



Victorian
Agency for
**Health
Information**

The health and wellbeing of Aboriginal Victorians

Findings from the
Victorian Population
Health Survey 2017

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We recognise the diversity of Aboriginal people living throughout Victoria. Whilst the terms 'Koorie' or 'Koori' are commonly used to describe Aboriginal people of southeast Australia, we have used the term 'Aboriginal' to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria.

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Acknowledgement of Aboriginal Victoria

The Victorian Government proudly acknowledges Victoria's Aboriginal communities and their rich culture and pays respect to their Elders past and present. We acknowledge Aboriginal people as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we live, work and play. We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches our society more broadly. We embrace the spirit of self-determination and reconciliation, working towards equality of outcomes and ensuring an equitable voice.

Victorian Aboriginal communities and peoples are culturally diverse, with rich and varied heritages and histories both pre and post-invasion. The impacts of colonisation – while having devastating effects on the traditional life of Aboriginal Nations – have

not diminished Aboriginal people's connection to country, culture or community. Aboriginal Nations continue to strengthen and grow with the resurgence of language, lore and cultural knowledge. These rich and varied histories need to be understood and acknowledged by all Victorians, to truly understand the resilience and strength of previous generations, as well as the history of the fight for survival, justice and country that has taken place across Victoria and around Australia.

As we work together to ensure Victorian Aboriginal communities continue to thrive, the government acknowledges the invaluable contributions of generations of Aboriginal warriors that have come before us, who have fought tirelessly for the rights of their people and communities towards Aboriginal self-determination. We are now honoured to be part of that vision.

KEY FINDINGS

Health and wellbeing status

Social and emotional wellbeing

Psychological distress

Almost 1 in 4 Aboriginal adults (23.2%) experienced high or very high level of psychological distress – significantly higher than non-Aboriginal adults (15.4%).

Depression and anxiety

A little over one-third (38.3%) of Aboriginal adults had ever been diagnosed by a doctor with depression or anxiety – significantly higher than non-Aboriginal adults (27.3%).

Almost one-half (49.8%) of Aboriginal women and 29.5% of Aboriginal men had ever been diagnosed with depression or anxiety by a doctor.

These findings suggest that depression and anxiety are significant causes of morbidity and mortality in Aboriginal adults who live in Victoria. Therefore, access to affordable and culturally safe mental health care for Aboriginal Victorians is urgently required, as well as policies and interventions to address the underlying determinants of depression and anxiety in order to prevent the development of depression and anxiety in the first place.

Subjective wellbeing

A vast majority (89.0%) of Aboriginal adults felt that the things they did in their lives were completely worthwhile, worthwhile or somewhat worthwhile, although 8.2% did not feel that the things they did in their lives were worthwhile at all – significantly higher than non-Aboriginal adults (3.9%).

Most (86.9%) Aboriginal adults were completely satisfied, satisfied or somewhat satisfied with their lives, although 10.1% were not satisfied with their lives at all – significantly higher than non-Aboriginal adults (5.1%).

Overall health status

Overall health status was assessed by asking survey participants to rate their current health status by indicating whether, in general, they would say their health was 'excellent', 'very good', 'good', 'fair' or 'poor'. Self-reported health status has been shown to be a reliable predictor of ill-health, future healthcare use and premature mortality, independent of other medical, behavioural or psychosocial risk factors (Burstrom & Fredlund 2001; Idler & Benyamini 1997; Manor et al. 2001).

Almost two-thirds (65.5%) of Aboriginal adults rated their health as excellent, very good or good, although just over one-third (34.5%) of Aboriginal adults rated their health as fair or poor – significantly higher than non-Aboriginal adults (20.1%).

Dental health

Dental health was assessed by asking survey participants to rate their dental health by indicating whether, in general, they would say their dental health was 'excellent', 'very good', 'good', 'fair' or 'poor'.

Half (50.8%) of Aboriginal adults rated their dental health as excellent, very good or good, although a little over one-third (35.7%) of Aboriginal adults reported that their dental health was fair or poor – significantly higher than non-Aboriginal adults (24.3%).

Almost one-quarter (23.2%) of Aboriginal men did not have any natural teeth – significantly higher than non-Aboriginal men (3.8%).

Social determinants of health

Connection to culture

There is strong and consistent evidence in the scientific literature that Aboriginal Australians who are strongly connected to their cultures enjoy better health and wellbeing than those who are not.

In Victoria, just over one-half (52.3%) of Aboriginal adults aged 18 years or older attended or participated in at least one of the following cultural events in the 12 months preceding the survey: a ceremony; NAIDOC week activity; a festival or carnival involving Aboriginal or Torres Strait Islander arts, craft, music or dance; or engaged with an Aboriginal or Torres Strait Islander organisation. A higher proportion of women (58.3%) than men (48.1%) participated in these activities.

A little over one-quarter (28.5%) of Aboriginal adults in Victoria attended a funeral or were involved in sorry business in the 12 months preceding the survey.

A higher proportion of Aboriginal women (63.6%) than men (49.9%) reported that attending an Aboriginal cultural event mattered a lot or a bit.

A little over one-half (59.4%) of Aboriginal adults sometimes, often, or very often talked with an Elder or older relative about Aboriginal history or culture in the 12 months preceding the survey.

A little over 2 in 3 (70.8%) Aboriginal adults who attended an Aboriginal cultural event reported being in excellent, very good or good health compared with 59.4% of Aboriginal adults who did not attend an Aboriginal cultural event.

Just over 2 in 3 (68.8%) Aboriginal adults who often or very often spoke with an Elder or older relative about Aboriginal history or culture reported being in excellent, very good or good health compared with those who never or rarely spoke with an Elder or older relative about Aboriginal history or culture (60.0%).

The data reinforces the wider literature that suggests Aboriginal adults who are strongly connected to culture have better health than those who are not. Therefore, this data supports policies and interventions that seek to strengthen the connections of Aboriginal adults in Victoria to their culture(s).

Experiences of racism

Survey participants were deemed to have experienced racism if they responded that they had experienced discrimination in the 12 months preceding the survey due to their Aboriginal status, skin colour, nationality, race or ethnic group.

Almost 1 in 5 (18.8%) Aboriginal adults experienced racism in the 12 months preceding the survey.

- The most common place where racism was experienced was in public, perpetrated by a member of the public – reported by 70.2% of Aboriginal adults who experienced racism.
- The second most common place was in a healthcare setting, perpetrated by a member of staff such as a doctor or nurse – reported by 47.0% of Aboriginal adults who experienced racism.
- The third most common setting in which Aboriginal adults experienced racism was at home, by neighbours, or in someone else's home – reported by 36.6% of Aboriginal adults who experienced racism.
- The fourth most common setting in which Aboriginal adults experienced racism was when applying for work or at work – reported by 36.1% of Aboriginal adults who experienced racism.

A little less than one-third (31.3%) of Aboriginal adults who experienced racism reported or made a complaint about their experience(s).

Experiences of racism were associated with poorer social and emotional wellbeing, and poorer physical health.

- Approximately two-thirds (65.5%) of Aboriginal adults who experienced racism had ever been diagnosed by a doctor with depression or anxiety – significantly higher than Aboriginal adults who did not experience racism (32.1%) and non-Aboriginal adults who experienced racism (30.6%).
- This suggests that experiences of racism may make a substantial contribution to the significantly higher prevalence of lifetime depression and anxiety among Aboriginal adults compared with non-Aboriginal adults.
- The proportion of Aboriginal adults who experienced racism was highest among those who were tertiary educated (went to university) (39.9%), significantly higher than non-Aboriginal adults who were tertiary educated (8.0%).

The proportion of Aboriginal adults who experienced racism significantly increased with increasing level of educational attainment. A little over two-thirds (39.9%) of Aboriginal adults who were tertiary educated experienced racism compared with 15.1% of Aboriginal adults who did not complete secondary education.

The findings indicate that racism directed against Aboriginal adults in Victoria is substantial, occurs in multiple settings including the healthcare sector, and is damaging to both mental and physical health. The data supports policies and interventions that challenge racist attitudes and beliefs whether conscious or unconscious, interpersonal or institutional.

Food insecurity

Food insecurity is defined as ‘whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable food in socially acceptable ways is limited or uncertain’ (Radimer 2002, p. 861). Two measures of food insecurity were included in the 2017 VPHS.

Aboriginal adults in Victoria were significantly more likely to experience food insecurity with hunger than their non-Aboriginal counterparts – 14.4% of Aboriginal adults in Victoria ran out of food and could not afford to buy more at least once in the 12 months preceding the survey interview compared with 6.2% of non-Aboriginal adults.

A higher proportion of Aboriginal parents experienced food insecurity without hunger – 25.4% of Aboriginal parents sometimes or always relied on a restricted range of low-cost food for their children to avoid running out of money to buy food compared with 14.5% of non-Aboriginal parents.

Food insecurity was associated with poorer social and emotional wellbeing and poorer physical health.

- Just over one-half (52.1%) of Aboriginal adults who experienced food insecurity with hunger in the 12 months preceding the survey had high or very high psychological distress, compared with 17.7% of Aboriginal adults who did not experience food insecurity with hunger.
- Just under two-thirds (64.0%) of Aboriginal adults who experienced food insecurity with hunger had ever been told by a doctor that they had depression or anxiety compared with 33.7% of Aboriginal adults who did not experience food insecurity with hunger.
- Two-thirds (66.8%) of Aboriginal adults who experienced food insecurity with hunger had fair or poor health compared with 29.6% of Aboriginal adults who did not experience food insecurity with hunger.

Given that food insecurity is a significant risk factor for obesity, the substantially higher prevalence of food insecurity experienced by Aboriginal adults in Victoria may partly explain the higher prevalence of obesity that is consistently observed among Aboriginal Australians and Victorians, compared with their non-Aboriginal counterparts (Department of Health and Human Services 2017a).

Financial stress

A little over 1 in 4 Aboriginal adults (28.3%) were financially stressed, defined as being unable to raise \$2,000 within 2 days in an emergency – significantly higher than non-Aboriginal adults (13.5%).

Financial stress was associated with poorer social and emotional wellbeing and poorer physical health.

- A little over two-thirds (37.1%) of Aboriginal adults who were financially stressed had high or very high psychological distress compared with 17.1% of Aboriginal adults who were not financially stressed.
- Almost one-half (47.8%) of Aboriginal adults who were financially stressed had ever been told by a doctor that they had depression or anxiety compared with 34.8% of Aboriginal adults who were not financially stressed.
- Just over one-half (52.2%) of Aboriginal adults who were financially stressed were in fair or poor health compared with 26.8% of Aboriginal adults who were not financially stressed.

Family violence

According to the *Family Violence Protection Act 2008* (Vic), family violence is behaviour by a person towards a family member of that person that is: physically abusive; sexually abusive; emotionally or psychologically abusive; economically abusive; threatening; coercive; or in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person. It is also family violence when a child witnesses or is exposed to any of those behaviours.

A significantly higher proportion of Aboriginal adults in Victoria (12.3%) experienced family violence in the 2 years preceding the survey, compared with 5.4% of non-Aboriginal adults.

A significantly higher proportion of Aboriginal women (17.2%) experienced family violence compared with 9.3% of Aboriginal men.

Social capital

Social capital is the ‘resources that are accessed by individuals as a result of their membership of a network or a group’ (Berkman et al. 2014). There are three types of social capital: bonding, bridging and linking.

Bonding social capital describes the close connections between members of a network who see themselves as similar and is considered good for ‘getting by’ in life. In the context of Aboriginal communities, bonding social capital refers to relationships within the Aboriginal community (Mignone 2009).

Bridging social capital describes the weaker but more cross-cutting connections between members of a network who do not see themselves as similar and is considered good for ‘getting ahead’ in life. It is the relationship between the Aboriginal and non-Aboriginal communities (Mignone 2009).

Linking social capital describes the connections across social strata that are good for accessing support from formal institutions; these bring state–society relations and considerations of power into the social capital framework (Szreter & Woolcock 2004). It is the relationship between the Aboriginal community and the formal institutions of power, such as governments (Mignone 2009).

The wider literature shows that higher levels of social capital are strongly and consistently associated with better health and wellbeing outcomes (Kawachi & Berkman 2014).

The survey found that similar proportions of Aboriginal and non-Aboriginal adults were able to get help when needed from family, friends or neighbours, indicating that there were no differences in levels of bonding social capital.

In contrast, 25.8% of Aboriginal adults did not agree that most people could be trusted – significantly higher than non-Aboriginal adults (17.4%), indicating that Aboriginal adults had lower levels of bridging social capital.

Similarly, 43.7% of Aboriginal adults did not feel there were opportunities to have a real say on issues that were important to them – significantly higher than non-Aboriginal adults (25.9%), indicating that Aboriginal adults had lower levels of linking social capital.

The data supports policies and interventions to build bridging and linking social capital among Aboriginal adults and communities in Victoria. Given that the wider literature shows that racism is a significant barrier to bridging and linking social capital, policies and interventions that seek to address racism may also help build bridging and linking social capital, therefore improving Aboriginal health and wellbeing directly and indirectly through multiple pathways.

Aboriginal and Torres Strait Islander patient identification

The robustness of data on the health and wellbeing of Aboriginal Victorians depends on the systematic and accurate collection of data that includes the correct identification of people who identify as Aboriginal or Torres Strait Islander. Moreover, correct identification enables services and programs to be more appropriately targeted.

To determine whether routine health data collections such as administrative datasets that record all inpatient hospitalisations (the Victorian Admitted Episodes Dataset or VAED) or emergency department presentations (the Victorian Emergency Minimum Dataset or VEMD) were systematically and accurately identifying Aboriginal patients, two questions were included in the 2017 VPHS. A third question was included for the primary healthcare setting.

Just under two-thirds (65.2%) of Aboriginal adults in Victoria who were admitted to hospital in the 12 months preceding the survey were asked if they were of Aboriginal or Torres Strait Islander origin – 31.7% were not.

A little over one-half (59.5%) of Aboriginal adults who attended an emergency department in the 12 months preceding the survey were asked if they were of Aboriginal or Torres Strait Islander origin – 34.7% were not.

A little over over-half (52.3%) of Aboriginal adults who attended a doctor, general practitioner or community health centre in the 12 months preceding the survey were not asked if they were of Aboriginal or Torres Strait Islander origin.

