presence of somatic syndrome

To qualify for somatic syndrome four of the following must be present:
- loss of interest or pleasure in normal activities
- lack of emotional reactions
- waking early in the morning
- depression worse in the morning
- objective evidence of psychomotor retardation or agitation
- loss of appetite
- weight loss
- loss of libido

The survey was designed to collect information to enable differentiation of:
- Mild depressive episode without somatic syndrome (F32.00)
- Mild depressive episode with somatic syndrome (F32.01)
- Moderate depressive episode without somatic syndrome (F32.10)
- Moderate depressive episode with somatic syndrome (F32.11)

In the ICD–10, the presence or absence of the somatic syndrome is not specified for severe depressive episode.

Recurrent depressive disorder (F33)

The person has had at least one previous depressive episode and has not had a hypomanic or manic episode.

The survey collected information on the following:

- Recurrent depressive disorder, mild without somatic syndrome (F33.00)
- Recurrent depressive disorder, mild with somatic syndrome (F33.01)
- Recurrent depressive disorder, moderate without somatic syndrome (F33.10)
- Recurrent depressive disorder, moderate with somatic syndrome (F33.11)
- Recurrent depressive disorder, severe without psychotic symptoms (F33.2)

Dysthymia (F34.1)

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. Intervening periods of normal mood last less than two months. The person feels tired and depressed, sleeps badly and feels inadequate, but is usually able to cope with the basic demands of everyday life. There are no episodes of hypomania.

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 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

ANXIETY DISORDERS

Agoraphobia (F40.0)

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

- crowds
- public places
- travelling alone
- travelling away from home

The person experiences distress about the avoidance or anxiety symptoms and recognises that these are excessive or unreasonable.

At least two of the following anxiety symptoms must have been present together in 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
- nausea
- dizziness
- feelings of unreality
- fear of losing control
- fear of dying
- hot flushes or cold chills
- numbness or tingling sensations

Symptoms are restricted to, or predominate in, the feared situations or contemplation of the feared situations. They are not the result of a depressive episode, hypomania, mania, bipolar affective disorder or obsessive-compulsive disorder.

The survey collected information to differentiate the presence or absence of panic disorder (F41.0):

- Agoraphobia without panic disorder (F40.00)
- Agoraphobia with panic disorder (F40.01)

Note, for a diagnosis of Agoraphobia with panic disorder (F40.01), this survey did not restrict the panic-like symptoms to the feared situation. This was in order to resolve the logical inconsistency between panic-like symptoms being restricted to the feared situation and panic disorder symptoms not being associated with a specific situation.

Social phobia (F40.1)

Characterised by fears in social situations such as eating or drinking in public, encountering known individuals in public, or being in small group situations such as parties, meetings or classrooms.

Either of the following must be present:

- fear of being the focus of attention or fear of behaving in a way that will be embarrassing or humiliating; or
- avoidance of being the focus of attention, or of situations where there is fear of behaving in an embarrassing or humiliating way.

At least two of the anxiety symptoms defined in Agoraphobia (F40.0) must be manifest 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
- urgency or fear of losing control of bowels or bladder

Symptoms are restricted to, or predominate in, the feared situations or contemplation of the feared situations. The person experiences distress about the avoidance or the anxiety symptoms and recognises that these are excessive or unreasonable. The symptoms are not due to a depressive episode, hypomania, mania, bipolar affective disorder or obsessive-compulsive disorder.

Panic disorder (F41.0)

The essential feature of this disorder is recurrent panic (anxiety) attacks that are not consistently associated with a specific situation or object. A panic attack is a discrete episode of intense fear or discomfort that starts abruptly and reaches a peak within a few minutes. Panic attacks are not associated with marked exertion or with exposure to dangerous or life-threatening situations. At least four of the following symptoms are present, including one of the first four:

- pounding heart
- sweating
- trembling or shaking
- dry mouth
- difficulty breathing
- feeling of choking
- chest pain
- nausea
- dizziness
- feelings of unreality
- fear of losing control
- fear of dying
- hot flushes or cold chills
- numbness or tingling sensations

The symptoms are not due to a depressive episode, hypomania, mania or bipolar affective disorder.

Panic disorder—moderate (F41.00)

At least four panic attacks in a four-week period.

Panic disorder—severe (F41.01)

At least four panic attacks per week over a four-week period.

Generalised anxiety disorder (F41.1)

Characterised by a period of at least six months with tension, worry and apprehension about everyday events and problems that does not meet criteria for panic disorder, phobic disorders or obsessive-compulsive disorder. 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
- fear of losing control
- fear of dying
- hot flushes or cold chills
- numbness or tingling sensations
- muscle tension or aches and pains
- restlessness
- feeling on edge
- a sensation of a lump in the throat
- exaggerated response to minor surprises
- difficult concentrating
- irritability
- trouble falling or staying asleep

Obsessive-compulsive disorder (F42)

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:

- acknowledged as originating in the mind of the respondent;
- 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 interference with the person's functioning, usually by wasting time. They are not the result of a depressive episode, hypomania, mania or bipolar affective disorder.

The survey collected information to differentiate the following disorders:

- Obsessive-compulsive disorder—predominantly obsessional thoughts or ruminations (F42.0)
- Obsessive-compulsive disorder—predominantly compulsive acts (F42.1)
- Obsessive-compulsive disorder—mixed obsessional thoughts and acts (F42.2).

Post-traumatic stress disorder (F43.1)

Characterised by symptoms experienced within six months of exposure to an extremely traumatic event which would be likely to cause distress in almost anyone. For this survey, respondents were asked questions about post traumatic stress disorder symptoms if they had ever experienced:

- direct combat experience in a war;
- a life-threatening accident;
- a fire, flood or other natural disaster;
- witnessing someone being badly injured or killed;
- rape;
- sexual molestation;
- a serious physical attack or assault;
- being threatened with a weapon, held captive or kidnapped;
- torture or been the victim of terrorists; or
- any other extremely stressful or upsetting experience of this sort excluding bereavement, chronic illness, business loss, marital or family conflict, book, movie or television.

The traumatic event is persistently remembered or relived, e.g. flashbacks, dreams, or distress when reminded of the event. The person exhibits avoidance of circumstances resembling or associated with the event and exhibits either an inability to recall some or all aspects of the trauma or two or more of the following symptoms of increased sensitivity and arousal:

- difficulty in falling or staying asleep
- irritability
- difficulty concentrating
- hypervigilance
- exaggerated startle response

NEURASTHENIA (F48.0)

Either complaints of fatigue after minor mental effort, or complaints of fatigue and weakness after minor physical effort lasting at least three months. The person is unable to recover by means of rest, relaxation, or entertainment. These indications are accompanied by a variety of other physical symptoms such as muscular aches and pains, dizziness, tension headaches, sleep disturbance, inability to relax and irritability. The disorder does not occur in the presence of a depressive episode, hypomania, mania, bipolar affective disorder, panic disorder or generalised anxiety disorder.

APPENDIX 2 DSM–IV DIAGNOSES

INTRODUCTION

This Appendix presents descriptions of the CIDI diagnostic criteria according to the DSM–IV. Note that not all exclusions specified in the DSM–IV were able to be addressed in the SMHWB. Therefore the definitions set out below differ in some cases from the DSM–IV.

SUBSTANCE-RELATED 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. Additional questions about the use of specific drugs were only asked if the person: used that drug more than five times; used it without a prescription; or, if the drug was prescribed, overused it.

Substance abuse

A maladaptive pattern of substance use leading to impairment or distress occurring over a 12-month period. This pattern is manifest by failure to fulfil role obligations, use in situations which are dangerous, legal problems or continued substance use despite social and interpersonal problems caused or exacerbated by the effects of substance use. The symptoms have never met the criteria for substance dependence for this class of substance. This survey collected information on:

- Alcohol abuse (305.00)
- Opioid abuse (305.50)
- Cannabis abuse (305.20)
- Sedative abuse (305.40)
- Amphetamine abuse (305.70)

Substance dependence

A maladaptive pattern of substance use leading to impairment or distress. Three or more of the following problems occur in the same 12-month period:

- tolerance
- withdrawal
- taking more of the substance or for longer than intended
- desire or unsuccessful efforts to cut down
- a great deal of time obtaining, using or recovering from the effects of the substance
- reduction in important activities because of substance use
- continued use despite knowing it is causing significant problems

This survey collected information on:

- Alcohol dependence (303.90)
- Opioid dependence (304.00)
- Cannabis dependence (304.30)
- Sedative dependence (304.10)
- Amphetamine dependence (304.40)

MOOD (AFFECTIVE) DISORDERS

Major depressive episode

Five or more of the following symptoms, including at least one of the first two, have been present for at least two weeks:

- depressed mood
- loss of interest and pleasure
- weight change or appetite disturbance
- sleep disturbance
- psychomotor changes
- low energy
- feelings of worthlessness or guilt
- poor concentration or difficulty making decisions
- recurrent thoughts of death or suicidal ideation, plans or attempts

These symptoms must represent a change from previous functioning, and are not better accounted for by bereavement. In addition, the episode must be accompanied by significant distress or impairment in social, occupational or other important areas of functioning. A diagnosis of depressive disorder is only achieved if the person has never had a hypomanic, manic or mixed episode. Recurrence is indicated by the occurrence of separate episodes with an intervening period of at least two consecutive months.

Severity

The survey collected information to differentiate the following disorders based on the number of symptoms the person experienced:

- Major depressive disorder, single episode, mild (296.21)
- Major depressive disorder, single episode, moderate (296.22)
- Major depressive disorder, single episode, severe without psychotic features (296.23)
- Major depressive disorder, recurrent, mild (296.31)
- Major depressive disorder, recurrent, moderate (296.32)
- Major depressive disorder, recurrent, severe without psychotic features (296.33)

The episode is categorised as mild if five or six symptoms are present, moderate if seven are present, or severe if more than seven are present.