These findings suggest that Aboriginal status may be underestimated and misclassified by about one-third in the VAED and VEMD data collections. Identification of adults of Aboriginal or Torres Strait Islander origin may also be significantly underestimated in the primary healthcare setting.

1. INTRODUCTION

History of the Victorian Population Health Survey

In 2016 (the year of the last census), the Australian Bureau of Statistics (ABS) estimated there were 57,767 Aboriginal people living in Victoria – constituting 7.2% of the total Aboriginal Australian population and 0.9% of the Victorian population. Victoria has the lowest proportion of Aboriginal people per capita than any other state or territory in Australia (Australian Bureau of Statistics 2016a). Consequently, obtaining population-representative survey data for Aboriginal Victorians is difficult and necessitates sampling very large numbers of Victorians to obtain a sufficient sample size of Aboriginal Victorians so as to enable a statistically reliable analysis of the data by Aboriginal status.

The Victorian Population Health Survey (VPHS) is a computer-assisted telephone survey that was first undertaken in 2001 and is an ongoing source of high-quality information on the health of Victorians aged 18 years or older. The purpose of the information collected in the survey is to provide a statistical overview for informing the evidence base used for policy and practice development in Victoria, including planning. Moreover, the data may enable deeper explorations of pertinent issues that may be supported by qualitative data sources collected through community-informed monitoring, research and evaluation.

From 2001 to 2007 the sample size (approximately 7,500) was too small to recruit enough survey participants who identified as Aboriginal and/or Torres Strait Islander to enable any meaningful statistical analysis. This changed in 2008 when the sample size was increased to approximately 34,000 to enable estimates down to the local government area (LGA) level. It was therefore lucky, but not planned, that the 2008 VPHS recruited 339 adults who identified as Aboriginal and/or Torres Strait Islander – a sufficient sample size to analyse by Aboriginal status.

In 2011, the first report, *The health and wellbeing of Aboriginal Victorians: Victorian Population Health Survey – Supplementary report*, was published,

based on data from the 2008 VPHS. While this report should not be compared with the current report because the methodologies used were different, it can be accessed at <https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/health-and-wellbeing-of-aboriginal-victorians-2008>.

The LGA-level surveys are conducted every 3 years. The second, third and fourth LGA-level surveys were conducted in 2011, 2014 and 2017 respectively, with the fifth due in the field in 2020. In anticipation of being able to produce a second report on the health and wellbeing of Aboriginal Victorians from the 2011 VPHS, meetings were held with the Victorian Aboriginal Community Controlled Health Organisation and the Onemda VicHealth Koori Health Group (ceased operation in 2016) to seek advice on including Aboriginal-specific questions in the 2011 VPHS. These consultations resulted in questions about connection to culture, Aboriginal identification and health service use.

However, the 2011 and 2014 LGA-level surveys failed to recruit enough adults who identified as Aboriginal. This was due to changes in the technology of communications with the advent of the mobile telephone. The mobile telephone is fast replacing the landline telephone, exacerbated by the rollout of Australia's National Broadband Network, which has contributed to making landline telephones redundant.

Consequently, the survey methodology was revised in 2015 to include mobile telephones in addition to other changes. The change in methodology means that surveys conducted after 2014 cannot be compared with surveys conducted before 2015.

This report is the second population-based report on the health and wellbeing of Aboriginal Victorians in the state of Victoria, with a specific focus on the social determinants of health and includes the questions that were recommended by the consultations with the Victorian Aboriginal Community Controlled Health Organisation and the Onemda VicHealth Koori Health Group back in 2011.

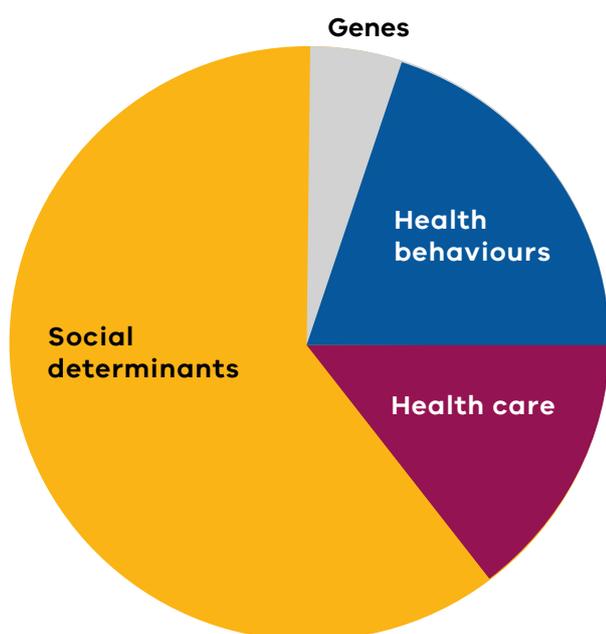
The report is based on the responses of 33,654 randomly selected adults aged 18 years or older across Victoria who participated in the 2017 VPHS – 293 who identified as being of Aboriginal or Torres Strait Islander origin. While 293 may seem like a small number of people, it is 0.9% of the total survey sample – equivalent to the proportion of adults in Victoria who identify as Aboriginal, and sufficient to enable a robust statistical analysis for most of the data collected.

What are the determinants of health?

Health is determined by a complex interaction between genetic inheritance, health behaviours (also known as lifestyle risk factors and behavioural risk factors), access to quality health care, and the social determinants of health.

As can be seen from Figure 1.1, the social determinants make the largest impact on health (Tarlov 1999). Moreover, it is the social determinants that are largely responsible for inequalities in health outcomes across populations.

Figure 1.1: Determinants of health



Source: Adapted from Tarlov 1999

However, across Australia and the developed world, primary prevention of ill-health is dominated by policies and interventions that seek to address the health behaviours of individuals, largely ignoring the social determinants of health. This appears to have been influenced by the domination of the biomedical model of health in epidemiology and clinical medicine. The biomedical model attributes disease to proximate biological factors at the level of the individual, ignoring the psychological, social, cultural, economic and environmental causes of ill-health (Johnson 2013).

Moreover, the focus on ‘behavioural risk factors’ is predicated on the questionable assumption that all individuals in a society are equally free and able to ‘choose’ a healthy lifestyle. Those who engage in unhealthy behaviours are therefore seen as engaging in ‘morally irresponsible bad behaviour’ and are to be held accountable for their own ill-health (Brown 2013). This not only stigmatises those who engage in unhealthy behaviours, but also shifts the focus of responsibility for their health from the government and private sector to the individual (Baum & Fisher 2011).

Overall, health policy in relation to Aboriginal Australians, both historical and contemporary, has been described as a deficit-based approach. ‘Deficit discourse’ portrays Aboriginal people in terms of deficiencies and lays the responsibility for correcting those deficiencies with Aboriginal people, disregarding the social, political and economic environments in which Aboriginal people live, and shielding existing institutions and power structures from the need to also change or change instead (Fogarty et al. 2018). It has typically relied on drawing comparisons of health outcomes and the recognised determinants (behavioural risk factors) of those health outcomes between the Aboriginal and non-Aboriginal populations, where the non-Aboriginal population is held up to be the gold standard (Fogarty et al. 2018).

Comparisons of the Aboriginal and non-Aboriginal populations are a double-edged sword that can on the one hand be used to promote deficit discourse but can also be used to draw attention to government

failure to provide effective and culturally appropriate services and policy solutions to address inequalities in health and wellbeing. However, divorced from the social and environmental context and constantly reiterated, such comparisons enabled narratives to be constructed that stereotyped Aboriginal people while simultaneously concealing structural inequalities. In other words, the context is the critical determinant of whether such comparisons promote deficit discourse or are used to hold governments to account.

What are the social determinants of health?

The World Health Organization (WHO) defines the social determinants of health as:

... the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems (World Health Organization 2008).

The social determinants are shaped by the distribution of money, power and resources and are mostly responsible for health inequities – the health inequalities that are unfair and avoidable. WHO lists 10 generic social determinants: the social gradient (socioeconomic status), stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport.

In 2008, WHO published a report entitled *Closing the gap in a generation: health equity through action on the social determinants of health* and invited all governments, civil society and other organisations to

begin addressing the social determinants of health in order to reduce and ultimately eliminate health inequities (World Health Organization 2008).

To date, this has largely not occurred because contemporary governments of countries such as Australia, the United States and Canada continue to privilege behavioural health promotion, which seeks to address chronic diseases by addressing the health behaviours of individuals, despite the large body of evidence that clearly demonstrates the failure of behavioural health promotion. Consequently health inequities continue to grow both within and between countries (Baum & Fisher 2014).

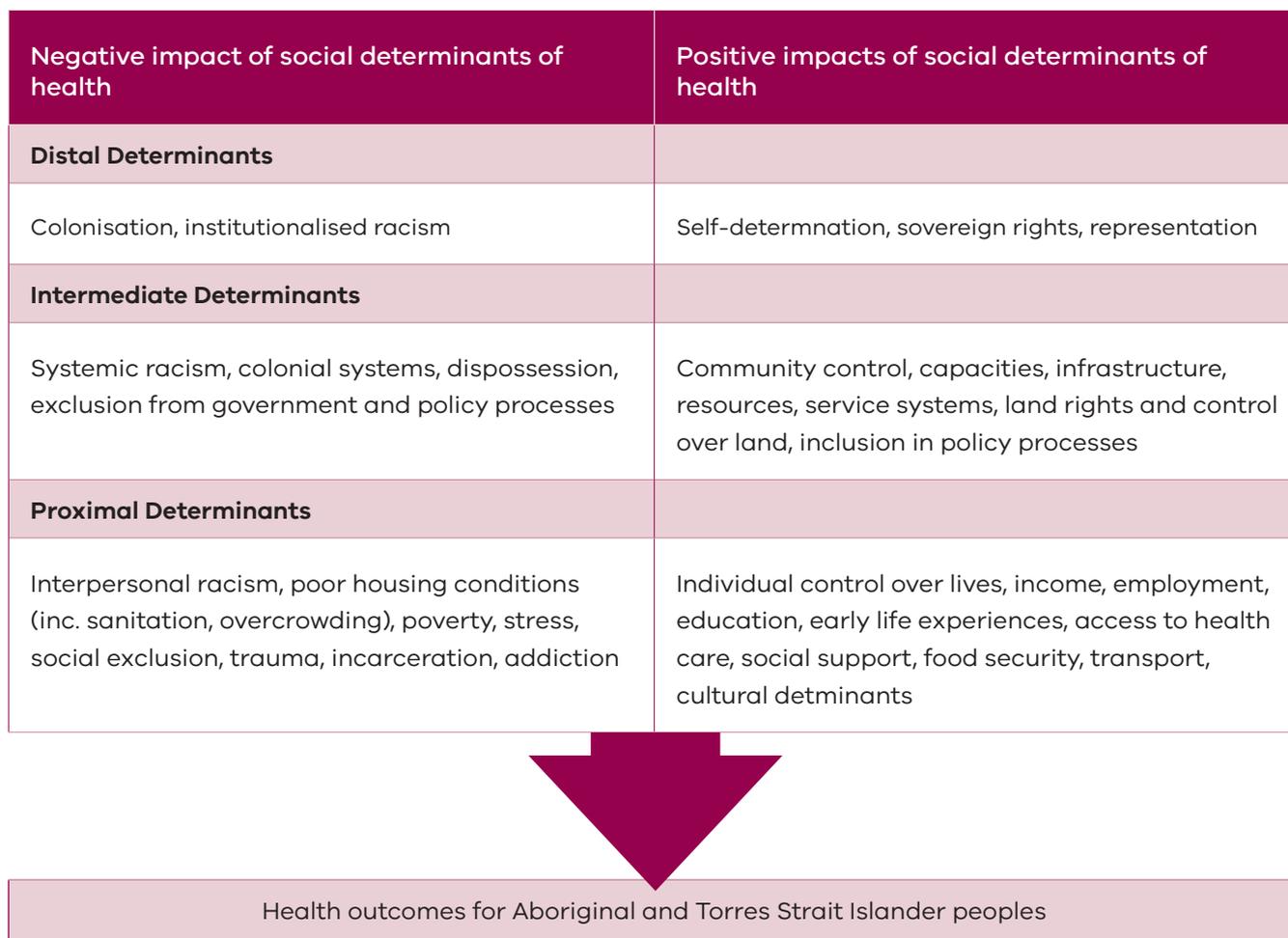
What are the social determinants of Aboriginal health?

Although WHO identifies 10 generic social determinants, it is recognised that the indigenous peoples of the world experience risks to their health and wellbeing that are either not experienced by non-indigenous populations or not experienced to the same extent, and are due to the historical and ongoing processes of colonisation (Vickery et al, 2007) Zubrick et al. 2010).

In 2004, the Cooperative Research Centre for Aboriginal Health commissioned work to identify the social determinants most relevant to Aboriginal health and wellbeing in Australia. The work brought together academics from across Australia culminating in a workshop in Adelaide where a consensus was reached.

The social determinants of Aboriginal health and wellbeing are summarised in Figure 1.2.

Figure 1.2: The social determinants of Aboriginal health



Source: Southgate Institute for Health, Society & Policy 2019

About this report

This report begins with an assessment of the health and wellbeing status of adults in Victoria, by Aboriginal status. This is followed by an analysis of the social determinants of health. While the VPHS does not specifically collect data on all the social determinants of Aboriginal health described above, the 2017 VPHS did collect data on connection to culture, experiences of racism, food insecurity, financial stress, family violence and social capital.

Lastly, while not entirely in keeping with the topic of health and wellbeing or the social determinants of health, the report includes an indirect audit of the systematic and accurate collection of data on whether a patient is of Aboriginal or Torres Strait Islander origin, by health service. Accurate identification of Aboriginal patients is important in developing and providing culturally safe health services, program and policies, and to provide a more complete understanding of the complex factors affecting Aboriginal health and wellbeing.

2. HEALTH AND WELLBEING STATUS

Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life (Swan & Raphael 1995).

This chapter reports on the health and wellbeing status of adults who live in the state of Victoria, by Aboriginal status. Data were collected on various indicators of social and emotional wellbeing, overall health status and dental health.