Dysthymic disorder (300.4)

Characterised by chronically depressed mood that occurs most of the day more days than not for at least two years, without a break of two months or more. A diagnosis of dysthymia can only be made if the initial two-year period of symptoms is free of major depressive episodes and the person has never had a hypomanic, manic or mixed episode.

At least two of the additional symptoms are present:

- appetite disturbance
- sleep disturbance
- low energy
- low self-esteem
- poor concentration or difficulty making decisions
- feelings of hopelessness

The episode must be accompanied by significant distress or impairment in social, occupational or other important areas of functioning.

Manic episode Characterised by abnormally elevated, expansive or irritable mood lasting at least seven days (or any duration if hospitalisation is required). Three or more of the following symptoms (four if the mood is only irritable) are present:

- inflated self-esteem or grandiosity
- decreased need for sleep
- increased talkativeness
- flight of ideas or the feeling that thoughts are racing
- distractibility
- increase in goal-directed activity or psychomotor agitation
- excessive involvement in pleasurable activities that have a high potential for painful consequences

The episode causes marked impairment in occupational functioning or relationships. Psychotic features may be present. The person does not meet criteria for a mixed episode.

Hypomanic episode Characterised by abnormally elevated, expansive or irritable mood lasting at least four days. Three or more of the following symptoms (four if the mood is only irritable) are present:

- inflated self-esteem or grandiosity
- decreased need for sleep
- increased talkativeness
- flight of ideas or the feeling that thoughts are racing
- distractibility
- increase in goal-directed activity or psychomotor agitation
- excessive involvement in pleasurable activities that have a high potential for painful consequences

While the episode is associated with a change in functioning that is not characteristic of the person, it is not severe enough to cause marked impairment in occupational functioning or relationships. There are no psychotic features.

Mixed episode Criteria are met for both a major depressive episode and a manic episode for at least seven days.

Note Due to a problem in the instrument identified since the release of the initial publication, responses from those who indicated that they had not been abnormally happy or excited, but had been unusually irritable, were not coded to the computer file during the CAI. As a result, the survey does not provide a prevalence rate of hypomanic and manic episodes and therefore, bipolar I and bipolar II disorders. Therefore it is likely that published data slightly underestimate the prevalence of affective disorders.

Bipolar I disorder (296.0x/296.4x)

Characterised by the occurrence of one or more manic episodes. Often individuals have also had one or more major depressive episodes. Recurrence is indicated by either a shift in the polarity of the episode or an interval between episodes of at least two months without manic symptoms.

Severity

The survey collected information to differentiate the following disorders based on the number of symptoms the person experienced:

- Bipolar I disorder, single manic episode, mild (296.01)
- Bipolar I disorder, single manic episode, moderate (296.02)
- Bipolar I disorder, single manic episode, severe without psychotic symptoms (296.03)
- Bipolar I disorder, mild (296.41)
- Bipolar I disorder, moderate (296.42)
- Bipolar I disorder, severe without psychotic symptoms (296.43)

Since the survey did not allow assessment of the nature of the most recent episode, 296.4x is used as a label for recurrent manic episodes, manic and depressive episodes or manic and mixed episodes. The episode is categorised as mild if three or four manic symptoms are present, moderate if five or six are present, or severe if more than six are present.

Bipolar II disorder (296.89)

Characterised by one or more major depressive episode accompanied by at least one hypomanic episode. The person has never had a manic or mixed episode.

ANXIETY DISORDERS

Panic attack

A period of intense fear or discomfort which begins suddenly and reaches a peak within a few minutes. At least four of the following symptoms are present:

- pounding heart
- sweating
- trembling or shaking
- shortness of breath
- feeling of choking
- chest pain
- nausea
- dizziness
- feelings of unreality
- fear if losing control
- fear of dying
- numbness or tingling sensations
- hot flushes or cold chills

Agoraphobia

Characterised by anxiety about being in situations from which escape might be difficult or in which help may not be available if the person has a panic attack. Such situations include being outside the home alone, being in a crowd, travelling in trains, buses or cars and being in a public place. The person avoids the situations, endures them with distress or requires the presence of a companion. These symptoms are not better accounted for by Social phobia, Obsessive-compulsive disorder or Post-traumatic stress disorder.

Panic disorder

The essential feature of this disorder is recurrent panic (anxiety) attacks that occur suddenly and unpredictably. At least one of the attacks has been followed by one month or more of at least one of the following:

- concern about having additional attacks
- worry that the attack means that the person is 'going crazy', losing control or having a heart attack
- change in behaviour because of the attacks

These symptoms cannot be better accounted for by Social phobia, Obsessive-compulsive disorder or Post-traumatic stress disorder.

The survey collected information to differentiate the presence or absence of agoraphobia:

- Panic disorder without agoraphobia (300.01)
- Panic disorder with agoraphobia (300.21)

Agoraphobia without history of panic disorder (300.22)

Characterised by the presence of agoraphobia related to fear of developing panic-like symptoms, without the criteria for panic disorder ever being met.

Social phobia (300.23)

Characterised by a persistent fear of one or more social or performance situations. The person fears that he or she will act in a way (or show anxiety symptoms) that will be embarrassing or humiliating. Exposure to the feared situation almost always provokes anxiety which may take the form of a panic attack. For this survey, the presence of two or more symptoms of a panic attack was required. The feared situations are avoided, or endured with distress and the person recognises that the fear is excessive or unreasonable. The disorder is accompanied by distress and interference with normal routine and functioning. For those who were less than 18 years when the phobia ended, the duration must be at least six months The fear or avoidance are not better accounted for by panic disorder with or without agoraphobia.

Obsessive-compulsive disorder (300.3)

Either obsessions or compulsions are present.

Obsessions are defined by the following:

- recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety;
- the thoughts, impulses or images are not simply excessive worries about real-life problems;
- the person tries to ignore or suppress such thoughts, impulses or images or to neutralise them; and
- the person realises that the thoughts, impulses or images come from his or her own mind, and are not imposed from without.

Compulsions are defined by the following:

- repetitive behaviours or mental acts that the person feels driven to perform; and
- the behaviours or mental acts are aimed at preventing or reducing distress or some dreaded event or situation, but are not realistic or are clearly excessive.

The content of the obsessions or compulsions is not exclusively a preoccupation with another disorder in the form of feelings of guilt, body shape, weight or eating, drugs, a serious illness, or some combination of these. The obsessions or compulsions cause distress, are time consuming or interfere with the person's normal routine or functioning. The person realises that the obsessions or compulsions are excessive or unreasonable.

Post-traumatic stress disorder (309.81)

Characterised by symptoms lasting more than one month following exposure to an extremely traumatic event in which the person experienced or witnessed an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. Further, the person's response involved intense fear, helplessness or horror.

The traumatic event is persistently re-experienced in one or more of the following ways:

- recollections
- dreams
- acting or feeling as if the event were recurring
- distress when reminded of the event
- physiological reactivity when reminded of the event

In addition, the person exhibits avoidance of things associated with the event evidenced by three or more of the following:

- efforts to avoid thinking, feeling or talking about the event
- efforts to avoid activities, places or people that arouse recollections of the event
- inability to recall aspects of the trauma
- diminished interest or participation in significant events
- feelings of estrangement from others
- restricted range of affect (e.g. unable to have loving feelings)
- sense of a foreshortened future

Further, two or more of the following symptoms of increased arousal are present

- difficulty falling or staying asleep
- irritability
- difficulty concentrating
- hypervigilance
- exaggerated startle response

The disturbance causes significant distress or impairment in functioning.

Generalised anxiety disorder (300.02)

Characterised by excessive anxiety and worry about a number of events or activities, occurring more days than not for at least six months. Three or more of the following symptoms are present (with at least some present for more days that not for the past six months):

- restlessness
- fatigue
- difficulty concentrating
- irritability
- muscle tension
- sleep disturbance

The person finds it difficult to control the worry, and it causes significant distress or impairment in social, occupational or other important areas of functioning. The anxiety and worry are not confined to the features of another disorder (e.g. Panic disorder, Social phobia, Obsessive-compulsive disorder or Post-traumatic stress disorder), and the disturbance does not occur exclusively during a mood disorder.

APPENDIX 3 PERSONALITY DISORDERS SCREENER ..

INTRODUCTION

Personality disorders are characterised by evidence that the person's characteristic and enduring patterns of inner experience and behaviour deviate markedly from the cultural norm. This survey included screening questions for nine ICD–10 personality disorders. It is important to note that these provide indicators of possible prevalence only.

Assessment of the general criteria for personality disorders was limited to the following two criteria:

- the symptoms cause personal distress, or adverse impact on the social environment, or both; and
- the deviation is stable and of long duration, having its onset in late childhood or adolescence.

The specific criteria for each personality disorder in this survey are presented below.