Social and emotional wellbeing

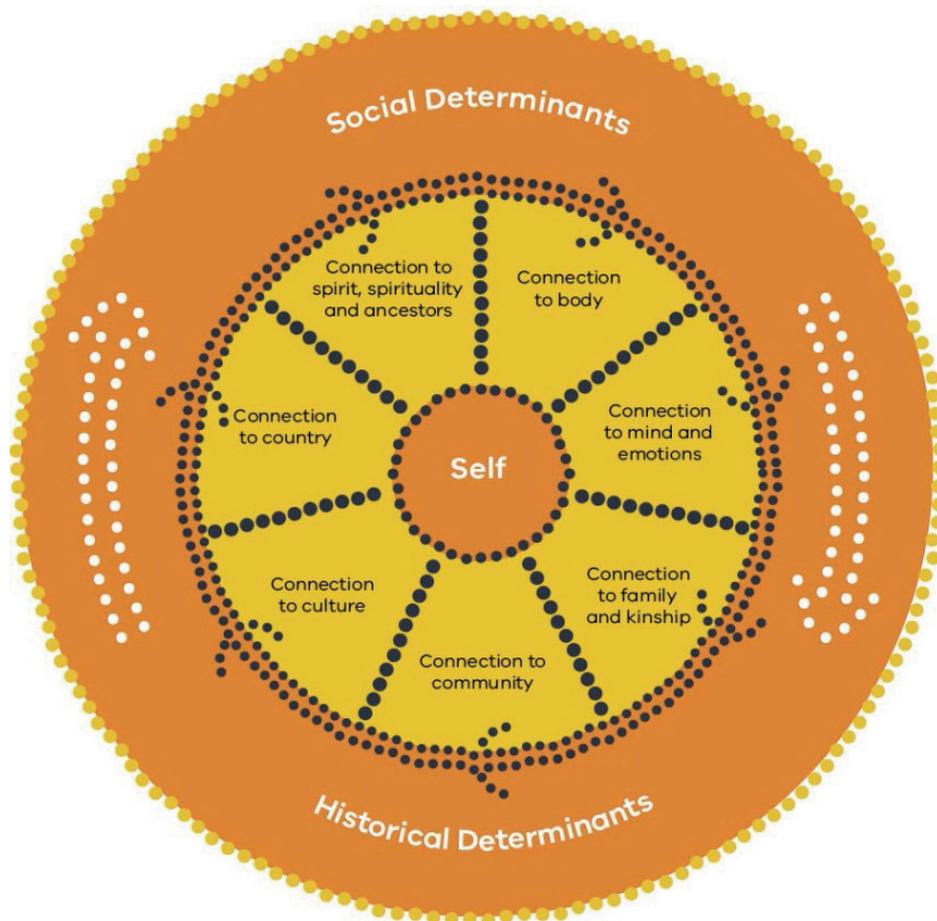
'Social and emotional wellbeing' is the term preferred by many Aboriginal Australians to describe the social, emotional, spiritual and cultural wellbeing of a person (Henderson et al. 2007).

Social and emotional wellbeing is used in preference to the term 'mental health' because mental health is often associated with stigma and does not reflect the social and historical nature of human wellbeing. Mainstream biomedical explanatory and treatment models for mental illness are considered at odds with Aboriginal cultural understandings of mental health (Figure 2.1), which are based on beliefs about the inextricable connections between the physical,

emotional and spiritual wellbeing of a person, their community and the environment (Gee et al. 2014).

Importantly, social and emotional wellbeing is a source of resilience which can help protect against the worst impacts of stressful life events for Aboriginal people and provide a buffer to mitigate risks of poor mental health (Department of Health and Human Services 2017b, p. 10).

Figure 2.1: Aboriginal social and emotional wellbeing



Source: Gee et al. 2014

The survey collected information on:

- psychological distress
- lifetime prevalence of doctor-diagnosed depression and anxiety
- subjective wellbeing.

Psychological distress

Psychological distress is an important incident and/or secondary risk factor for a number of diseases and conditions including fatigue, migraine, cardiovascular disease, chronic obstructive pulmonary disease, cerebrovascular disease, injury, obesity, depression and anxiety (Andrews & Slade 2001; Hamer et al. 2012; Russ et al. 2012). Moreover, psychological distress is associated with a higher risk of mortality, even after adjusting for potential confounders such as socioeconomic status (Pratt 2009).

Psychological distress is also significantly associated with lifestyle risk factors such as smoking, excessive consumption of alcohol and drug use (Holden et al. 2010) (Leung et al. 2011). Therefore, the evidence shows that psychological distress impacts negatively on health both directly and indirectly.

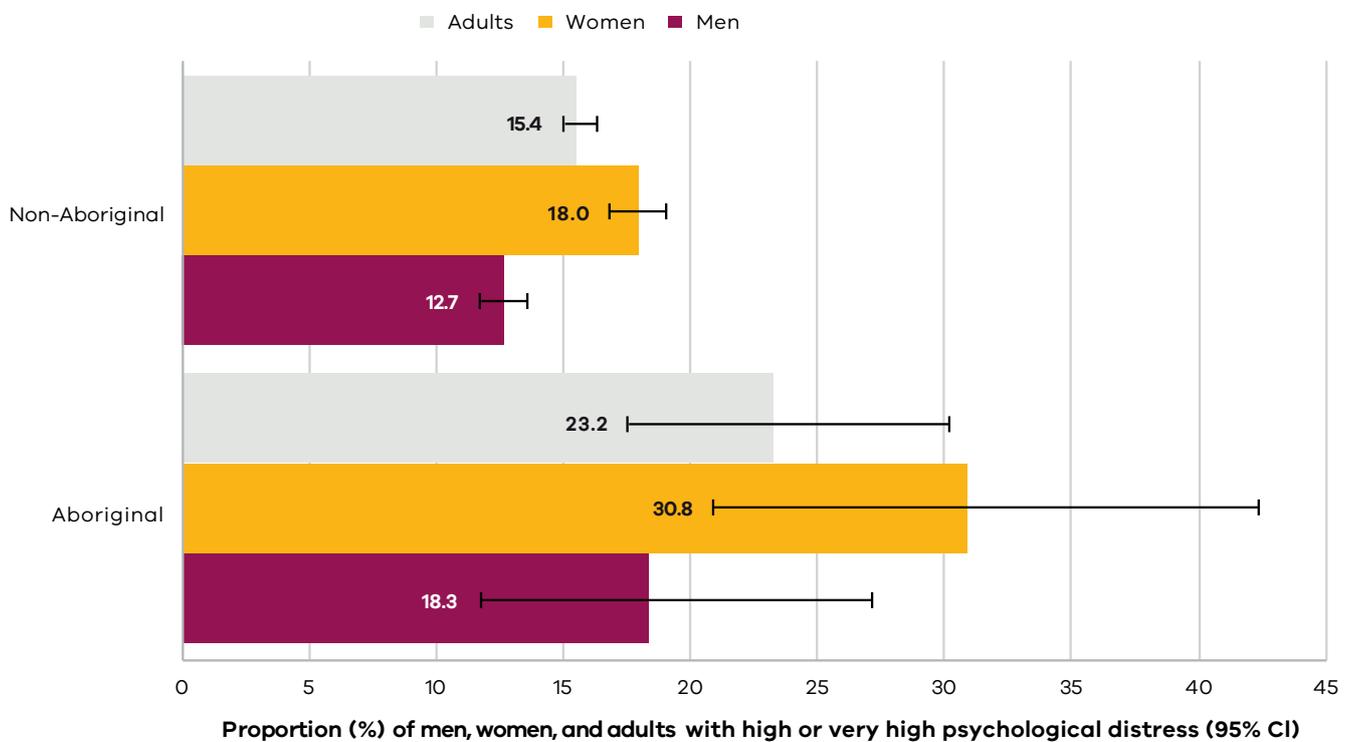
The VPHS employs the Kessler 10 Psychological Distress Scale (K10) to measure psychological distress. The K10 is commonly used by general practitioners (GPs) in Australia as a diagnostic tool for diagnosing depression and anxiety in individuals who present with symptoms of depression or anxiety.

The K10 covers the dimensions of nervousness, hopelessness, restlessness, sadness and worthlessness. It consists of 10 questions that have the same response categories: all of the time, most of the time, some of the time, a little of the time and none of the time (that are scored 5 through to 1). The 10 items are summed to yield scores ranging from 10 to 50. Individuals are categorised to four levels of psychological distress based on their score: low (10–15), moderate (16–21), high (22–29) and very high (30–50) (Andrews & Slade 2001).

Appendix 2 Table 1 and Figure 2.2 show the proportions of adults with psychological distress by gender and Aboriginal status. The key findings were:

- Overall, 23.2% of Aboriginal adults had high or very high levels of psychological distress, significantly higher than the 15.4% of non-Aboriginal adults who had high or very high levels of psychological distress.
- Just under 1 in 5 (18.3%) Aboriginal men had high or very high levels of psychological distress compared with 12.7% of non-Aboriginal men.
- Almost one-third (30.8%) of Aboriginal women had high or very high levels of psychological distress, significantly higher than non-Aboriginal women (18.0%).

Figure 2.2: Proportion (%) of adults with high or very high psychological distress, by gender and Aboriginal status, Victoria, 2017



Depression and anxiety

Poor social and emotional wellbeing can have a significant negative impact on physical health, as evidenced by a lower life expectancy in people with mental illness compared with those who do not have mental illness (Lawrence et al. 2013).

The VPHS collects data on the prevalence of the affective disorders of depression and anxiety. Depression and anxiety are the most common mental health disorders, with depression being the leading cause of disability in both males and females and, at its worst, leading to suicide (Department of Human Services 2005).

Moreover, there is strong and consistent evidence of an association between depression and anxiety and the National Health Priority Area conditions of heart disease, stroke, diabetes, asthma, cancer, arthritis and osteoporosis (Clarke & Currie 2009). Depression is also associated with poorer health outcomes in those with physical disease.

To ensure that survey participants do not self-diagnose and potentially confuse general feelings of unhappiness or worry from clinical depression or anxiety, they were asked if a doctor had ever told them that they had depression or anxiety.

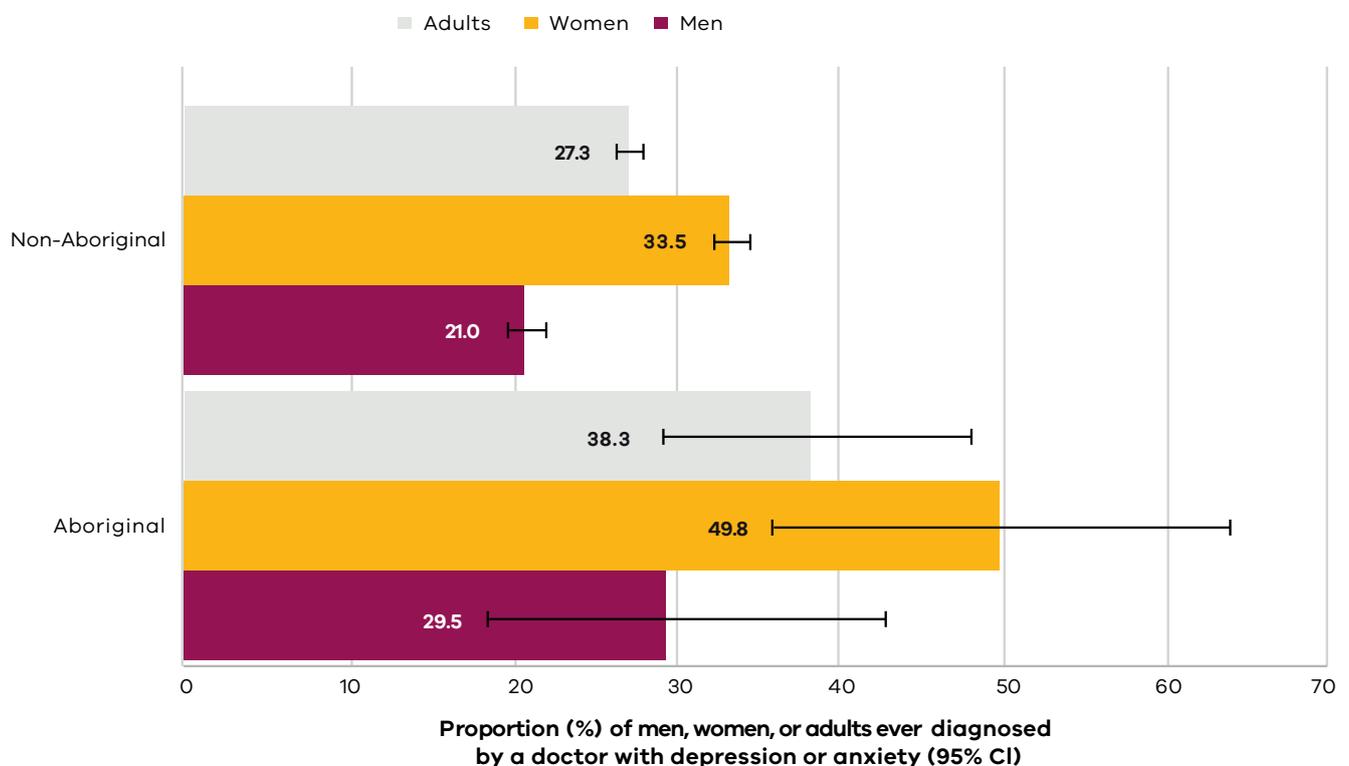
Appendix 2 Table 2 and Figure 2.3 show the proportion of adults who were ever told by a doctor that they had depression or anxiety, by gender and Aboriginal status. The key findings were:

- Overall, a little over one-third (38.3%) of Aboriginal adults in Victoria had ever been diagnosed by a doctor with depression or anxiety – significantly higher than non-Aboriginal adults (27.3%).
- Women, regardless of Aboriginal status, were significantly more likely than men to have ever had doctor-diagnosed depression or anxiety.
- Almost one-half (49.8%) of Aboriginal women in Victoria had ever had doctor-diagnosed depression or anxiety – significantly higher than non-Aboriginal women (33.5%).

- Almost one-third (29.5%) of Aboriginal men had ever had doctor-diagnosed depression or anxiety, higher than non-Aboriginal men (21.0%).

These data suggest that depression and anxiety are significant causes of morbidity and mortality in Aboriginal adults who live in Victoria. Therefore, access to affordable and culturally safe mental health care for Aboriginal Victorians is urgently required, as well as policies and interventions to address the antecedents of depression and anxiety to prevent the development of depression and anxiety in the first place.

Figure 2.3: Proportion (%) of adults who had ever been told by a doctor that they had depression or anxiety, by gender and Aboriginal status, Victoria, 2017



Subjective wellbeing

Over the past two decades evidence has accumulated to show that subjective wellbeing can be measured in population surveys, and the measures are valid and reliable (Diener & Chan 2001). Subjective wellbeing and its relationship to health has been extensively investigated, and it is well recognised that poor subjective wellbeing is a health risk factor.

For example:

- People with high subjective wellbeing live four to 10 years longer than people with low subjective wellbeing (Diener & Chan 2011).
- The lower a person's subjective wellbeing the more likely he or she is to engage in harmful health behaviours such as consuming a poor diet, smoking and inadequate physical activity (Grant et al. 2009).
- Low subjective wellbeing puts people at high risk of clinical depression (Wood & Joseph 2010).
- Low subjective wellbeing is a short- and long-term predictor of suicide (Bray & Gunnell 2006).
- In contrast, high subjective wellbeing lowers the risk of mortality in both healthy and diseased populations (Chida & Steptoe 2008).
- High subjective wellbeing reduces healthcare use and its associated costs and may result in substantial savings in overall healthcare expenditure (Sears et al. 2013).

Two measures of subjective wellbeing were used in the 2017 VPHS. The first question asked of the survey participants was: 'To what extent do you feel that the things you do in your life are worthwhile, on a scale from 0 to 10, where 0 is not worthwhile at all and 10 is completely worthwhile?'. A score of 0–4 was deemed to be 'life is not at all worthwhile', a score of 5–6 was 'somewhat worthwhile', a score of 7–8 was 'life is worthwhile' and a score of 9–10 was 'life is completely worthwhile' (Appendix 2 Table 3 and Figure 2.4).

The key findings were:

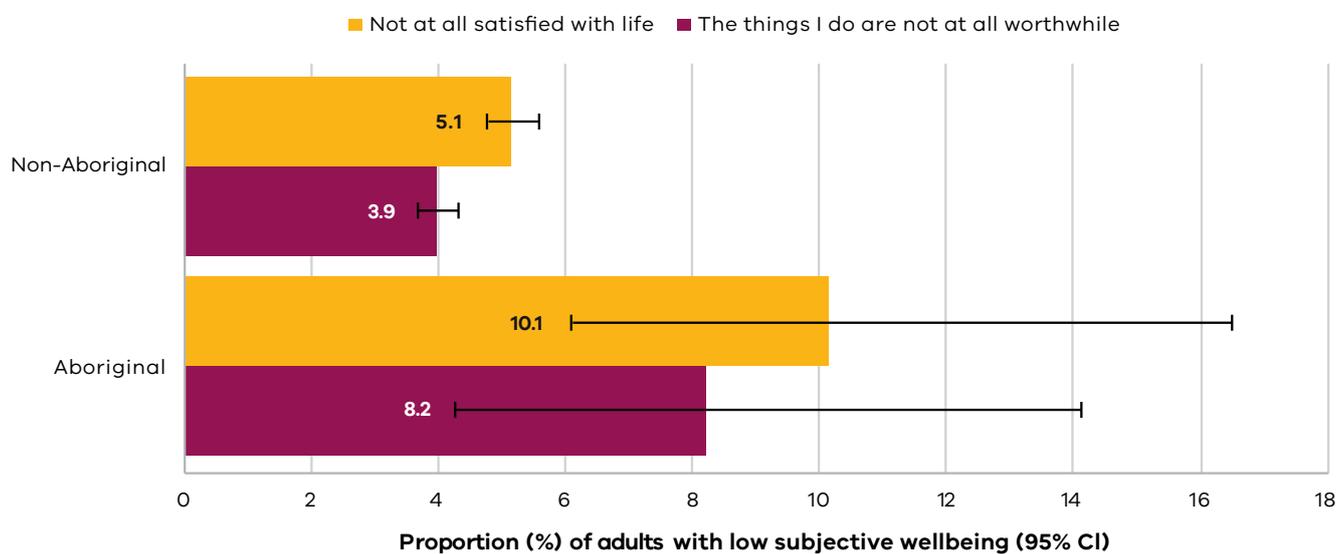
- Overall, 37.8% of Aboriginal and 34.1% of non-Aboriginal adults felt that life was completely worthwhile.
- A further 40.7% of Aboriginal and 46.3% of non-Aboriginal adults felt that life was worthwhile.
- A further 10.5% of Aboriginal and 12.7% of non-Aboriginal adults felt that life was somewhat worthwhile.
- In contrast, 8.2% of Aboriginal adults felt that the things they did in their lives were not worthwhile at all – significantly higher than non-Aboriginal adults (3.9%).

The second question asked of the survey participants was: 'How satisfied are you with your life overall, on a scale from 0 to 10, where 0 is not at all satisfied and 10 is completely satisfied?'. A score of 0–4 was deemed to be 'not at all satisfied with life', a score of 5–6 was 'somewhat satisfied with life', a score of 7–8 was 'satisfied with life' and a score of 9–10 was 'completely satisfied with life' (Appendix 2 Table 4 and Figure 2.4).

The key findings were:

- Overall, 24.4% of Aboriginal and 27.0% of non-Aboriginal adults were completely satisfied with life.
- A further 45.4% of Aboriginal and 51.0% of non-Aboriginal adults were satisfied with life.
- A further 17.1% of Aboriginal and 15.2% of non-Aboriginal adults were somewhat satisfied with life.
- In contrast, 10.1% of Aboriginal adults were not at all satisfied with their lives – significantly higher than non-Aboriginal adults (5.1%).

Figure 2.4: Proportion (%) of adults with low subjective wellbeing, by Aboriginal status, Victoria, 2017



These findings confirm and support the work of the Royal Commission into Victoria’s Mental Health System, which identified the urgent need to address mental illness in Aboriginal communities. The Royal Commission was established in February 2019 and the final report was tabled in parliament by the Victorian Government on 2 March 2021.

The Royal Commission concluded that the current mental healthcare system is deficient and requires a radical overhaul, recognising that in regard to Aboriginal and Torres Strait Islander Victorians Aboriginal self-determination must be respected in

the design and delivery of care. In the new system, Aboriginal people should be able to choose to receive care within Aboriginal community-controlled organisations, mainstream services, or a mix of both. Irrespective of where treatment, care and support are delivered for Aboriginal people, communities, and families, it is fundamental that it is culturally safe, inclusive, respectful and responsive.

For more information, including the list of recommendations of the Royal Commission, visit <http://rcvmhs.archive.royalcommission.vic.gov.au/>.

Overall health status

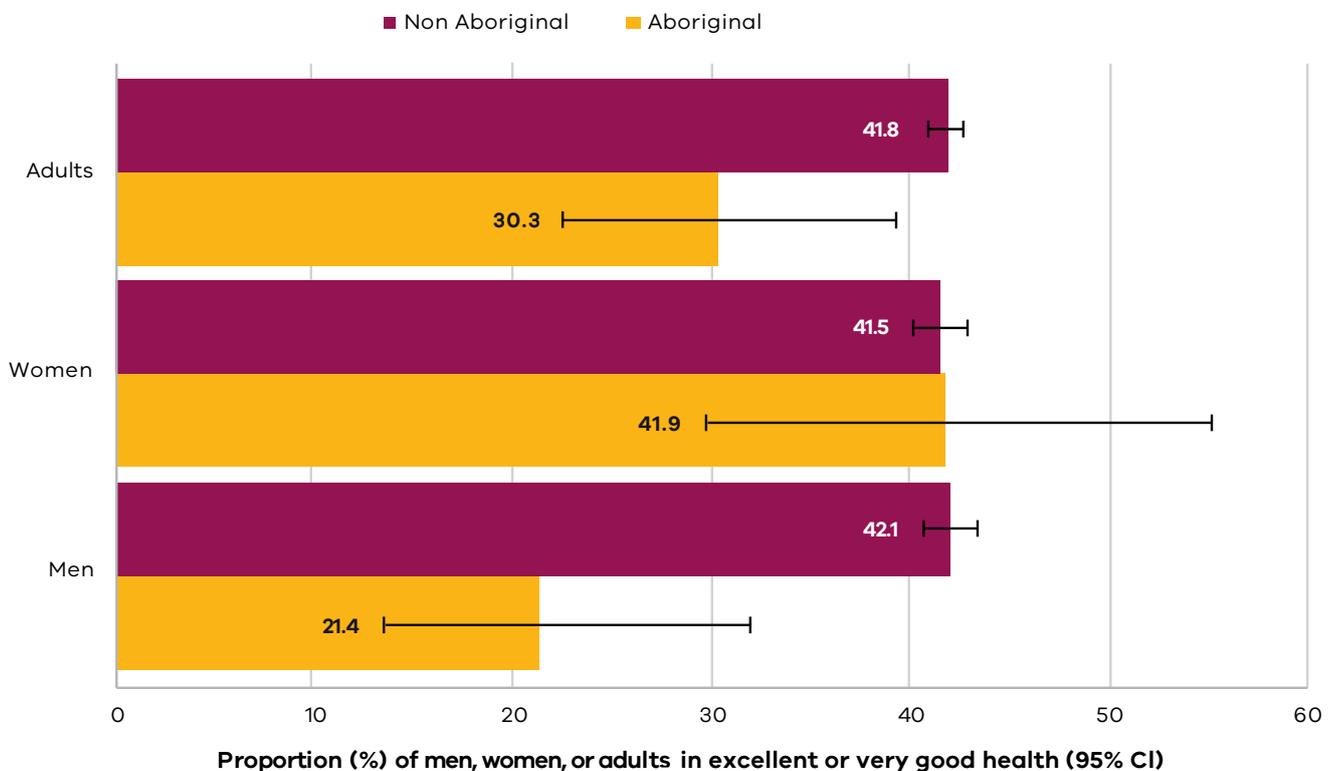
Survey participants were asked to rate their current health status by indicating whether, in general, they would say their health was ‘excellent’, ‘very good’, ‘good’, ‘fair’ or ‘poor’.

Self-reported health status has been shown to be a reliable predictor of ill-health, future healthcare use and premature mortality, independent of other medical, behavioural or psychosocial risk factors (Burstrom & Fredlund 2001; Idler & Benyamini 1997; Manor et al. 2001).

Appendix 2 Table 5 and Figure 2.5 show self-reported health status, by gender and Aboriginal status. The key findings were:

- Overall, 65.5% of Aboriginal adults rated their health as excellent, very good or good – significantly lower than non-Aboriginal adults (79.4%).
- In contrast, 34.5% of Aboriginal adults rated their health as fair or poor – significantly higher than non-Aboriginal adults (20.1%).
- There was no difference by gender in the proportion of adults who rated their health as fair or poor for Aboriginal or non-Aboriginal Victorians.

Figure 2.5: Proportion (%) of adults who reported their health as excellent or very good, by gender and Aboriginal status, Victoria, 2017



Dental health

Dental health was assessed by asking survey participants 'How would you rate your dental health?'. Appendix 2 Table 6 and Figure 2.6 show self-reported dental health status by gender and Aboriginal status. The key findings were:

Overall, 50.8% of Aboriginal adults rated their dental health as excellent, very good or good – significantly lower than non-Aboriginal adults (71.4%).

- In contrast, 35.7% of Aboriginal adults rated their dental health as fair or poor – significantly higher than non-Aboriginal adults (24.3%).
- More than twice as many Aboriginal women (34.2%) than Aboriginal men (15.8%) reported being in excellent or very good dental health.
- Almost one-quarter (23.2%) of Aboriginal men did not have any natural teeth (Figure 2.7) – significantly higher than non-Aboriginal men (3.8%).

Figure 2.6: Proportion (%) of adults with excellent or very good self-reported dental health, by gender and Aboriginal status, Victoria, 2017