Paranoid personality disorder (F60.0) screener

At least four of the following must be present:

- excessive sensitivity to setbacks and rebuffs
- tendency to bear grudges persistently
- suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others
- combative and tenacious sense of personal rights out of keeping with the actual situation
- recurrent suspicions, without justification, regarding fidelity of sexual partner
- persistent self-referential attitude
- preoccupation with unsubstantiated conspiratorial explanations of events

Schizoid personality disorder (F60.1) screener

At least four of the following must be present:

- few, if any, activities provide pleasure
- emotional coldness, detachment
- a limited capacity to express either warm feelings or anger
- apparent indifference to either praise or criticism
- little interest in having sexual experiences with another person
- consistent choice of solitary activities
- preoccupation with fantasy and introspection
- no desire for, or possession of close friends or confiding relationships (or only one)
- insensitivity to prevailing social norms and conventions

Dissocial personality disorder (F60.2) screener

At least three of the following must be present:

- callous unconcern for the feelings of others
- attitude of irresponsibility and disregard for social norms, rules and obligations
- incapacity to maintain enduring relationships
- low tolerance to frustration, and a low threshold for aggressive behaviour
- incapacity to experience guilt, or to learn from adverse experience

Emotionally unstable personality disorder—impulsive type (F60.30) screener

At least three of the following must be present:
- tendency to act impulsively and without consideration of consequences
- tendency to quarrelsome behaviour and to conflict with others
- liability to outbursts of anger or violence
- difficulty in maintaining any course of action that offers no immediate reward
- unstable and changeable mood

Emotionally unstable personality disorder—borderline type (F60.31) screener

At least three of the following must be present:
- disturbances in and uncertainty about self-image, aims and preferences
- liability to become involved in intense and unstable relationships
- excessive efforts to avoid abandonment
- recurrent threats or acts of self-harm
- chronic feelings of emptiness

Histrionic personality disorder (F60.4) screener

At least four of the following must be present:
- self-dramatisation, theatricality or exaggerated expression of emotions
- suggestibility
- shallow and unstable affectivity
- seeking excitement and activities in which the person is the centre of attention
- inappropriate seductiveness
- overconcern with physical attractiveness

Anankastic personality disorder (F60.5) screener

At least four of the following must be present:
- feelings of excessive doubt and caution
- preoccupations with details
- perfectionism that interferes with task completion
- excessive conscientiousness and scrupulousness
- preoccupation with productivity to the exclusion of pleasure and interpersonal relationships
- excessive formality and adherence to social conventions
- rigidity and stubbornness
- insistence by the person that others submit to his or her way of doing things, or reluctance to allow others to do things

Anxious (avoidant) personality disorder (F60.6) screener

At least four of the following must be present:
- persistent and pervasive feelings of tension and apprehension
- belief that one is socially inept
- excessive preoccupation with being criticised or rejected
- unwillingness to become involved with people unless certain of being liked
- restrictions in lifestyle because of need for physical security
- avoidance of social or occupational activities that involve significant interpersonal contact

Dependent personality disorder (F60.7) screener

At least four of the following must be present:
- allowing others to make one's important life decisions
- subordination of one's own needs to those of others on whom one is dependent
- unwillingness to make reasonable demands on the people one depends on
- feeling uncomfortable or helpless when alone
- fears about being left alone and having to care for oneself
- limited capacity to take everyday decisions without advice and reassurance from others

APPENDIX 4 POTENTIAL MENTAL DISORDERS

The internal sequencing of the CIDI identified a group of respondents as people who may meet the criteria for mental disorder, i.e. they were people with a potential mental disorder. These respondents had a variety of symptoms of mental disorder in the 12 months prior to interview; i.e. recency of 12 months or less. This group was identified by the CIDI (before diagnosis of mental disorder had taken place) in order to ensure that these respondents answered specific questions on disability, service utilisation and perceived need for health services.

This broader group represents 41% of the Australian adult population, compared with 18% with a mental disorder. For some output purposes it may be useful to consider a wider population than those people with a diagnosed mental disorder. For example, in examining perceived need for health services it may be useful to consider all those who had symptoms which indicated a potential mental disorder, whether or not they met the criteria for a diagnosis.

The following potential mental disorders were identified:

- 'Drinking'—symptoms that contribute to a diagnosis of alcohol dependence.
- 'Drugs'—symptoms that contribute to a diagnosis of drug dependence.
- 'Happy-irritable'—symptoms that contribute to a diagnosis of mania.
- 'Sad two plus weeks'—symptoms that contribute to a diagnosis of depression.
- 'Sad two plus years'—symptoms that contribute to a diagnosis of dysthymia.
- 'Fear of travelling'—symptoms that contribute to a diagnosis of agoraphobia.
- 'Social fears'—symptoms that contribute to a diagnosis of social phobia.
- 'Fear of panic'—symptoms that contribute to a diagnosis of panic disorder.
- 'Months of worry'—symptoms that contribute to a diagnosis of generalised anxiety disorder.
- 'Recurrent thoughts'—symptoms that contribute to a diagnosis of obsessive-compulsive disorder.
- 'Traumatic event'—symptoms that contribute to a diagnosis of post-traumatic stress disorder.
- 'Tiredness'—symptoms that contribute to a diagnosis of neurasthenia.

It should be noted that although the SMHWB includes alcohol and drug harmful use/abuse disorders these are not included in the list of potential mental disorders outlined above.

In addition, the following were included as potential mental disorders although they do not lead to a diagnosis of disorder:

- 'Unusual thoughts' corresponds to three of the four items of the Psychosis (screener) endorsed.
- 'Nature-personality' corresponds to symptoms of any personality disorder in the 12 months prior to interview, and also throughout the adult life of the respondent.
- 'Memory problems' corresponds to 12 or more errors on the MMSE.

APPENDIX 5 LIST OF COMMITTEES AND COMMITTEE MEMBERS

INTRODUCTION

A Survey Management Group, Technical Advisory Committee and several expert subcommittees were established to make recommendations on the survey. The contribution of the people who participated is gratefully acknowledged. The following lists are based on membership during the life of the committees.

SURVEY MANAGEMENT GROUP

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Child and Adolescent sub-committee

Professor Robert Kosky, University of Adelaide, chaired an expert committee on The Child and Adolescent Mental Health Study.

Low Prevalence Disorders sub-committee

Professor Assen Jablensky, University of Western Australia, chaired an expert committee on The Low Prevalence (Psychotic) Disorders Study.

APPENDIX 6 DATA ITEM LIST

DATA ITEM	CATEGORIES	POPULATION	FIELD NAME
POPULATION CHARACTERISTICS			
Demographics			
Sex	Male Female	All	A1
Age	18–24 years 25–34 years 35–44 years 45–54 years 55–64 years 65 years and over Other age groupings available on request (subject to confidentiality restrictions)	All	A2
Country of birth	Born in Australia Born outside Australia United Kingdom and Ireland Italy Greece Netherlands Germany New Zealand Viet Nam Poland United States of America Canada South Africa Other	All	A3_1
Year of arrival	Arrived 1980 or before Arrived 1981–85 Arrived 1986–90 Arrived 1991–95 Arrived 1996 or later	All born outside Australia	A4
Number of times married/defacto	0 1–4 (single numbers) 5 or more	All	A15
Marital status	Married De facto Separated Divorced Widowed Never married	All	A15A

DATA ITEM	CATEGORIES	POPULATION	FIELD NAME
Number of children	0 1–5 (single numbers) 6 or more	Females	A15B
Age when only child born	Less than 19 years 19–35 (single years) 36 years or more	Females with one child only	A15C
Age when oldest child born	Less than 19 years 19–35 (single years) 36 years or more	Females with more than one child	A15D
Age when youngest child born	Less than 19 years 19–35 (single years) 36 years or more	Females with more than one child	A15E
Language			
Language usually spoken at home	English Other languages	All	A5A
Education			
Whether attending school	Not applicable Still attending Left school	All aged 18–20 years	A6
Whether completed secondary school	Not applicable Completed secondary school Did not complete secondary school	All aged 21 years and over, and those aged 18–20 years who are no longer attending school.	A8
Whether completed qualification since leaving school	Not applicable Completed qualification Did not complete qualification	All aged 21 years and over, and those aged 18–20 years who are no longer attending school.	A9
Whether currently studying	Not applicable Not currently studying Currently studying full-time Currently studying part-time	All aged 21 years and over, and those aged 18–20 years who are no longer attending school.	A14
Highest qualification	Bachelor degree or higher Undergraduate diploma Associate diploma Skilled vocational qualification Basic vocational qualification	All who completed qualification since leaving school	HQUALDRV

DATA ITEM	CATEGORIES	POPULATION	FIELD NAME
Employment			
Labour force status	Employed full-time Employed part-time Unemployed Not in labour force	All aged 18 years and over who have left school	MHSLFST
Occupation (main job)	Managers and administrators Professionals Associate professionals Tradespersons and related workers Advanced clerical and service workers Intermediate clerical, sales and service workers Intermediate production and transport workers Elementary clerical, sales and service workers Labourers and related workers	All aged 18 years and over who have left school, and worked in a job, business or farm in the week before the interview	OCCUP
Hours usually worked per week	1–14 hours 15–19 hours 20–24 hours 25–29 hours 30–34 hours 35–39 hours 40–49 hours 50 hours or more	All aged 18 years and over who have left school, and worked in a job, business or farm in the week before the interview	A23
Duration of employment	1–51 weeks 52 weeks or more Other groupings available on request (subject to confidentiality restrictions)	All aged 18 years and over who have left school, and have been looking for full-time or part-time work in the 4 weeks before the interview	UNEMPLOY
Income			
Main source of income	Wage or salary Any government pension or allowance or benefit Child support Superannuation/annuity Own business or share in a partnership Rental investment Dividends or Interest Other	All who currently receive income	A30

DATA ITEM	CATEGORIES	POPULATION	FIELD NAME
Dwelling details			
Tenure type	Owner Purchaser Renter Other	All	TENURE1
Household details			
Household type	Person living alone Married/de facto couple only Married/de facto couple living only with their unmarried child(ren) aged 15 years or over Married/de facto couple living only with their child(ren) aged 0–14 years Married/de facto couple living only with their child(ren) aged 0–14 years and their unmarried child(ren) aged 15 years or over One person living only with his/her unmarried child(ren) aged 15 years or over One person living only with his/her child(ren) aged 0–14 years One person living only with his/her child(ren) aged 0–14 years and his/her unmarried child(ren) aged 15 years or over Other family households All other households	All	HOUTYPE
Number of persons in household	0 1–7 (single numbers) 8 or more	All	NUMPERS
Number of children in household	0 1–4 (single numbers) 5 or more	All	KIDTO17
Number of elderly in household	0 1–3 (single numbers) 4 or more	All	OVER64
Number of males in household	0 1–4 (single numbers) 5 or more	All	MALEHH
Number of females in household	0 1–4 (single numbers) 5 or more	All	FEMALEHH