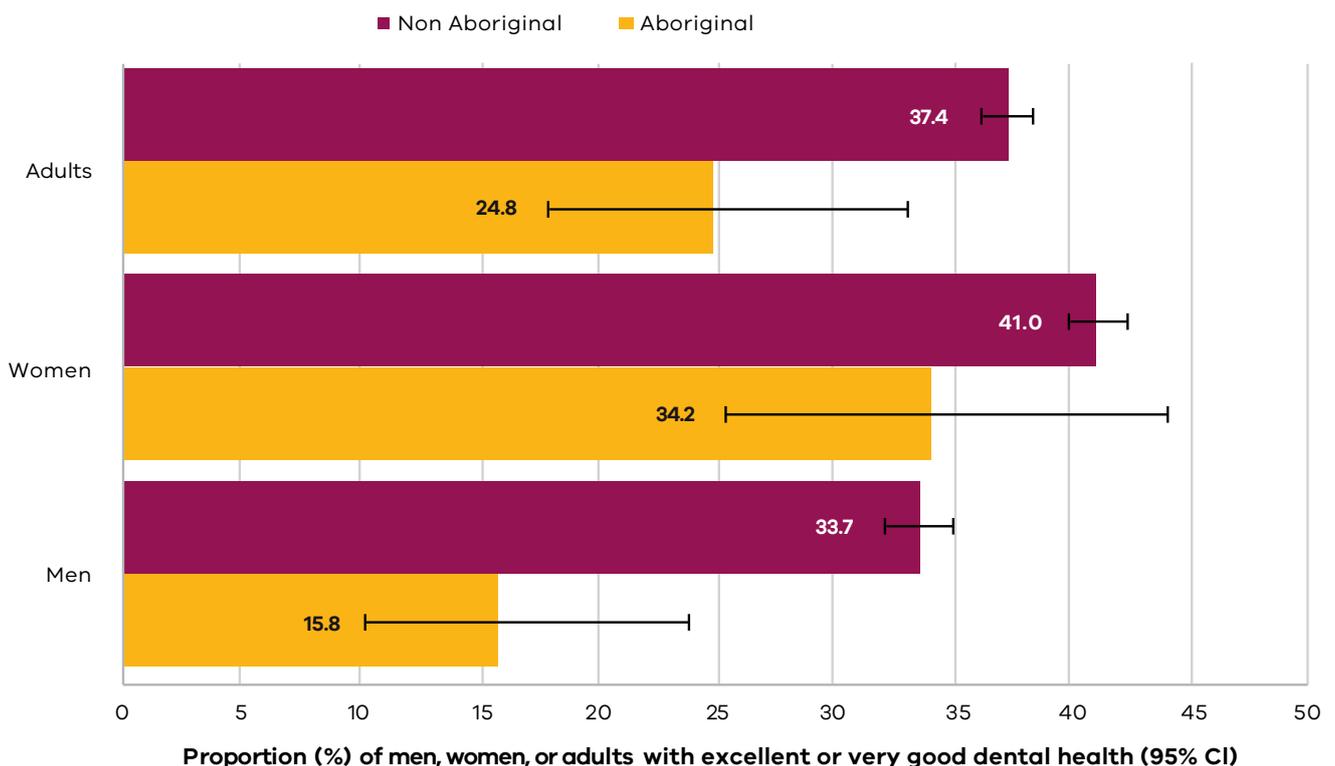
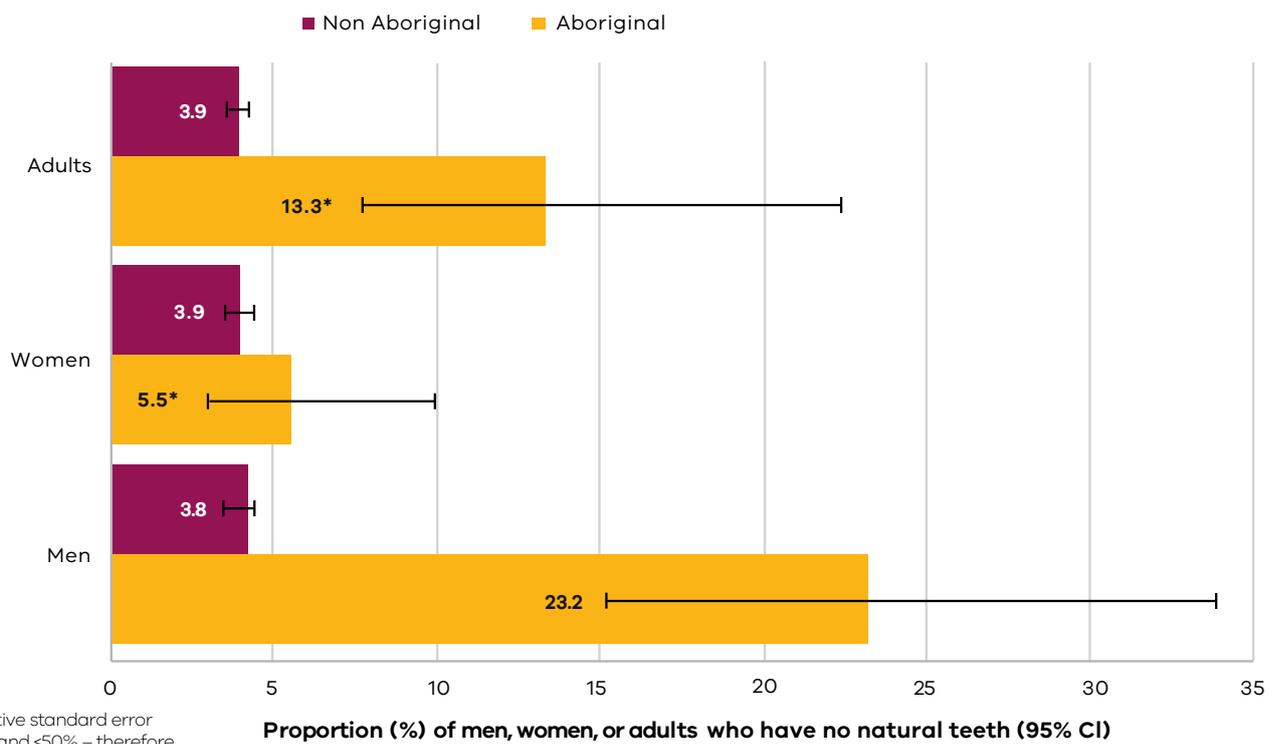


Figure 2.7: Proportion of adults who did not have any natural teeth, by gender and Aboriginal status, Victoria, 2017



3. SOCIAL DETERMINANTS OF HEALTH

This chapter reports on the social determinants of health and wellbeing. While the VPHS does not specifically collect data on all the social determinants of Aboriginal health described in chapter 1, the 2017 VPHS did collect data on connection to culture, experiences of racism, food insecurity, financial stress, family violence and social capital.

Connection to culture

For the first time, the VPHS has been able to explore the connection to culture enjoyed by Aboriginal Victorians. The three questions that were asked were sourced from the national Aboriginal social surveys conducted by the ABS. For further details, see Box 1, which shows the questions that were asked and their response options. Box 1 is located in Appendix 1 (Methods).

What is culture?

Culture has been variously defined, in part because it has been a topic of investigation in a number of different disciplines such as sociology and anthropology. Haviland (2002) defines culture as:

Culture consists of the abstract values, beliefs, and perceptions of the world that lie behind people's behaviour and that are reflected in their behaviour. These are shared by members of a society, and when acted upon, they produce behaviour that is intelligible to other members of that society. Cultures are learned, largely through the medium of language, rather than inherited biologically, and the parts of a culture function as an integrated whole.

What is the relationship between culture, health and wellbeing?

Connection to culture has been identified as an important determinant of Aboriginal social and emotional health and wellbeing (King et al. 2009; Morrissey et al. 2007; Social Health Reference Group 2004). Several studies show that being connected to culture is associated with better health and wellbeing (Dockery 2010; McDermott et al. 1998; Rowley et al. 2008).

In Victoria, a recently trialled new hospital-based treatment successfully treated 72% of Aboriginal children and adolescents with serious mental health problems. This compares with the successful treatment of only 31% of Aboriginal children and adolescents prior to implementing the program (Vance et al. 2017). The program was developed in extensive consultation with the Koori community, including 31 Elders. The treatment focused not only on Aboriginal ways of knowing and being, conducted in a culturally safe place with either a clinician of Aboriginal heritage or a non-Aboriginal clinician accompanied by a Koori mental health worker, but it included sharing the importance of Aboriginal culture with the patient and encouraged the patient to reciprocate.

More recently, a key study followed 408 Aboriginal children aged 9 to 12 years, for 2 years, investigating their social and emotional health and wellbeing in relation to the strength of their Aboriginal identity (Macedo et al. 2019). Compared with children who had a strong Aboriginal identity, children who had a low Aboriginal identity were at increased risk of hyperactive behaviour, conduct problems and total social and emotional health and wellbeing difficulties. In contrast, children with a strong Aboriginal identity were at increased risk of problems with their peers. The authors concluded that having a strong Aboriginal identity that reflects a strong connection to culture mitigates the health-damaging effects of racism. However, the finding that Aboriginal children with a strong Aboriginal identity were at increased risk of peer problems may reflect being targeted by their peers because of their strong Aboriginal identity and/or these children may be more likely to confront racist behaviour by their peers.

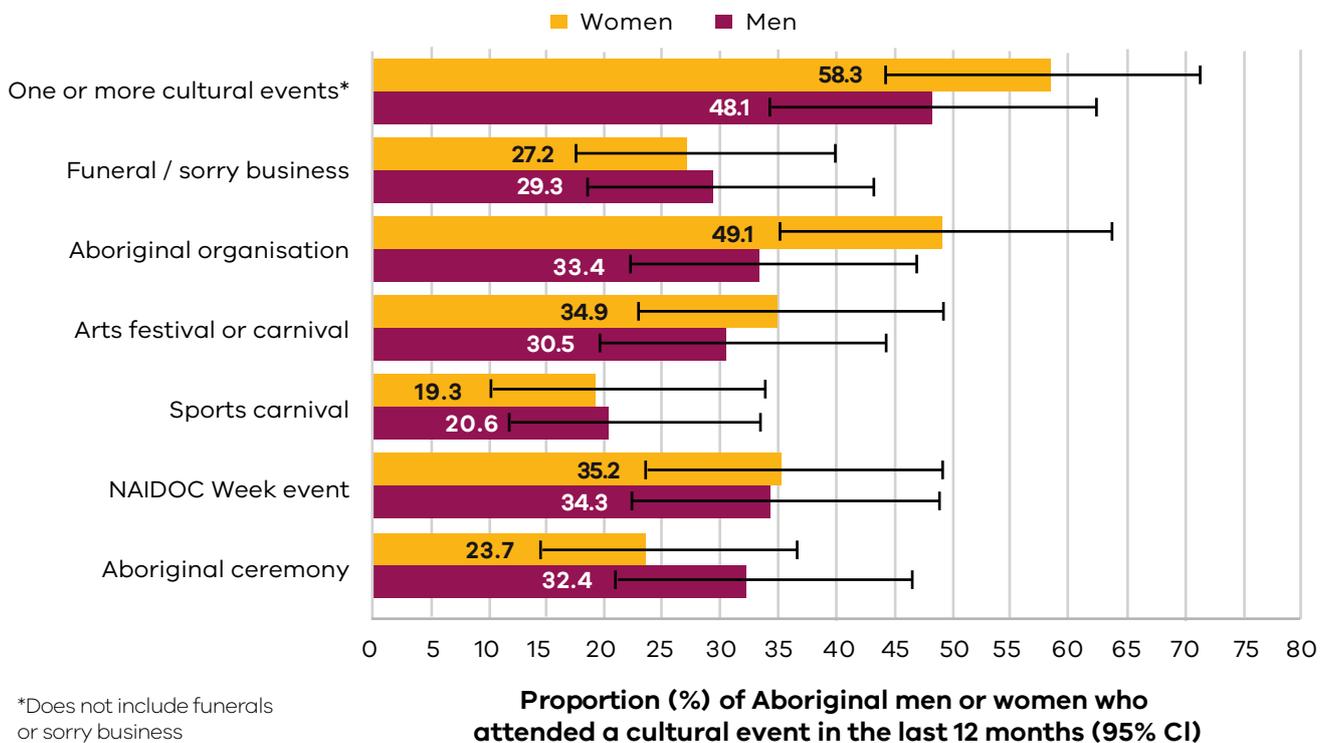
Proportion of adults who participated in cultural events

Appendix 2 Table 7 and Figure 3.1 show the proportion of Aboriginal adults living in Victoria who attended an Aboriginal cultural event in the 12 months preceding the survey. The cultural events included: ceremonies; NAIDOC (National Aboriginal and Islanders Day Observance Committee) Week; sports carnivals (excluding NAIDOC Week activities); festivals or carnivals involving Aboriginal or Torres Strait Islander arts, craft, music or dance (excluding NAIDOC Week activities); being involved with any Aboriginal or Torres Strait Islander organisation; and funerals or sorry business. The key findings were:

- A higher proportion of Aboriginal women (58.3%) than men (48.1%) attended at least one Aboriginal cultural event (not including a funeral or sorry business) in the 12 months preceding the survey.

- A higher proportion of Aboriginal men (32.4%) than women (23.7%) attended an Aboriginal ceremony.
- Similar proportions of Aboriginal men (34.3%) and women (35.2%) attended a NAIDOC Week event.
- Similar proportions of Aboriginal men (20.6%) and women (19.3%) attended a sports carnival.
- Similar proportions of Aboriginal men (30.5%) and women (34.9%) attended an arts festival or carnival involving Aboriginal arts, crafts, music or dance.
- A higher proportion of Aboriginal women (49.1%) than men (33.4%) were involved in an Aboriginal organisation.
- Similar proportions of Aboriginal men (29.3%) and women (27.2%) attended a funeral or sorry business.

Figure 3.1: Proportion (%) of Aboriginal adults who attended one or more Aboriginal cultural events in the 12 months preceding the survey, by gender and type of event, Victoria, 2017

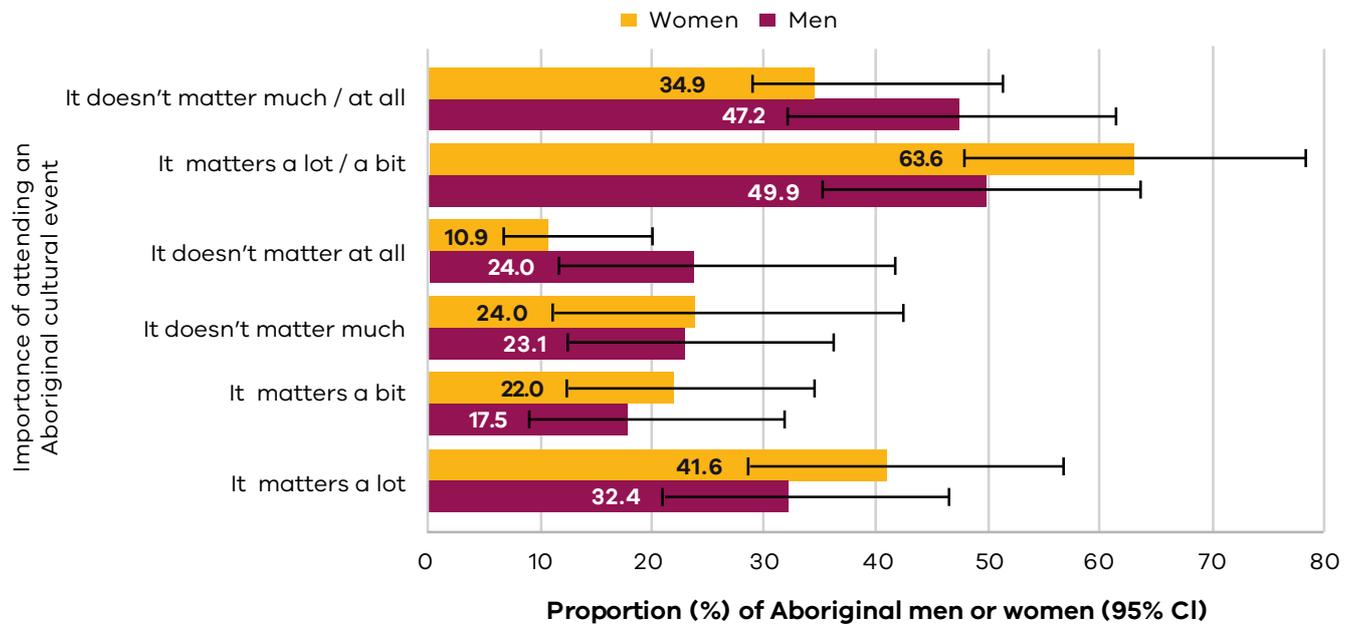


How important was it for adults to attend an Aboriginal cultural event?