DATA ITEM	CATEGORIES	POPULATION	FIELD NAME
Geography			
State	New South Wales Victoria Queensland South Australia Western Australia Tasmania Northern Territory Australian Capital Territory	All	STATE
Rural, remote and metropolitan areas	Capital city and other metropolitan centre Large/small rural centre Other rural areas and remote area	All	URBANRU
Part of State	Capital city Rest of State	All	PARTOS
Socio-Economic Indexes for Areas (SEIFA)— index of relative socio-economic disadvantage	1st decile 2nd decile 3rd decile 4th decile 5th decile 6th decile 7th decile 8th decile 9th decile 10th decile	All	DLOWSA
SEIFA index of relative social advantage—urban areas	As above	All who live in urban areas	DURBSA
SEIFA index of relative social advantage—rural areas	As above	All who live in rural areas	DRURSA
SEIFA index of economic resources	As above	All	DERSA
SEIFA index of education and occupation	As above	All	DEOSA

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
PHYSICAL CONDITIONS	
Physical : any listed medical conditions	C1
Physical : asthma	C1A
Physical : bronchitis	C2
Physical : anaemia	C3
Physical : blood pressure	C4
Physical : heart trouble	C5
Physical : arthritis	C6
Physical : kidney disease	C7
Physical : diabetes	C8
Physical : cancer	C9
Physical : stomach or duodenal ulcer	C10
Physical : liver or gallbladder trouble	C11
Physical : hernia or rupture	C12
ICD–10 CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS	
Neurasthenia	F48_0
Neurasthenia : onset	F48_0A
Neurasthenia : recency	F48_0C
Neurasthenia : duration	DURF480
Substance use disorders—alcohol	
Dependence syndrome : alcohol	F10_2
Dependence syndrome : alcohol—onset	J20_ONS
Dependence syndrome : alcohol—recency	J20_REC
Dependence syndrome : alcohol—duration	DURF102
Harmful use : alcohol	F10_1
Harmful use : alcohol—onset	J8_ONS
Harmful use : alcohol—recency	J8_REC
Harmful use : alcohol—duration	DURF101
Substance use disorders–drugs	
Dependence syndrome : opioids	F11_2
Dependence syndrome : opioids—onset	L24_4ONS
Dependence syndrome : opioids—recency	L24_4REC
Dependence syndrome : opioids—duration	DURF112
Dependence syndrome : cannabinoids	F12_2
Dependence syndrome : cannabinoids—onset	L24_1ONS
Dependence syndrome : cannabinoids—recency	L24_1REC
Dependence syndrome : cannabinoids—duration	DURF122
Dependence syndrome : sedatives	F13_2
Dependence syndrome : sedatives—onset	L24_3ONS
Dependence syndrome : sedatives—recency	L24_3REC
Dependence syndrome : sedatives—duration	DURF132
Dependence syndrome : stimulants	F15_2
Dependence syndrome : stimulants—onset	L24_2ONS
Dependence syndrome : stimulants—recency	L24_2REC
Dependence syndrome : stimulants—duration	DURF152

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
Substance use disorders—drugs *continued*	
Harmful use : opioids	F11_1
Harmful use : opioids—onset	L11_4ONS
Harmful use : opioids—recency	L11_4REC
Harmful use : opioids—duration	DURF111
Harmful use : cannabinoids	F12_1
Harmful use : cannabinoids—onset	L11_1ONS
Harmful use : cannabinoids—recency	L11_1REC
Harmful use : cannabinoids—duration	DURF121
Harmful use : sedatives or hypnotics	F13_1
Harmful use : sedatives or hypnotics—onset	L11_3ONS
Harmful use : sedatives or hypnotics—recency	L11_3REC
Harmful use : sedatives or hypnotics—duration	DURF131
Harmful use : stimulants	F15_1
Harmful use : stimulants—onset	L11_2ONS
Harmful use : stimulants—recency	L11_2REC
Harmful use : stimulants—duration	DURF151
Affective disorders	
Hypomania	F30_0
Hypomania : onset	F30_0A
Hypomania : recency	F30_0C
Hypomania : duration	DURF300
Mania without psychotic symptoms	F30_1
Mania without psychotic symptoms : onset	F30_1A
Mania without psychotic symptoms : recency	F30_1C
Mania without psychotic symptoms : duration	DURF301
Mania with psychotic symptoms	F30_2
Mania with psychotic symptoms : onset	F30_2A
Mania with psychotic symptoms : recency	F30_2C
Mania with psychotic symptoms : duration	DURF302
Mild depressive episode	F32_0
Mild depressive episode : onset	F32_0A
Mild depressive episode : recency	F32_0C
Mild depressive episode : duration	DURF320
Moderate depressive episode	F32_1
Moderate depressive episode : onset	F32_1A
Moderate depressive episode : recency	F32_1C
Moderate depressive episode : duration	DURF321
Severe depressive episode without psychotic symptoms	F32_2
Severe depressive episode without psychotic symptoms : onset	F32_2A
Severe depressive episode without psychotic symptoms : recency	F32_2C
Severe depressive episode without psychotic symptoms : duration	DURF322
Mild depressive episode without somatic syndrome	F32_00
Mild depressive episode without somatic syndrome : onset	F32_00A
Mild depressive episode without somatic syndrome : recency	F32_00C
Mild depressive episode without somatic syndrome : duration	DURF3200
Mild depressive episode with somatic syndrome	F32_01
Mild depressive episode with somatic syndrome : onset	F32_01A
Mild depressive episode with somatic syndrome : recency	F32_01C

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
Affective disorders *continued*	
Mild depressive episode with somatic syndrome : duration	DURF3201
Moderate depressive episode without somatic syndrome	F32_10
Moderate depressive episode without somatic syndrome : onset	F32_10A
Moderate depressive episode without somatic syndrome : recency	F32_10C
Moderate depressive episode without somatic syndrome : duration	DURF3210
Moderate depressive episode with somatic syndrome	F32_11
Moderate depressive episode with somatic syndrome : onset	F32_11A
Moderate depressive episode with somatic syndrome : recency	F32_11C
Moderate depressive episode with somatic syndrome : duration	DURF3211
Recurrent depressive episode : mild—without somatic syndrome	F33_00
Recurrent depressive episode : mild—without somatic syndrome—onset	F33_00A
Recurrent depressive episode : mild—without somatic syndrome—recency	F33_00C
Recurrent depressive episode : mild—without somatic syndrome—duration	DURF3300
Recurrent depressive episode : mild—with somatic syndrome	F33_01
Recurrent depressive episode : mild—with somatic syndrome—onset	F33_01A
Recurrent depressive episode : mild—with somatic syndrome—recency	F33_01C
Recurrent depressive episode : mild—with somatic syndrome—duration	DURF3301
Recurrent depressive episode : moderate—without somatic syndrome	F33_10
Recurrent depressive episode : moderate—without somatic syndrome—onset	F33_10A
Recurrent depressive episode : moderate—without somatic syndrome—recency	F33_10C
Recurrent depressive episode : moderate—without somatic syndrome—duration	DURF3310
Recurrent depressive episode : moderate—with somatic syndrome	F33_11
Recurrent depressive episode : moderate—with somatic syndrome—onset	F33_11A
Recurrent depressive episode : moderate—with somatic syndrome—recency	F33_11C
Recurrent depressive episode : moderate—with somatic syndrome—duration	DURF3311
Recurrent depressive episode : severe—without psychotic symptoms	F33_2
Recurrent depressive episode : severe—without psychotic symptoms—onset	F33_2A
Recurrent depressive episode : severe—without psychotic symptoms—recency	F33_2C
Recurrent depressive episode : severe—without psychotic symptoms—duration	DURF332
Bipolar affective disorder	F31
Bipolar affective disorder : onset	F31A
Bipolar affective disorder : recency	F31C
Bipolar affective disorder : duration	DURF31
Dysthymia	F34_1
Dysthymia : recency	F34_1C
Dysthymia : duration	DURF341
Anxiety disorders	
Panic disorder	F41_0
Panic disorder : onset	F41_0A
Panic disorder : recency	F41_0C
Panic disorder : duration	DURF410
Panic disorder : moderate	F41_00
Panic disorder : moderate—onset	F41_00A
Panic disorder : moderate—recency	F41_00C
Panic disorder : moderate—duration	DURF4100

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
Anxiety disorders *continued*	
Panic disorder : severe	F41_01
Panic disorder : severe—onset	F41_01A
Panic disorder : severe—recency	F41_01C
Panic disorder : severe—duration	DURF4101
Agoraphobia	F40_0
Agoraphobia : onset	F40_0A
Agoraphobia : recency	F40_0C
Agoraphobia : duration	DURF400
Agoraphobia without panic disorder	F40_00
Agoraphobia without panic disorder : onset	F40_00A
Agoraphobia without panic disorder : recency	F40_00C
Agoraphobia without panic disorder : duration	DURF4000
Agoraphobia with panic disorder	F40_01
Agoraphobia with panic disorder : onset	F40_01A
Agoraphobia with panic disorder : recency	F40_01C
Agoraphobia with panic disorder : duration	DURF4001
Social phobia	F40_1
Social phobia : onset	F40_1A
Social phobia : recency	F40_1C
Social phobia : duration	DURF401
Generalised anxiety disorder	F41_1
Generalised anxiety disorder : onset	F41_1A
Generalised anxiety disorder : recency	F41_1C
Generalised anxiety disorder : duration	DURF411
Obsessive-compulsive disorder : predominantly obsessional thoughts or ruminations	F42_0
Obsessive-compulsive disorder : thoughts—onset	F42_0A
Obsessive-compulsive disorder : thoughts—recency	F42_0C
Obsessive-compulsive disorder : thoughts—duration	DURF420
Obsessive-compulsive disorder : predominantly compulsive behaviours	F42_1
Obsessive-compulsive disorder : behaviours—onset	F42_1A
Obsessive-compulsive disorder : behaviours—recency	F42_1C
Obsessive-compulsive disorder : behaviours—duration	DURF421
Obsessive-compulsive disorder : mixed thoughts and behaviours	F42_2
Obsessive-compulsive disorder : mixed—onset	F42_2A
Obsessive-compulsive disorder : mixed—recency	F42_2C
Obsessive-compulsive disorder : mixed—duration	DURF422
Post-traumatic stress disorder	F43_1
Post-traumatic stress disorder : onset	F43_1A
Post-traumatic stress disorder : recency	F43_1C
Post-traumatic stress disorder : duration	DURF431