Appendix 2 Table 8 and Figure 3.2 show the importance of attending an Aboriginal cultural event in the 12 months preceding the survey, by gender. The key findings were:

- A higher proportion of Aboriginal women (41.6%) than men (32.4%) reported that attending an Aboriginal cultural event mattered ‘a lot’.
- A similar proportion of Aboriginal women (22.0%) and men (17.5%) reported that attending an Aboriginal cultural event mattered ‘a bit’.
- A similar proportion of Aboriginal women (23.1%) and men (24.0%) reported that attending an Aboriginal cultural event didn’t matter much.
- More than twice as many Aboriginal men (24.0%) than women (10.9%) reported that attending an Aboriginal cultural event did not matter at all.

Figure 3.2: Proportion (%) of Aboriginal men and women, by the importance of attending an Aboriginal cultural event, Victoria, 2017



Proportion of adults who spoke with an Elder or older relative about Aboriginal history or culture

Appendix 2 Table 9 and Figure 3.3 show the proportions of Aboriginal men and women who spoke with an Elder or older relative about Aboriginal history or culture in the 12 months preceding the survey. The key findings were:

- Similar proportions of Aboriginal men (59.9%) and women (58.6%) sometimes, often, or very often talked with an Elder or older relative about Aboriginal history or culture in the 12 months preceding the survey.
- In contrast, similar proportions of Aboriginal men (40.1%) and women (40.3%) rarely or never talk with an Elder or older relative about Aboriginal history or culture.

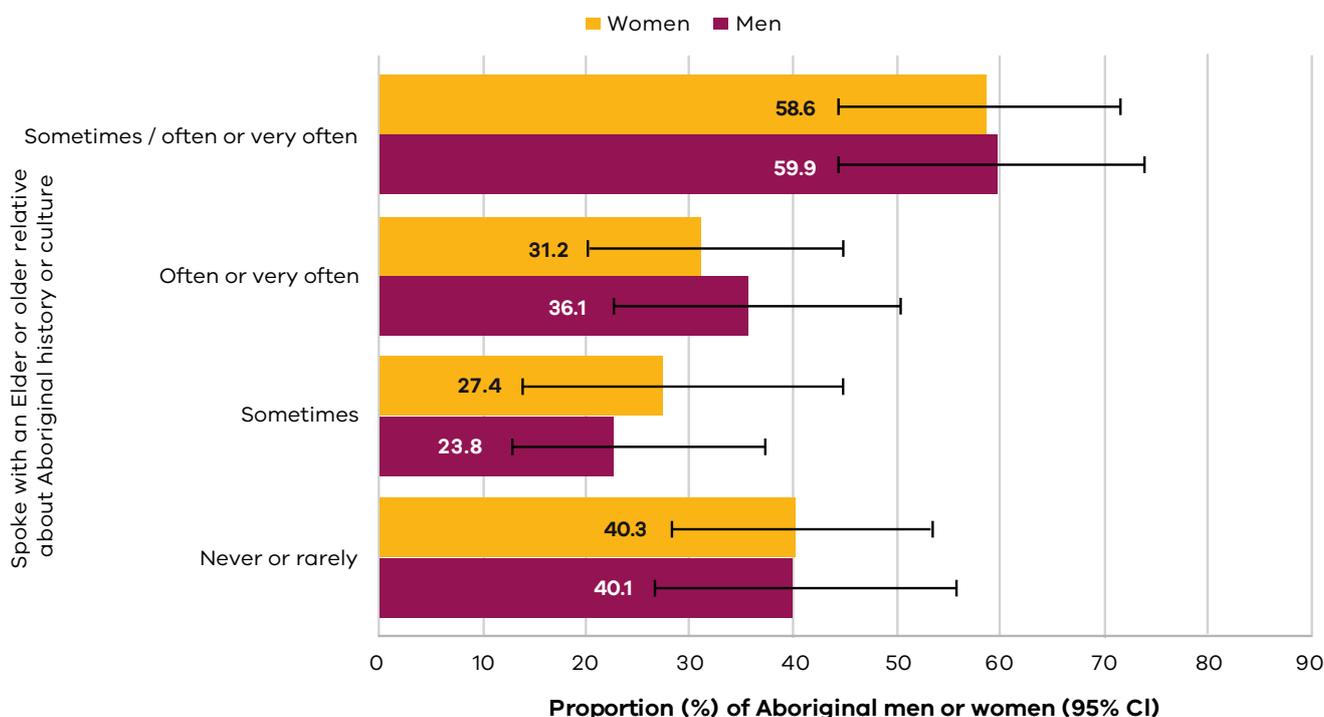
Overall health status of adults connected to culture

Assuming that the measures described above are valid measures of connection to culture, we investigated whether being connected to culture was associated with better health.

Self-reported health status has been shown to be a reliable predictor of ill-health, future health care use and premature mortality, independent of other medical, behavioural or psychosocial risk factors (Burstrom & Fredlund 2001; Idler & Benyamini 1997; Manor et al. 2001).

Survey participants were asked to rank their current health status by indicating whether, in general, they would say their health was 'excellent', 'very good', 'good', 'fair' or 'poor'.

Figure 3.3: Proportion (%) of Aboriginal men and women, by how often they spoke with an Elder or older relative about Aboriginal history or culture in the 12 months preceding the survey, Victoria, 2017



Appendix 2 Table 10, Figure 3.4, Appendix 2 Table 11 and Figure 3.5 show two measures of connection to culture by self-reported health status. The key findings were:

- A higher proportion of Aboriginal adults who attended at least one Aboriginal cultural event in the 12 months preceding the survey (30.6%) reported being in excellent or very good health compared with 23.1% of Aboriginal adults who did not attend an Aboriginal cultural event.

- A higher proportion of Aboriginal adults who often or very often spoke with an Elder or older relative about Aboriginal culture or history (31.3%) reported being in excellent or very good health compared with 22.1% of Aboriginal adults who rarely or never spoke with an Elder or older relative about Aboriginal culture or history.

Figure 3.4: Proportion (%) of Aboriginal adults who did or did not attend at least one Aboriginal cultural event in the 12 months preceding the survey, by self-reported health status, Victoria, 2017

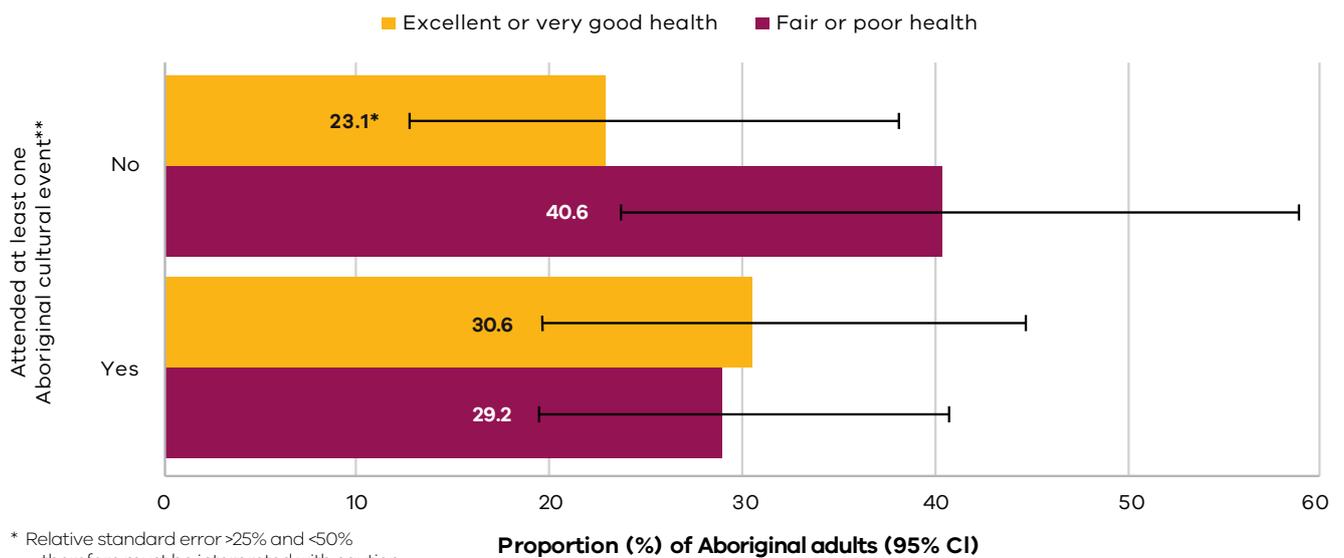
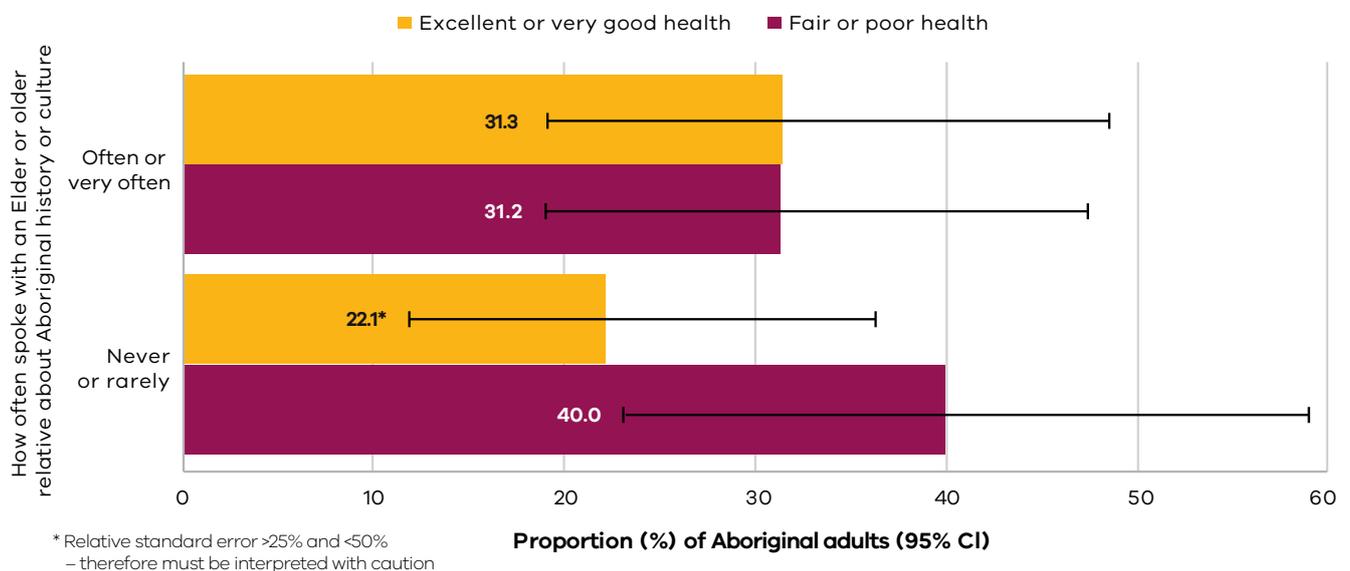


Figure 3.5: Proportion (%) of Aboriginal adults, by how often they spoke with an Elder or older relative about Aboriginal history or culture in the 12 months preceding the survey and self-reported health status, Victoria, 2017



Experiences of racism

What is racism?

On an individual level, racism refers to the beliefs and attitudes that members of certain groups have of their superiority in relation to other groups who are regarded as inferior, based on race, ethnicity, or cultural background (Sanson et al. 1998). Those who are assumed to be inferior are treated differently and unfavourably.

At a societal level, racism can be defined as ‘that which maintains or exacerbates inequality of opportunity among ethn racial groups’ and racial discrimination as ‘the racist behaviours and practices that result in inequality of opportunity among ethn racial groups’ (Berman & Paradies 2010, p. 217).

Racism occurs at three levels (Paradies 2018):

1. Internalised – where a person incorporates attitudes, beliefs and/or ideologies within their world view that serves to maintain or exacerbate the unequal distribution of opportunity across ethnic groups. It takes two forms:
 - a. ‘internalised dominance’ – where the individual believes that their ethnic group is superior while other ethnic groups are inferior
 - b. ‘internalised oppression’ – where the individual believes that their ethnic group is inferior while other ethnic groups are superior. People who respond to experiences of racism with feelings of shame are more likely to be at risk of internalised oppression.

2. Interpersonal – where the interactions between people serve to maintain or exacerbate the unequal distribution of opportunity across ethnic groups.
3. Systemic or institutional – when the control of, and access to, societal resources serve to maintain or exacerbate the unequal distribution of opportunity across ethnic groups.

Racism is not harmless. Repeated exposure to racism over time has profound health-damaging effects on its recipients through multiple pathways. Although racism is not always intentional and much of systemic racism is carried out by people who are ignorant or in denial, it is important to remember that this does not lessen its harmful effects and so intent is not relevant.

Implicit bias, also known as ‘unconscious bias’, is an unconscious belief, feeling or attitude towards the members of another social group that leads to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender (FitzGerald & Hurst 2017). These can exist even when contrary to the individual’s conscious or declared beliefs.

A recent study that measured implicit bias or unconscious bias found that approximately 75% of non-Aboriginal Australians hold an implicit bias against Aboriginal, with a third holding a strong implicit bias (Shirodkar 2019).

The study used the internationally validated Implicit Association Test to measure the prevalence of implicit bias in approximately 17,000 non-Aboriginal Australians over a 10-year period from 2009 to 2019 (Shirodkar 2019). The authors concluded that:

Perhaps the reason why policy makers are facing a hard ceiling on progress against the Closing the Gap targets partially reflects the fact that as a society, we have yet to genuinely address a significant barrier to Indigenous progress – the potential implicit bias that non-Indigenous Australia holds against them (Shirodkar 2019, p. 26).

What is the experience of racism among Aboriginal Australians?

Most Aboriginal Australians experience racism at some point in their lives, with survey prevalence estimates ranging between 15 and 97% (Australian Bureau of Statistics 2016b; Department of Health and Human Services 2017c; Ferdinand et al. 2012). The wide range of estimates reflects the type of questions(s) asked, the time period in question, the study design, and whether the respondent personally experienced or witnessed racism.