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
DSM–IV CLASSIFICATION OF MENTAL DISORDERS	
Substance related disorders—alcohol	
Alcohol dependence	D303_90
Alcohol dependence—onset	J20_ONS
Alcohol dependence—recency	J20_REC
Alcohol dependence—duration	DURF102
Alcohol abuse	D305_00
Alcohol abuse—onset	J8_ONS
Alcohol abuse—recency	J8_REC
Alcohol abuse—duration	DURF101
Substance related disorders–drugs	
Opioid dependence	D304_00
Opioid dependence—onset	L24_4ONS
Opioid dependence—recency	L24_4REC
Opioid dependence—duration	DURF112
Cannabis dependence	D304_30
Cannabis dependence—onset	L24_1ONS
Cannabis dependence—recency	L24_1REC
Cannabis dependence—duration	DURF122
Sedative dependence	D304_10
Sedative dependence—onset	L24_3ONS
Sedative dependence—recency	L24_3REC
Sedative dependence—duration	DURF132
Amphetamine dependence	D304_40
Amphetamine dependence—onset	L24_2ONS
Amphetamine dependence—recency	L24_2REC
Amphetamine dependence—duration	DURF152
Opioid abuse	D305_50
Opioid abuse—onset	L11_4ONS
Opioid abuse—recency	L11_4REC
Opioid abuse—duration	DURF111
Cannabis abuse	D305_20
Cannabis abuse—onset	L11_1ONS
Cannabis abuse—recency	L11_1REC
Cannabis abuse—duration	DURF121
Sedative abuse	D305_40
Sedative abuse—onset	L11_3ONS
Sedative abuse—recency	L11_3REC
Sedative abuse—duration	DURF131
Amphetamine abuse	D305_70
Amphetamine abuse—onset	L11_2ONS
Amphetamine abuse—recency	L11_2REC
Amphetamine abuse—duration	DURF151

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
Mood (affective) disorders	
Major depressive disorder : single episode—mild	D296_21
Major depressive disorder : single episode—mild—onset	D296_21A
Major depressive disorder : single episode—mild—recency	D296_21C
Major depressive disorder : single episode—moderate	D296_22
Major depressive disorder : single episode—moderate—onset	D296_22A
Major depressive disorder : single episode—moderate—recency	D296_22C
Major depressive disorder : single episode—severe without psychotic features	D296_23
Major depressive disorder : single episode—severe without psychotic features—onset	D296_23A
Major depressive disorder : single episode—severe without psychotic features—recency	D296_23C
Major depressive disorder : recurrent—mild	D296_31
Major depressive disorder : recurrent—mild—onset	D296_31A
Major depressive disorder : recurrent—mild—recency	D296_31C
Major depressive disorder : recurrent—moderate	D296_32
Major depressive disorder : recurrent—moderate—onset	D296_32A
Major depressive disorder : recurrent—moderate—recency	D296_32C
Major depressive disorder : recurrent—severe without psychotic features	D296_33
Major depressive disorder : recurrent—severe without psychotic features—onset	D296_33A
Major depressive disorder : recurrent—severe without psychotic features—recency	D296_33C
Bipolar I disorder : single manic episode—mild	D296_01
Bipolar I disorder : single manic episode—mild—onset	D296_01A
Bipolar I disorder : single manic episode—mild—recency	D296_01C
Bipolar I disorder : single manic episode—moderate	D296_02
Bipolar I disorder : single manic episode—moderate—onset	D296_02A
Bipolar I disorder : single manic episode—moderate—recency	D296_02C
Bipolar I disorder : single manic episode—severe	D296_03
Bipolar I disorder : single manic episode—severe—onset	D296_03A
Bipolar I disorder : single manic episode—severe—recency	D296_03C
Bipolar I disorder : manic—mild	D296_41
Bipolar I disorder : manic—mild—onset	D296_41A
Bipolar I disorder : manic—mild—recency	D296_41C
Bipolar I disorder : manic—moderate	D296_42
Bipolar I disorder : manic—moderate—onset	D296_42A
Bipolar I disorder : manic—moderate—recency	D296_42C
Bipolar I disorder : manic—severe	D296_43
Bipolar I disorder : manic—severe—onset	D296_43A
Bipolar I disorder : manic—severe—recency	D296_43C
Bipolar II disorder	D296_89
Bipolar II disorder : onset	D296_89A
Bipolar II disorder : recency	D296_89C
Dysthymic disorder	D300_4
Anxiety disorders	
Obsessive-compulsive disorder	D300_3
Obsessive-compulsive disorder : onset	D300_3A
Obsessive-compulsive disorder : recency	D300_3C
Post-traumatic stress disorder	D309_81
Post-traumatic stress disorder : onset	D309_81A
Post-traumatic stress disorder : recency	D309_81C

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
Anxiety disorders *continued*	
Panic disorder without agoraphobia	D300_01
Panic disorder without agoraphobia : onset	D300_01A
Panic disorder without agoraphobia : recency	D300_01C
Panic disorder with agoraphobia	D300_21
Panic disorder with agoraphobia : onset	D300_21A
Panic disorder with agoraphobia : recency	D300_21C
Agoraphobia without history of panic disorder	D300_22
Agoraphobia without history of panic disorder : onset	D300_22A
Agoraphobia without history of panic disorder : recency	D300_22C
Social phobia	D300_23
Social phobia : onset	D300_23A
Social phobia : recency	D300_23C
Generalised anxiety disorder	D300_02
Generalised anxiety disorder : onset	D300_02A
Generalised anxiety disorder : recency	D300_02C
PERSONALITY DISORDERS SCREENER	
Paranoid personality disorder	F60_0
Paranoid personality disorder : onset	F60_0A
Paranoid personality disorder : recency	F60_0C
Paranoid personality disorder : duration	DURF600
Schizoid personality disorder	F60_1
Schizoid personality disorder : onset	F60_1A
Schizoid personality disorder : recency	F60_1C
Schizoid personality disorder : duration	DURF601
Dissocial personality disorder	F60_2
Dissocial personality disorder : onset	F60_2A
Dissocial personality disorder : recency	F60_2C
Dissocial personality disorder : duration	DURF602
Impulsive personality disorder	F60_30
Impulsive personality disorder : onset	F60_30A
Impulsive personality disorder : recency	F60_30C
Impulsive personality disorder : duration	DURF6030
Borderline personality disorder	F60_31
Borderline personality disorder : onset	F60_31A
Borderline personality disorder : recency	F60_31C
Borderline personality disorder : duration	DURF6031
Histrionic personality disorder	F60_4
Histrionic personality disorder : onset	F60_4A
Histrionic personality disorder : recency	F60_4C
Histrionic personality disorder : duration	DURF604
Anankastic personality disorder	F60_5
Anankastic personality disorder : onset	F60_5A
Anankastic personality disorder : recency	F60_5C
Anankastic personality disorder : duration	DURF605

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
PERSONALITY DISORDERS SCREENER *continued*	
Anxious personality disorder	F60_6
Anxious personality disorder : onset	F60_6A
Anxious personality disorder : recency	F60_6C
Anxious personality disorder : duration	DURF606
Dependent personality disorder	F60_7
Dependent personality disorder : onset	F60_7A
Dependent personality disorder : recency	F60_7C
Dependent personality disorder : duration	DURF607
PSYCHOSIS SCREENER	
Psychosis : interfered with or controlled thoughts	G1
Psychosis : hard for others to believe	G1A
Psychosis : feel people too interested	G2
Psychosis : feel things arranged specially	G2A
Psychosis : special powers	G3
Psychosis : belong to a group with powers	G3A
Psychosis : has a doctor said schizophrenia	G4
OTHER MEASURES	
Score on Kendler's neuroticism items from the EPQ	EPQ12
Score on Kessler's Psychological Distress Scale	KESLR10
Number of medical conditions present	MEDCON
Psychosis screener questions	PSYCH
Score on MMSE	MMSE
Likert score on the GHQ–12	GHQLIK
GHQ–12 score on the GHQ–12	GHQGHQ
Delighted–Terrible : feel about life as a whole	B40
DISABILITY	
SF–12	
SF–12 physical summary scale score	PCS_12
SF–12 mental summary scale score	MCS_12
Brief disability questionnaire	
Total BDQ score (WHO)	BDQWHO
Total BDQ score (MOS)	BDQMOS
Number of days effected by disability	BDQALD
BDQ score for main problem/positive diagnosis	BDQMAIN

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
SERVICE UTILISATION AND DAYS OUT OF ROLE	
Physical conditions	
Physical : doctor consultations	C13
Physical : total days out of role	C14
Physical : partial days out of role	C15
SF–12	
SF–12 : doctor consultations	B13
SF–12 : total days out of role	B14
SF–12 : partial days out of role	B15
Neurasthenia	
Neurasthenia : doctor consultations	C27
Neurasthenia : total days out of role	C28
Neurasthenia : partial days out of role	C29
Anxiety (panic disorder, agoraphobia, social phobia and generalised anxiety disorder)	
Anxiety : doctor consultancies	D70
Anxiety : total days out of role	D71
Anxiety : partial days out of role	D72
Depressive disorders and dysthymic disorder	
Depressive disorders : doctor consultancies	E55
Depressive disorders : total days out of role	E56
Depressive disorders : partial days out of role	E57
Manic and bipolar disorders	
Mania : doctor consultations	F24
Mania : total days out of role	F25
Mania : partial days out of role	F26
Obsessive-dompulsive disorder	
Obsessive-dompulsive disorder : doctor consultations	K21A
Obsessive-dompulsive disorder : total days out of role	K21B
Obsessive-dompulsive disorder : partial days out of role	K21C
Post-traumatic stress disorder	
Post-traumatic stress disorder : doctor consultations	K46
Post-traumatic stress disorder : total days out of role	K47
Post-traumatic stress disorder : partial days out of role	K48
Alcohol	
Alcohol : doctor consultations	J21
Alcohol : total days out of role	J22
Alcohol : partial days out of role	J23

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
Drugs	
Drugs : doctor consultancies	L25
Drugs : total days out of role	L26
Drugs : partial days out of role	L27
OTHER DATA ITEMS	
Suicide	
Depression : thinking about death	E18_I
Depression : thought about committing suicide	E19_I
Depression : made a plan to commit suicide	E19A_I
Depression : attempted suicide (last 12 months)	E20_I
Suicide : ever thought about suicide	E58
Suicide : ever attempted suicide	E59
Suicide : attempted suicide in last 12 months	E59A
Smoking	
Smoking : currently	C30
Smoking : regularly smoke	C31
Smoking : ever smoked regularly	C32
POTENTIAL MENTAL DISORDERS	
Any potential disorder	LIKDIAG0
Tiredness	LIKDIAG1
Social fears	LIKDIAG2
Fear travelling	LIKDIAG3
Fear of panic	LIKDIAG4
Months of worry	LIKDIAG5
Sad 2+ years	LIKDIAG6
Sad 2+ weeks	LIKDIAG7
Happy/irritable	LIKDIAG8
Unusual ideas	LIKDIAG9
Memory failure	LIKDIA10
Recurrent thoughts	LIKDIA11
Traumatic event	LIKDIA12
Nature/personality	LIKDIA13
Drug use	LIKDIA14
Drinking	LIKDIA15

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
HEALTH SERVICE UTILISATION AND PERCEIVED HEALTH NEEDS	
Hospital admissions	
Hospital : one night any hospital	R1
Hospital : overnight general hospital	R2
Hospital : admission to general hospital for physical condition	R2A
Hospital : times in general hospital for physical condition	R2A_1
Hospital : nights in general hospital for physical condition	R2A_2
Hospital : admission to general hospital for mental problem	R2B
Hospital : times in general hospital for mental problem	R2B_1
Hospital : nights in general hospital for mental problem	R2B_2
Hospital : public or private general hospital	R2B_3
Hospital : admission to psychiatric hospital	R3
Hospital : times in psychiatric hospital	R3A_1
Hospital : nights in psychiatric hospital	R3A_2
Hospital : public or private psychiatric hospital	R3A_3
Hospital : admission to drug and alcohol unit in a hospital	R4
Hospital : times in drug and alcohol unit in a hospital	R4A_1
Hospital : nights in drug and alcohol unit in a hospital	R4A_2
Hospital : public or private drug and alcohol unit	R4A_3
Hospital : other hospital	R4A_4
Health professional consultations	
Professional : any health practitioners	R5
Professional : general practitioner	R5A_1
Professional : radiologist	R5A_2
Professional : pathologist	R5A_3
Professional : physician or other medical specialist	R5A_4
Professional : surgical specialist or gynaecologist	R5A_5
Professional : psychiatrist	R5A_6
Professional : psychologist	R5A_7
Professional : social worker or welfare officer or welfare officer	R5A_8
Professional : drug and alcohol counsellor	R5A_9
Professional : other counsellor	R5A_10
Professional : nurse	R5A_11
Professional : mental health team	R5A_12
Professional : chemist	R5A_13
Professional : ambulance officer	R5A_14
Professional : other health professional	R5A_15
Professional : times general practitioner	R6_1
Professional : times general practitioner for mental problem	R7_1
Professional : where general practitioner	R8_1
Professional : times radiologist	R6_2
Professional : times radiologist for mental problem	R7_2
Professional : where radiologist	R8_2
Professional : times pathologist	R6_3
Professional : times pathologist for mental problem	R7_3
Professional : where pathologist	R8_3
Professional : times physician or other medical specialist	R6_4
Professional : times physician or other medical specialist for mental problem	R7_4
Professional : where physician or other medical specialist	R8_4

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
Health professional consultations *continued*	
Professional : times surgical specialist or gynaecologist	R6_5
Professional : times surgical specialist or gynaecologist for mental problem	R7_5
Professional : where surgical specialist or gynaecologist	R8_5
Professional : times psychiatrist	R6_6
Professional : times psychiatrist for mental problem	R7_6
Professional : where psychiatrist	R8_6
Professional : times psychologist	R6_7
Professional : times psychologist for mental problem	R7_7
Professional : where psychologist	R8_7
Professional : times social worker or welfare officer	R6_8
Professional : times social worker or welfare officer for mental problem	R7_8
Professional : where social worker or welfare officer	R8_8
Professional : times drug and alcohol counsellor	R6_9
Professional : times drug and alcohol counsellor for mental problem	R7_9
Professional : where drug and alcohol counsellor	R8_9
Professional : times other counsellor	R6_10
Professional : times other counsellor for mental problem	R7_10
Professional : where other counsellor	R8_10
Professional : times nurse	R6_11
Professional : times nurse for mental problem	R7_11
Professional : where nurse	R8_11
Professional : times mental health team	R6_12
Professional : times mental health team for mental problem	R7_12
Professional : where mental health team	R8_12
Professional : times chemist	R6_13
Professional : times chemist for mental problem	R7_13
Professional : where chemist	R8_13
Professional : times ambulance	R6_14
Professional : times ambulance for mental problem	R7_14
Professional : where ambulance	R8_14
Professional : times other professional	R6_15
Professional : times other professional for mental problem	R7_15
Professional : where other professional	R8_15
Perceived need for help	
Perceived need : information	R9_1
Perceived need : medicine	R9_2
Perceived need : psychotherapy	R9_3
Perceived need : cognitive behaviour therapy	R9_4
Perceived need : counselling	R9_5
Perceived need : house money problems	R9_6
Perceived need : ability work	R9_7
Perceived need : look after self	R9_8
Perceived need : meet people	R9_9
Perceived need : other	R9_10
Perceived need : main problem—information	R9A_1
Perceived need : main problem—medicine	R9A_2
Perceived need : main problem—psychotherapy	R9A_3
Perceived need : main problem—cognitive behaviour therapy	R9A_4

DATA ITEM GROUP / FIELD DESCRIPTION LABEL	FIELD NAME
Perceived need for help *continued*	
Perceived need : main problem—counselling	R9A_5
Perceived need : main problem—house money	R9A_6
Perceived need : main problem—ability to work	R9A_7
Perceived need : main problem—look after self	R9A_8
Perceived need : main problem—meet people	R9A_9
Perceived need : main problem—other	R9A_10
Perceived need : most help with main problem	R9B
Perceived need : information—get enough help	R10_1A
Perceived need : information—get more help	R10_1B
Perceived need : information—needed help	R10_2A
Perceived need : information—why didn't get	R10_2B
Perceived need : medicine—get enough help	R11_1A
Perceived need : medicine—get more help	R11_1B
Perceived need : medicine—needed help	R11_2A
Perceived need : medicine—why didn't get	R11_2B
Perceived need : therapy—get enough help	R12_1A
Perceived need : therapy—get more help	R12_1B
Perceived need : therapy—needed help	R12_2A
Perceived need : therapy—why didn't get	R12_2B
Perceived need : practical issues—get enough help	R13_1A
Perceived need : practical issues—get more help	R13_1B
Perceived need : practical issues—needed help	R13_2A
Perceived need : practical issues—why didn't get	R13_2B
Perceived need : self care ability—get enough help	R14_1A
Perceived need : self care ability—get more help	R14_1B
Perceived need : self care ability—needed help	R14_2A
Perceived need : self care ability—why didn't get	R14_2B
Perceived need : needed information	R15
Perceived need : why didn't get information	R15A
Perceived need : needed medicine	R16
Perceived need : why didn't get medicine	R16A
Perceived need : needed counselling therapy	R17
Perceived need : why didn't get counselling therapy	R17A
Perceived need : needed practical issues help	R18
Perceived need : why didn't get practical issues help	R18A
Perceived need : needed improve self care ability	R19
Perceived need : why didn't get help self care ability	R19A

APPENDIX 7 STANDARD ERRORS

ESTIMATION PROCEDURES

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 as described on page 34.

RELIABILITY OF THE ESTIMATES

Two types of error may arise 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 from the survey are based on information obtained from a random selection of 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 persons had been included in the survey.

One measure of the likely difference is given by the 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 persons had been included, and about 19 chances in 20 that the difference will be less than two SEs. Another measure of the likely difference is the 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.

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.

Space does not allow for the separate indication of the SEs of all published estimates. A table of SEs and RSEs for national estimates of numbers of persons is given in table A7.1. These figures will not give a precise measure of the SE for a particular estimate but will provide an indication of its magnitude. Table A7.2 provides RSEs for the States and Territories and is presented in order to allow users to determine the capacity of the survey to provide State estimates. Note that the survey does not support estimates for Tasmania and the Northern Territory.

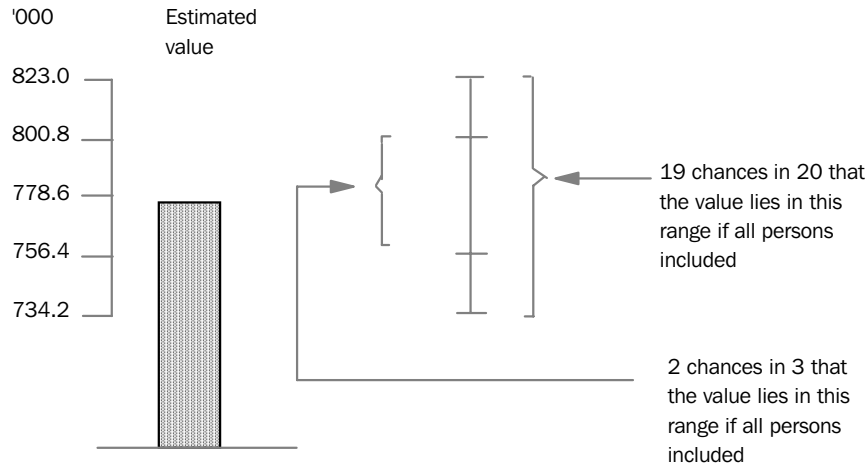
CALCULATION OF STANDARD ERRORS

As the SEs in table A7.1 show, 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. For the SMHWB, 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 in published results and are preceded by an asterisk (e.g. *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 (e.g. **3.4). Such estimates are considered unreliable for most uses.