Do experiences of racism harm health and wellbeing?

A number of systematic reviews and meta-analyses (the highest level of evidence) show that the balance of evidence confirms that racism is a significant health risk factor for both mental and physical health (Paradies et al. 2015; Pascoe & Smart Richman 2009; Schmitt et al. 2014).

The most recent systematic review and meta-analysis examined 293 studies conducted between 1983 and 2013, representing 309,687 people across the world including Australia (Paradies et al. 2015). This analysis showed that racism is clearly associated with both poorer mental and physical health even after controlling for age, sex, birthplace and education. The authors concluded that racism is an important determinant of health.

The harmful effects of racism on mental health have been shown to include conditions such as psychological distress, depression, anxiety, post-traumatic stress disorder, psychosis and substance abuse disorders (Berger & Sarnyai 2015; Paradies et al. 2015).

The harmful effects of racism on physical health include diseases and conditions such as cardiovascular disease (Lewis et al. 2014), hypertension (Dolezsar et al. 2014), poor self-reported health (Paradies and Cunningham 2012), obesity (Cozier et al. 2014), adult-onset asthma (Coogan et al. 2014) and cancer (Taylor et al. 2007).

How does racism harm health and wellbeing?

Racism affects health directly and indirectly via a number of pathways (Harrell et al. 2011; Paradies et al. 2015):

Indirect pathways:

- Racism reduces access to employment, housing and education, resulting in low socioeconomic status. As socioeconomic status declines so do mental and physical health.
- Racism decreases participation in healthy behaviours such as sleep and exercise, and increases participation in unhealthy behaviours such as smoking, consumption of alcohol and overeating, as a means of coping.
- Maternal exposure to racism elicits a physiological stress response that affects the uterine environment and epigenetic activity, causing subtle but harmful effects on a fetus that can be maintained into adulthood.

Direct pathways:

1. Racism acts as a chronic stressor that overstimulates the body's responses to stress. When a person encounters an acute stressor, various systems in the body are triggered in what is commonly referred to as the 'flight-or-fight' response that prepares the person to cope with the threat by either removing themselves from it or by directly challenging the threat. Once the threat is over, the body returns to normal (Chrousos 1995).

While this is an important short-term physiological response to ensure survival, chronic stimulation of the fight-or-flight response over time leads to pathological changes that can trigger diseases or conditions such as metabolic syndrome, type 2 diabetes, cardiovascular disease and increased susceptibility to addictions (Burke et al. 2005; Golden 2007).

2. Racism causes adverse cognitive and emotional responses that are associated with psychopathology such as depression and anxiety (Burke et al. 2005).
3. Racism can result in physical injury due to racially motivated violence.

How was racism measured?

Survey participants were asked four questions. These are described in Box 2 located in Appendix 1 (Methods). Survey participants were deemed to have experienced racism if they responded that they had experienced discrimination in the 12 months preceding the survey due to their Aboriginal status, skin colour, nationality, race or ethnic group.

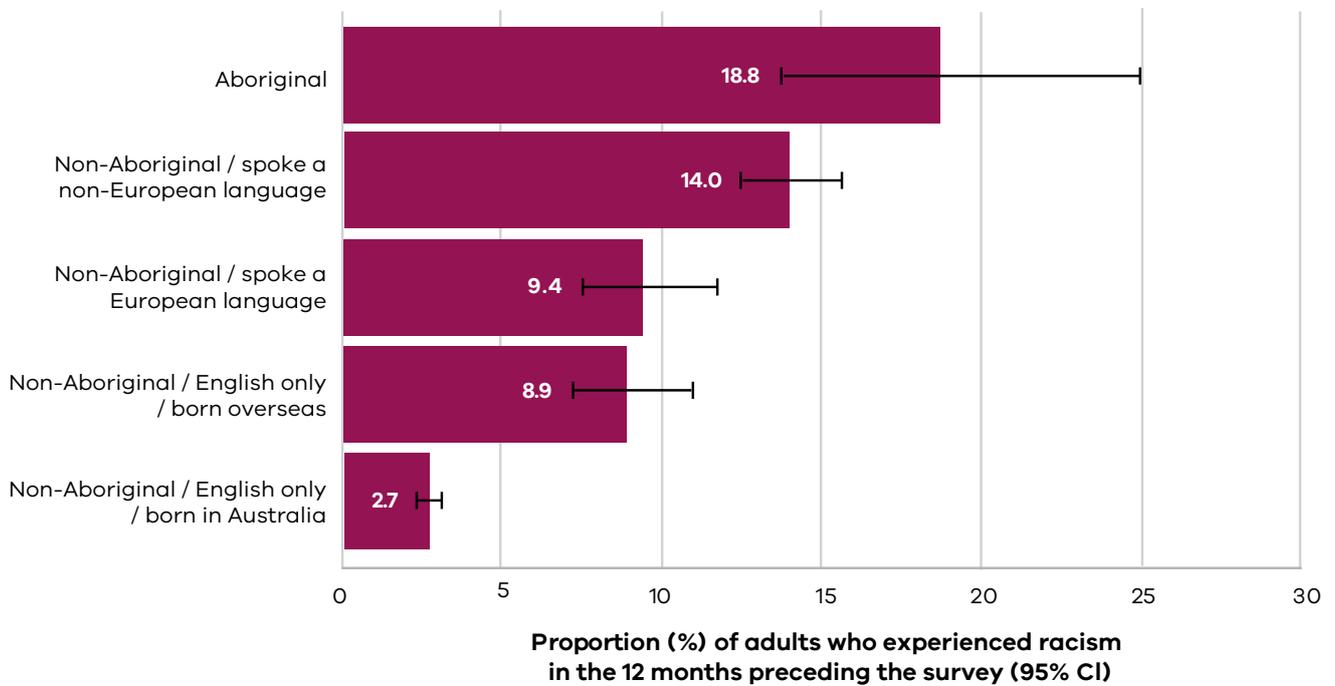
Proportion of adults who experienced racism

Appendix 2 Table 12 and Figure 3.6 show the proportion of adults in Victoria who experienced racism, by ethnicity. Survey participants were asked about their country of birth and whether they spoke a language other than English at home. Survey participants who identified as Aboriginal, regardless of what language(s) they spoke, were deemed to be Aboriginal. Those who spoke a language other than English at home were categorised into European and non-European languages. Those who only spoke English at home were categorised into Australian or overseas born.

The key findings were:

- Almost 1 in 5 (18.8%) Aboriginal adults experienced racism in the 12 months preceding the survey.
- Adults who identified as Aboriginal (18.8%) were significantly more likely to have experienced discrimination in the 12 months preceding the survey than adults who spoke a European language at home (9.4%), adults who only spoke English and were born overseas (8.9%), and adults who were non-Aboriginal, only spoke English, and were born in Australia (2.7%). The proportion of adults who experienced racism was also higher in adults who spoke a non-European language at home (14.0%).

Figure 3.6: Proportion (%) of adults who experienced racism in the 12 months preceding the survey, by ethnicity, Victoria, 2017



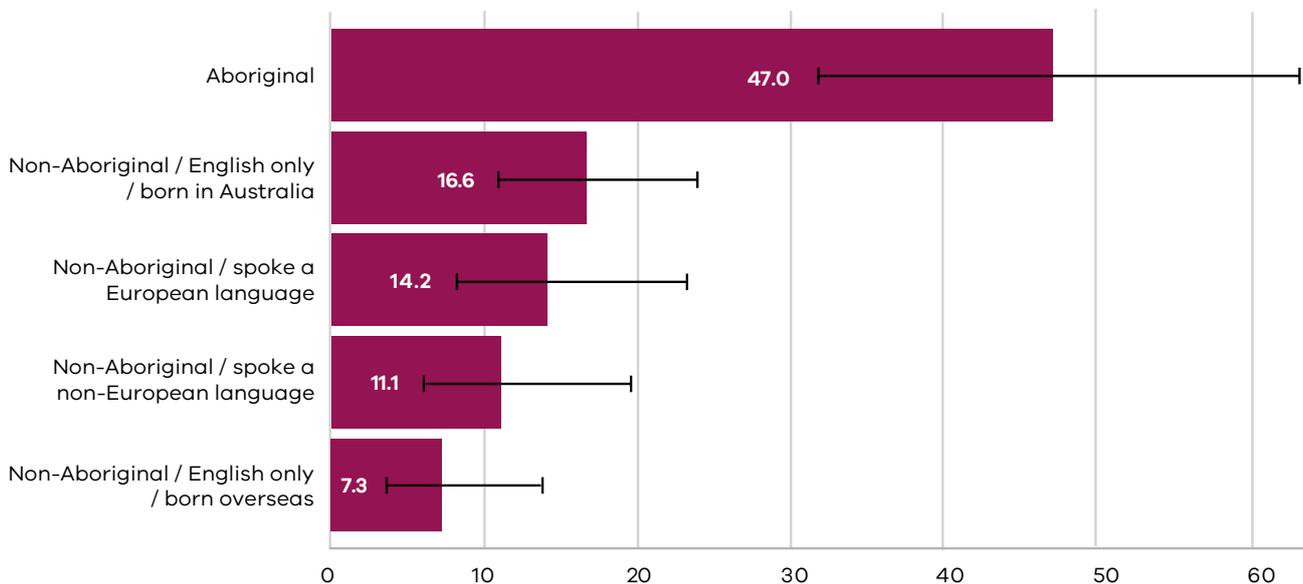
Where racism was experienced

Survey participants who experienced discrimination on the basis of their Aboriginal status, skin colour, nationality, race or ethnic group were asked whether they had experienced the racism in a predetermined list of settings.

Appendix 2 Table 13 shows the settings where racism was experienced, by ethnicity. The key findings were:

- The most common place where racism was experienced was in public, perpetrated by a member of the public. Of those who experienced racism, 70.2% of Aboriginal adults experienced racism perpetrated by members of the public.
- The second most common place in which Aboriginal adults experienced racism was in a healthcare setting perpetrated by a member of staff such as a doctor or nurse (Figure 3.7). Of those who experienced racism, Aboriginal adults were significantly more likely to experience racism in a healthcare setting (47.0%) than all other adults.

Figure 3.7: Proportion (%) of adults who experienced racism in the 12 months preceding the survey, perpetrated by a doctor, nurse or other staff at a hospital or doctor's surgery, by ethnicity, Victoria, 2017

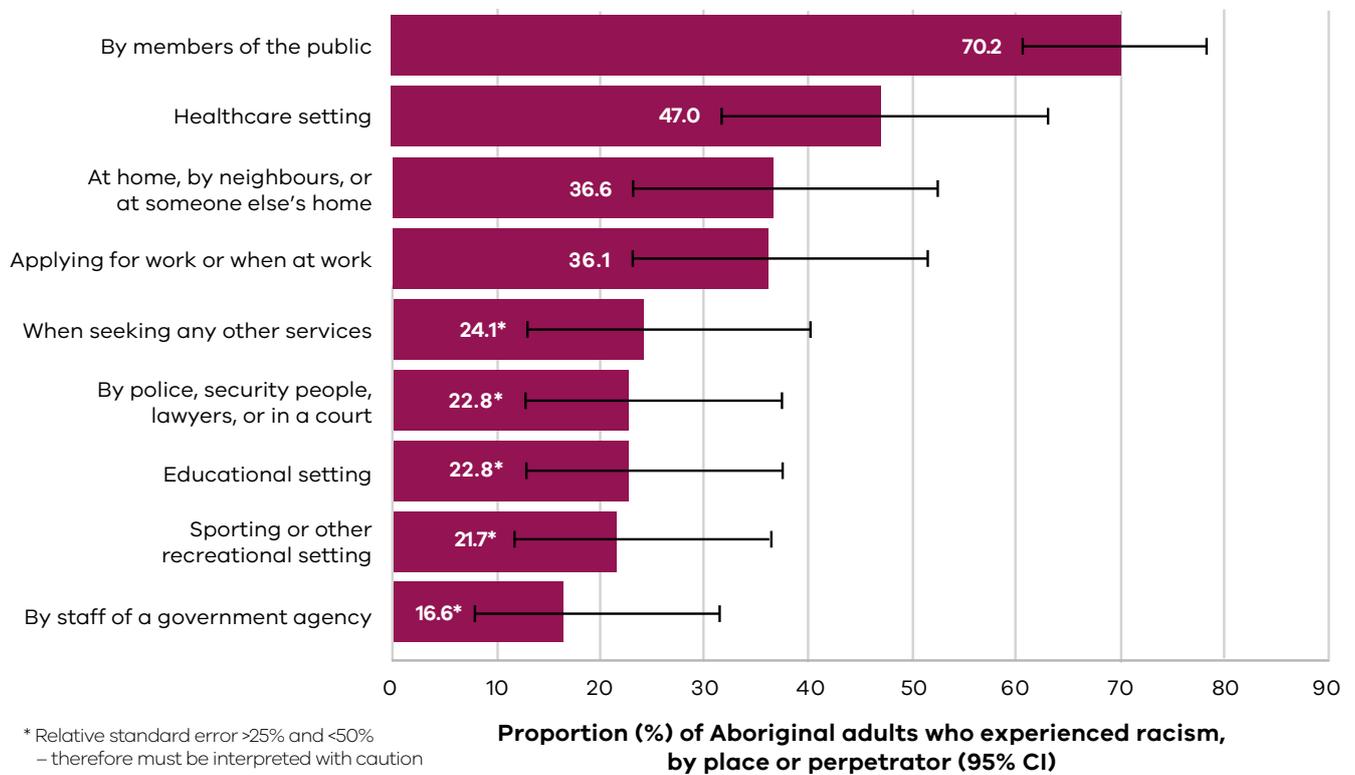


Note: the denominator is adults who experienced racism

Proportion (%) of those who experienced racism in a healthcare setting by a healthcare provider (95% CI)

- The third most common setting in which Aboriginal adults experienced racism was at home, by neighbours, or in someone else's home. Of those who experienced racism, 36.6% of Aboriginal adults experienced it at home, by neighbours, or in someone else's home.
- The fourth most common setting where racism was experienced was: applying for work or at work (36.1%); followed by seeking any other services (24.1%); by police, security people, lawyers of a court of law (22.8%); in an educational setting (22.8%); at a sporting, recreational or leisure activity setting (21.7%); and when attending a government service (16.6%).
- Figure 3.8 summarises the settings in which Aboriginal adults in Victoria experienced racism in the 12 months preceding the survey.