The estimated number of persons who had an affective disorder in the 12 months prior to interview was 778,600. Using table A7.1 the SE is calculated as follows:

- The size of the estimate lies between 500,000 and 1,000,000. The corresponding SEs for these two numbers in table A7.1 are 19,400 and 24,450.
- The SE for 778,600 is calculated by interpolation using the following formula:
  SE = lower SE + ((size of estimate – lower size) / (upper size – lower size)) x (upper SE – lower SE)
  = 19,400 + ((778,600 – 500,000) / (1,000,000 – 500,000)) x (24,450 – 19,400)
  = 22,200 (rounded to the nearest hundred)

Therefore, there are about two chances in three that the value that would have been produced if all dwellings had been included in the survey will fall in the range of 756,400 to 800,800 and about 19 chances in 20 that the value will fall within the range 734,200 to 823,000. This example is illustrated in the following diagram.



STANDARD ERRORS OF PROPORTIONS AND PERCENTAGES

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. A formula to approximate the RSE of a proportion or percentage (based on person estimates) is given below:

$$RSE\ (x/y) = \sqrt{\ ([RSE(x)]^2 - RSE(y)]^2\ )}$$

As an example, there were 8.6% of males aged 18–24 years with an anxiety disorder during the last 12 months; the numerator is approximately 79,300 and the denominator is approximately 921,900. The SE of 921,900 is approximately 23,700, so the RSE is 2.6%. The SE of 79,300 is approximately 9,200, so the RSE is 11.6%. Applying the above formula, the RSE of the percentage is $\sqrt{\ [\ (11.6)^2 - (2.6)^2\ ]}$ or 11.3%, giving a SE for the proportion (8.6%) of 1.0 percentage points. Therefore, there are about two chances in three that the percentage of men aged 18–24 years who experienced an anxiety disorder is between 7.6% and 9.6% and 19 chances in 20 that the proportion is within the range 6.6% and 10.6%.

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, i.e. 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.

STANDARD ERRORS OF DIFFERENCES

As with estimates of proportions and percentages, published figures may also be used to estimate the difference between survey estimates (of numbers or percentages). Such a figure is itself an estimate and 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:

$$SE\ (x-y) = \sqrt{([SE(x)]^2 + [SE(y)]^2)}$$

While this formula will only be exact for differences between separate and uncorrelated characteristics or sub-populations it is likely to give reasonable SE estimates for the differences likely to be of interest.

STANDARD ERRORS OF STANDARDISED RATES

For age standardised rates for Australia, there is little difference in calculating RSEs to those given in table A7.1. Calculations of SEs for age standardised rates therefore remain as described above.

A7.1 STANDARD AND RELATIVE STANDARD ERRORS(a) OF PERSON ESTIMATES

Size of estimate	*SE* no.	*RSE(a)* %
(b)1 000	820	82.0
(b)1 500	1 070	71.3
(b)2 000	1 280	64.0
(b)2 500	1 500	60.0
(b)3 000	1 650	55.0
(b)3 500	1 800	51.4
(c)4 000	1 950	48.8
(c)5 000	2 250	45.0
(c)7 000	2 750	39.3
(c)10 000	3 350	33.5
(c)15 000	4 150	27.7
20 000	4 800	24.0
30 000	5 900	19.7
40 000	6 800	17.0
50 000	7 550	15.1
100 000	10 350	10.4
150 000	12 250	8.2
200 000	13 800	6.9
300 000	16 150	5.4
500 000	19 400	3.9
1 000 000	24 450	2.4
2 000 000	30 050	1.5
5 000 000	38 000	0.8
10 000 000	44 050	0.4

(a) Shows these for Australia as a percentage of the estimate.

(b) Estimates with a RSE of 50% or more. These estimates are considered unreliable for most purposes.

(c) Estimates with a RSE between 25% and less than 50%. These estimates should be treated with caution.

A7.2 RELATIVE STANDARD ERRORS(a) OF PERSON ESTIMATES

Size of estimate	*NSW*	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*
700	102.3	92.6	103.8	107.9	101.8	158.3	72.2	54.6
1 000	90.2	83.7	89.5	91.7	87.9	113.2	54.3	45.1
1 500	77.6	73.7	75.2	75.7	73.8	79.0	40.1	36.2
2 000	69.3	66.9	66.2	65.9	65.0	61.9	32.8	31.0
2 500	63.4	61.7	59.8	59.1	58.7	51.7	28.3	27.4
3 000	58.8	57.7	55.0	53.9	53.9	44.8	25.2	24.8
3 500	55.1	54.4	51.2	49.9	50.1	39.8	22.9	22.8
4 000	52.0	51.6	48.0	46.6	47.0	36.1	21.2	21.2
5 000	47.1	47.0	43.2	41.5	42.1	30.7	18.7	18.8
7 000	40.5	40.7	36.6	34.8	35.6	24.4	15.6	15.6
10 000	34.2	34.6	30.6	28.7	29.6	19.5	13.1	12.8
15 000	28.1	28.4	24.8	22.9	23.8	15.3	11.0	10.2
20 000	24.2	24.5	21.3	19.5	20.3	13.1	9.8	8.7
30 000	19.6	19.7	17.0	15.4	16.2	10.7	8.6	6.9
40 000	16.8	16.8	14.5	13.0	13.7	9.4	7.9	5.9
50 000	14.8	14.7	12.8	11.4	12.0	8.6	7.4	5.2
100 000	9.9	9.6	8.5	7.4	7.8	6.7	6.5	3.5
150 000	7.7	7.3	6.7	5.7	6.0	6.0	6.2	2.8
200 000	6.5	6.0	5.6	4.8	5.0	5.6	. .	2.4
300 000	5.0	4.5	4.3	3.6	3.8	5.2	. .	1.9
500 000	3.5	3.1	3.1	2.6	2.7	4.8	. .	. .
1 000 000	2.2	1.8	1.9	1.6	1.6	. .	. .	. .
2 000 000	1.3	1.0	1.2	1.0	1.0	. .	. .	. .
5 000 000	0.6	0.4	0.6	. .	. .	. .	. .	. .

(a) Shows the SE as a percentage of the estimate.

Note: Estimates with a RSE of 50% or more are considered unreliable for most purposes. Estimates with an RSE between 25% and less than 50% should be treated with caution.

GLOSSARY

Affective/mood disorders	Mood disturbance. Includes mania, hypomania, bipolar affective disorder, depression 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.
Anankastic personality disorder	Characterised by feelings of doubt, perfectionism, excessive conscientiousness, rigidity and preoccupation with details.
Anxiety disorders	Feelings of tension, distress or nervousness. Includes Agoraphobia, Social phobia, Panic disorder, Generalised anxiety disorder, Obsessive-compulsive disorder, and Post-traumatic stress disorder.
Anxious (avoidant) personality disorder	Characterised by tension, apprehension, insecurity, feelings of inferiority, fear of rejection and restricted personal attachments.
Bipolar disorders	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).
Brief Disability Questionnaire	A standard questionnaire which measures general levels of disability.
Comorbidity	The occurrence of more than one disorder at the same time.
Composite International Diagnostic Interview	A comprehensive modular interview which can be used to assess current and lifetime prevalence of mental disorders through the measurement of symptoms and their impact on day-to-day activities.
Country of birth	Classified as Australia, main English-speaking (comprises New Zealand, the United Kingdom, Ireland, Canada, United States of America and South Africa) or Other.
Days out of role	Number of days in the four weeks prior to interview respondents were unable to carry out usual activities.
Delighted–Terrible Scale	An overall rating from the respondent regarding their life as a whole: delighted, pleased, mostly satisfied, mixed, mostly dissatisfied, unhappy, or terrible.
Dependent personality disorder	Characterised by a pervasive reliance on others to make decisions, fear of abandonment and feelings of helplessness and incompetence.
Depression	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	A measure which uses the Brief Disability Questionnaire score to characterise respondents as having none (score of 0–2), mild (3–4), moderate (5–9) or severe (10 or more).
Dissocial personality disorder	Characterised by repeated harm or deception of others, a lack of feelings of remorse and indifference to social rules.

DSM–IV Diagnostic and Statistical Manual of Mental Disorders—fourth edition. The DSM–IV focuses on clinical, research and educational purposes, supported by an extensive empirical foundation.

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

Emotionally unstable personality disorder—borderline type Characterised by chronic feelings of uncertainty, abandonment and emptiness; and unstable personal relationships.

Emotionally unstable personality disorder— impulsive type Characterised by emotional instability, a lack of impulsive control and a tendency to quarrelsome behaviour.

Eysenck Personality Questionnaire—Neuroticism A general measure of mental health and wellbeing which measures a person's perception of themselves as emotional or sensitive.

General Health Questionnaire–12 item scale A general measure of mental health and wellbeing which was designed to detect psychiatric disorders among respondents in community settings. It does not provide clinical diagnoses.

Generalised anxiety disorder Unrealistic or excessive anxiety and worry about two or more life circumstances for six months or more during which the person has these concerns more days than not.

Histrionic personality disorder Characterised by dramatic behaviour, a tendency to draw attention to oneself, exaggerated expression of emotions, egocentricity and easily hurt feelings.

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.

ICD–10 International Classification of Diseases—10th revision. The ICD is produced by the World Health Organization and is used in the diagnosis, study and classification of diseases, Chapter V is related specifically to mental and behavioural disorders.

Kessler–10 A scale of current psychological distress that asks about negative emotional states in the four weeks prior to interview.

Main problem Respondent's self-identified condition or set of symptoms which troubled them the most.

Main reason need not met Main reason identified by respondents with a perceived health need not met or partially met:

- preferred to manage myself;
- didn't think anything more could help;
- didn't know how or where to get more help;
- afraid to ask for more help, or of what others would think of me if I did;
- couldn't afford the money;
- asked but didn't get the help; or
- got help from another source.

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, distractability and over-familiar or reckless behaviour.

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, p. 5). 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 or not they met criteria for mental disorders.

Mixed episode Criteria are met for both a major depressive episode and a manic episode for at least seven days.

Neurasthenia Either complaints of fatigue after minor mental effort, or complaints of fatigue and weakness after minor physical effort lasting at least three months.

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.

Panic disorder The essential feature of this disorder is recurrent panic (anxiety) attacks that occur suddenly and unpredictably. A panic attack is a discrete episode of intense fear or discomfort.

Paranoid personality disorder Characterised by excessive sensitivity to setbacks, and suspiciousness.

Perceived health needs For each type of help, respondents were classified as follows:

- no need—those who were not receiving help and felt that they had no need of 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; or
- need not met—those who were not receiving help but felt that they needed it.

Personality disorder Characterised by extreme deviations from the cultural norm in thoughts, feelings and behaviour.

Physical conditions The presence of any of the following selected chronic (long-lasting) and current conditions: asthma, chronic bronchitis, anaemia, high blood pressure, heart trouble, arthritis, kidney disease, diabetes, cancer, stomach or duodenal ulcer, chronic gall bladder or liver trouble, hernia or rupture.

Post-traumatic stress disorder A delayed and/or protracted response to a psychologically distressing event that is outside the range of usual human experience (such as bereavement, chronic illness, business losses, and marital conflict). Experiencing such an event is usually associated with intense fear, terror, and 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 The number of cases of a disease present in a population at a given time.

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.

Psychotic symptoms Indicated by delusions of grandiosity (for disorders involving mania or hypomania only).

Schizoid personality disorder Characterised by withdrawal from affection and social contacts, and preference for fantasy, solitary activities and introspection.

Service use Admissions to hospitals and consultations with health professionals.

Hospital. Includes general hospitals, psychiatric hospitals and drug and alcohol rehabilitation centres.

Doctor. A person holding a medical degree and therefore includes general practitioners and medical specialists, such as surgeons, physicians, pathologists, and psychiatrists.

Health professional. Includes health professionals, other than medically qualified doctors, that might be consulted for health problems within the respondent's cultural framework such as: acupuncturist, audiologist, chiropractor, chemist/pharmacist, chiropodist, dietitian, herbalist, hypnotherapist, naturopath, nurses, optician/optometrist, osteopath, occupational therapist, physiotherapist, psychologist, social worker, and speech therapist.

Service Utilisation and Days Out of Role (SUDOR) The SUDOR module was used to measure the disability associated with each potential disorder. Specifically, respondents were asked about visits to doctors and other health professionals, and days when usual activities were not fully carried out.

Short Form–12 A standard international instrument designed to provide information on general health and wellbeing. The questionnaire produces separate physical and mental component summaries.

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.

Socio-Economic Indexes For Areas (SEIFA) The SEIFA indexes were derived from the 1991 Census. They describe the characteristics of the area in which a person lives, rather than the characteristics of the person. The SEIFA index of relative social disadvantage, for example, assigns an index to geographic areas based on socio-economic variables such as economic resources, education and occupation.

Somatic syndrome A set of depressive symptoms widely regarded as having special clinical significance. Other terms for these symptoms include melancholic, vital, biological or endogenomorphic.

Substance-related disorders

Includes abuse, harmful use and/or dependence on drugs and/or alcohol. Four drug categories, including both illegal and prescription drugs, have been included in this survey:

- sedatives, e.g. barbiturates, librium, serepax, sleeping pills, valium;
- stimulants, e.g. amphetamines, dexedrine, speed;
- marijuana, i.e. hashish; and
- opioids, e.g. heroin, methadone, opium.

Abuse. A maladaptive pattern of substance use leading to impairment or distress recurring within a 12-month period.

Harmful use. A pattern of use of psychoactive substances that is causing damage to physical or mental health.

Dependence. A maladaptive pattern of substance use in which the use of the substance 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.

Type of help

A range of assistance provided by health services for mental problems:

- information;
- medication;
- counselling;
- social intervention to help sort out practical issues, such as housing or financial problems; and
- skills training to improve your ability to work, to look after yourself or to use your time.

BIBLIOGRAPHY

American Psychiatric Association 1994, *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition DSM–IV*, American Psychiatric Association, Washington, DC.

Andrews, F. M. & Withey, S. B. 1976, *Social indicators of wellbeing,* Plenum, New York.

Australian Bureau of Statistics 1986, *Australian Standard Classification of Occupations (ASCO)—Statistical Classification (First Edition),* Cat. no. 1222.0, ABS, Canberra.

Australian Bureau of Statistics 1994, *Information Paper: 1991 Census—Socio-Economic Indexes for Areas,* Cat. no. 2912.0, ABS, Canberra.

Australian Bureau of Statistics 1998a, *Information Paper: Mental Health and Wellbeing of Adults, Australia, Confidentialised Unit Record file, 1997,* Cat. no. 4329.0, ABS, Canberra.

Australian Bureau of Statistics 1998b, *Mental Health and Wellbeing: Profile of Adults, Australia, 1997,* Cat. no. 4326.0, ABS, Canberra.

Australian Bureau of Statistics (unpub.), *Mental Health and Wellbeing: Profile of Adults, Western Australia, 1997–98,* Cat. no. 4326.5, ABS, Canberra.

Australian Institute of Health and Welfare & Commonwealth Department of Health and Family Services 1997, *First report on National Health Priority Areas 1996*, AIHW and HFS, Canberra.

Belloc, N. B., Breslow, L. & Hochstim, R. J. 1971, 'Measurement of physical health in a general population survey', *American Journal of Epidemiology*, vol. 93, pp. 328–376.

Carter, G., Meadows, G. & Andrews, G. (unpub.), *Health Service Utilisation*, Department of Psychiatry, Newcastle Mater Misericordiae Hospital, 1997.

Eysenck, S. B. G., Eysenck, K. H. J & Barret, P. A. 1985, 'A revised version of the psychoticism scale', *Personality and Individual Differences*, vol. 6, no. 1, pp. 21–29.

Folstein, M. F., Folstein, S. E. & McHugh, P. R. 1975, ' Mini-mental state: a practical method for grading the cognitive state of patients for the clinician', *Journal of Psychiatric Research*, vol. 12, pp. 189–198.

Goldberg, D.P. 1972, *The Detection of Psychiatric Illness by Questionnaire*, Oxford University Press, London.

Goldberg, D. & Williams, P. 1988, *A User's Guide to the General Health Questionnaire GHQ*, NFER-NELSON, Winsor, Berkshire.

Human Rights and Equal Opportunity Commission 1993, *Human Rights and Mental Illness, Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra.

Jablensky, A. (unpub.), *Psychosis Screener*, Department of Psychiatry and Behavioural Science, University of Western Australia.

Kessler, R. C. (unpub.), *The National Survey of Health and Stress*, University of Michigan, 1990–1992.

Kessler, R. C. & Mrozcek, D. (unpub.), *Nonspecific distress screening scales*, University of Michigan, 1992.

Loranger, A. W., Janca, A. & Sartorius, N. 1997, *Assessment and Diagnosis of Personality Disorders: The ICD–10 Personality Disorder Examination (IPDE)*, Cambridge University Press, Cambridge, UK.

Meadows, G. (unpub.), *Perceived Needs*, Academic Department of Psychiatry, Royal Park Hospital, Parkville, Vic, 1997.

Meltzer, H., Gill, B., Petticrew, M. & Hinds, K. 1995, *The prevalence of psychiatric morbidity among adults living in private households, OPCS Surveys of Psychiatric Morbidity in Great Britain Report 1*, HMSO, London.

Ormel, J., VonKorff, M., Ustun, T. B., Pini, S., Korten, A. & Oldehinkel, T. 1994, 'Common Mental Disorders and Disability Across Cultures, Results From the WHO Collaborative Study on Psychological Problems in General Health Care', *Journal of The American Medical Association*, vol. 272, no. 22, pp. 1,741–1,748.

Robins, L. N. & Regier, D. A (eds), 1991, *Psychiatric Disorders in America, The Epidemiologic Catchment Area Study*, The Free Press, New York.

Tombaugh, T. N. & McIntyre, N. J. 1992, 'The Mini-Mental State Examination: A Comprehensive Review', *Journal of the American Geriatrics Society,* vol. 40, no. 9, pp. 922–935.

Ustun, T. B. & Sartorius, N. (eds) 1995, *Mental Illness in General Health Care An International Study,* John Wiley and Sons, Chichester.

Ware, J. E. Jr., Kosinski, M. & Keller, S. D. 1995, *SF–12: How to Score the SF–12 Physical and Mental Health Summary Scales*, The Health Institute, New England Medical Centre, Boston, Massachusetts.

Ware, J. E. Jr., Kosinski, M. & Keller, S. D. 1996, 'A 12–Item Short-Form Health Survey, Construction of Scales and Preliminary Tests of Reliability and Validity', *Medical Care*, vol. 34, no. 3, pp. 220–233.

Wittchen, H. 1994, 'Reliability and validity studies of the WHO Composite International Diagnostic Interview (CIDI): A critical review', *Journal of Psychiatric Research*, vol. 28, no. 1, pp. 57–84.

Wittchen, H-U. & Essau, C. A. 1993, 'An overview of the Composite International Diagnostic Interview (CIDI)', *International Journal of Methods in Psychiatric Research*, vol. 3, pp. 79–85.

World Health Organization 1992, *The ICD–10 Classification of Mental and Behavioural Disorders Clinical descriptions and diagnostic guidelines,* World Health Organization, Geneva.

World Health Organization 1993a, *Composite International Diagnostic Interview (CIDI) Interviewer's Manual (Version 1.1, 1994),* World Health Organization, Geneva.

World Health Organization 1993b, *The ICD–10 Classification of Mental and Behavioural Disorders Diagnostic criteria for research*, World Health Organization, Geneva.

World Health Organization 1994, *Composite International Diagnostic Interview (CIDI) Researcher's Manual (Version 1.1, 1994),* World Health Organization, Geneva.

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