Figure 3.8: Proportion (%) of Aboriginal adults who experienced racism in the 12 months preceding the survey, by place of experience or perpetrator, Victoria, 2017

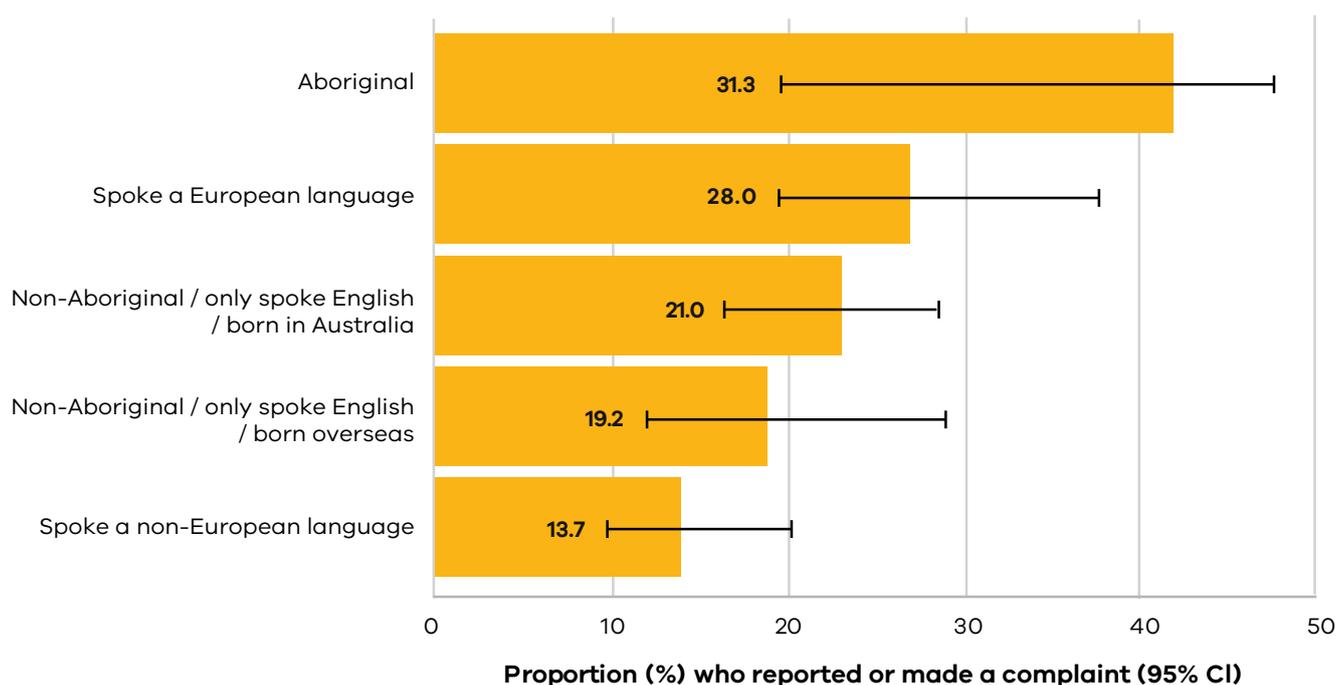


Response to racism

Survey participants who reported experiencing racism on the basis of their Aboriginal status, skin colour, nationality, race or ethnic group were asked whether they reported or made a complaint about their experience(s). This did not include telling a family member or a friend.

Appendix 2 Table 14 and Figure 3.9 show that 31.3% of Aboriginal adults who experienced racism in the 12 months preceding the survey reported or made a complaint about the experience(s) – higher than non-Aboriginal adults who experienced racism.

Figure 3.9: Proportion (%) of adults who experienced racism and reported the incident or made a complaint, by ethnicity, Victoria, 2017



Health and wellbeing of adults who experienced racism

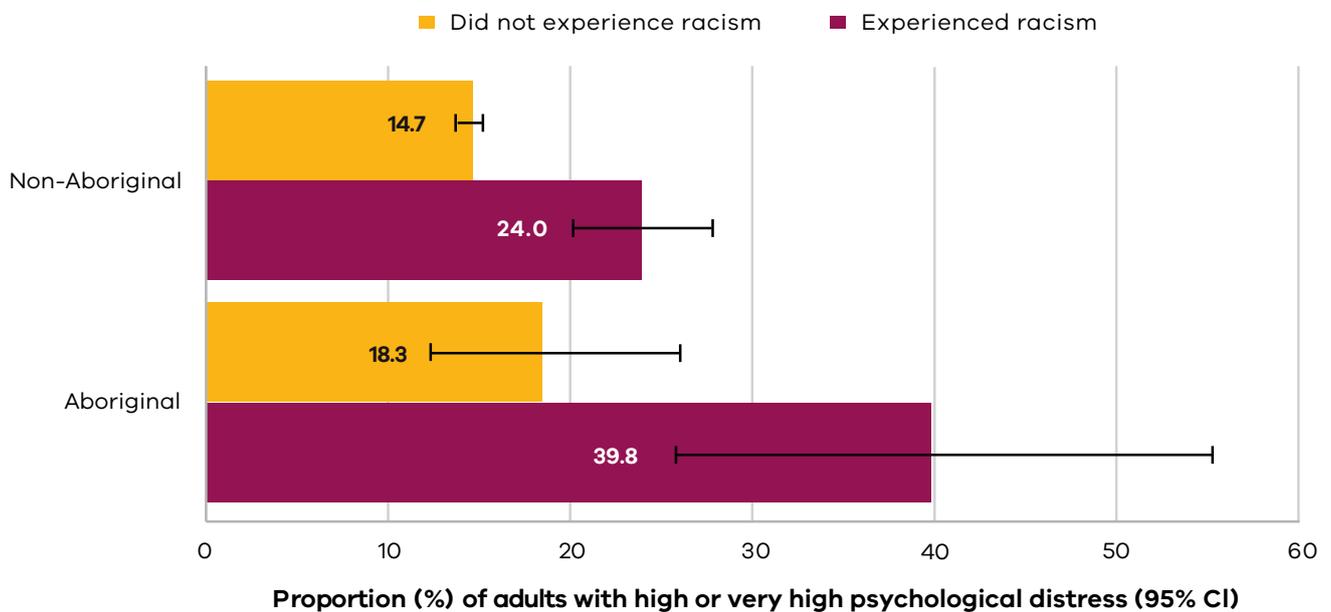
Psychological distress

Survey participants were asked a series of 10 questions that constituted the Kessler PSychological Distress Scale (K10) scale to determine their psychological distress level. Appendix 2 Table 15 and Figure 3.10 show the psychological distress levels of adults by experiences of racism and Aboriginal status.

The key findings were:

- Experiences of racism were associated with high and very high psychological distress in both Aboriginal and non-Aboriginal adults.
- A little over one-third (39.8%) of Aboriginal adults who experienced racism had high or very high levels of psychological distress – higher than Aboriginal adults who did not experience racism (18.3%) and non-Aboriginal adults who experienced racism (24.0%).

Figure 3.10: Proportion (%) of adults with high or very high psychological distress, by experiences of racism and Aboriginal status, Victoria, 2017



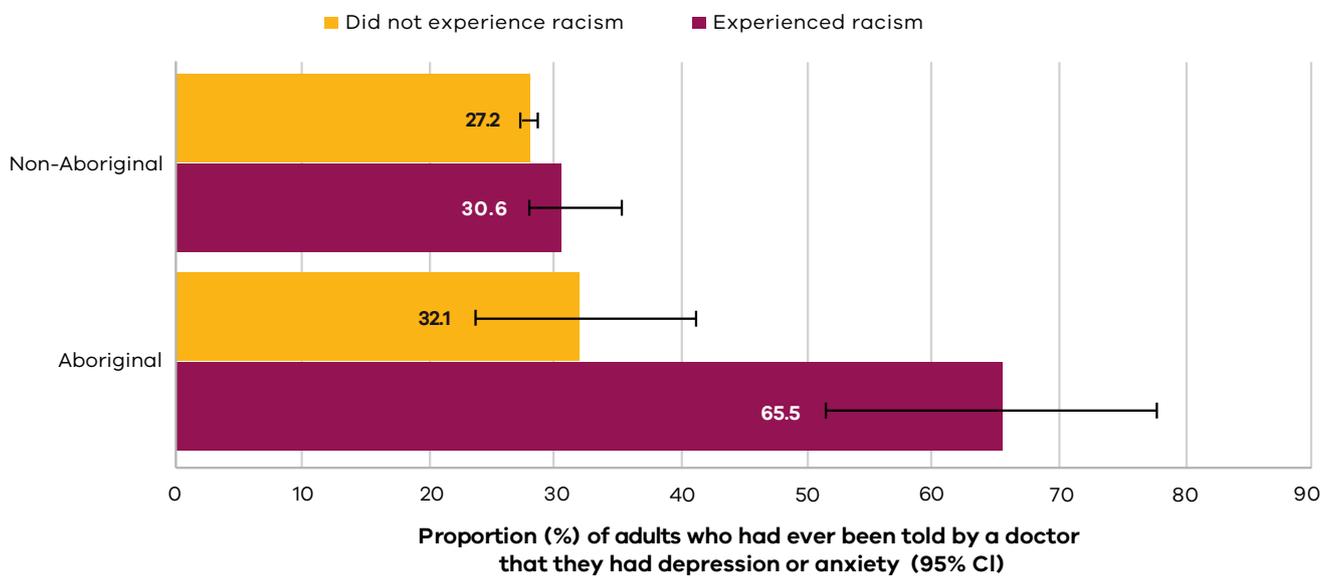
Depression and anxiety

Survey participants were asked if they had ever been told by a doctor that they had depression or anxiety. Appendix 2 Table 16 and Figure 3.11 show the proportion of adults who had ever been told by a doctor that they had depression or anxiety, by experiences of racism and Aboriginal status. The key findings were:

- Depression and anxiety were strongly associated with experiences of racism in Aboriginal but not non-Aboriginal adults in Victoria.
- Approximately two-thirds (65.5%) of Aboriginal adults who experienced racism had ever been diagnosed by a doctor with depression or anxiety – significantly higher than Aboriginal adults who did not experience racism (32.1%) and non-Aboriginal adults who experienced racism (30.6%).

This suggests that experiences of racism may make a substantial contribution to the significantly higher prevalence of lifetime depression and anxiety among Aboriginal adults compared with non-Aboriginal adults.

Figure 3.11: Proportion (%) of adults who had ever been told by a doctor that they had depression or anxiety, by experiences of racism and Aboriginal status, Victoria, 2017

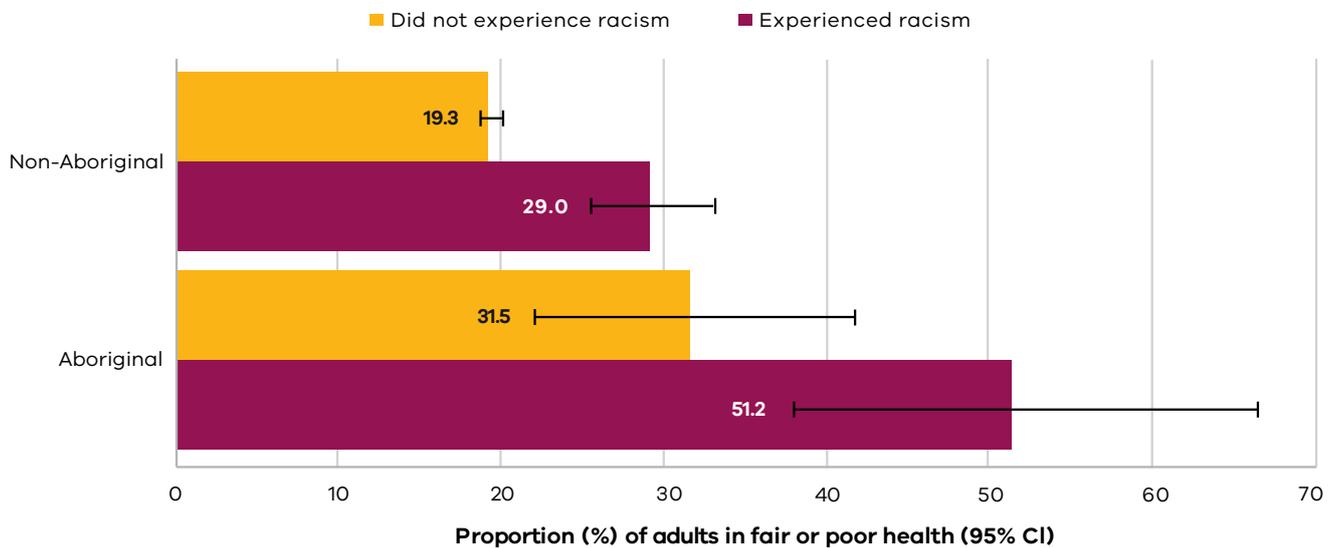


Self-reported health status

Survey participants were asked to rate their overall health status. Appendix 2 Table 17 and Figure 3.12 show self-reported health status by experiences of racism and Aboriginal status. The key findings were:

- Experiences of racism were strongly associated with fair or poor self-reported health status in Aboriginal and non-Aboriginal adults in Victoria.
- Just over one-half (51.2%) of Aboriginal adults who experienced racism reported being in fair or poor health – higher than Aboriginal adults who did not experience racism (31.5%) and non-Aboriginal adults who experienced racism (29.0%).

Figure 3.12: Proportion (%) of adults in fair or poor health, by experiences of racism and Aboriginal status, Victoria, 2017



Experiences of racism and educational attainment

Socioeconomic status is typically measured by income, education and/or occupation at the level of the individual. However, while people often use these measures interchangeably, they are only moderately correlated with each other and each measure can mean something different in different populations (Adler & Snibbe 2003). This section investigates the relationship between experiences of racism and level of educational attainment.

Survey participants were asked to indicate their highest level of educational achievement. Although many participants attended vocational education training at a TAFE (Technical and Further Education), participants were not asked about the course they had undertaken. Therefore, since the courses

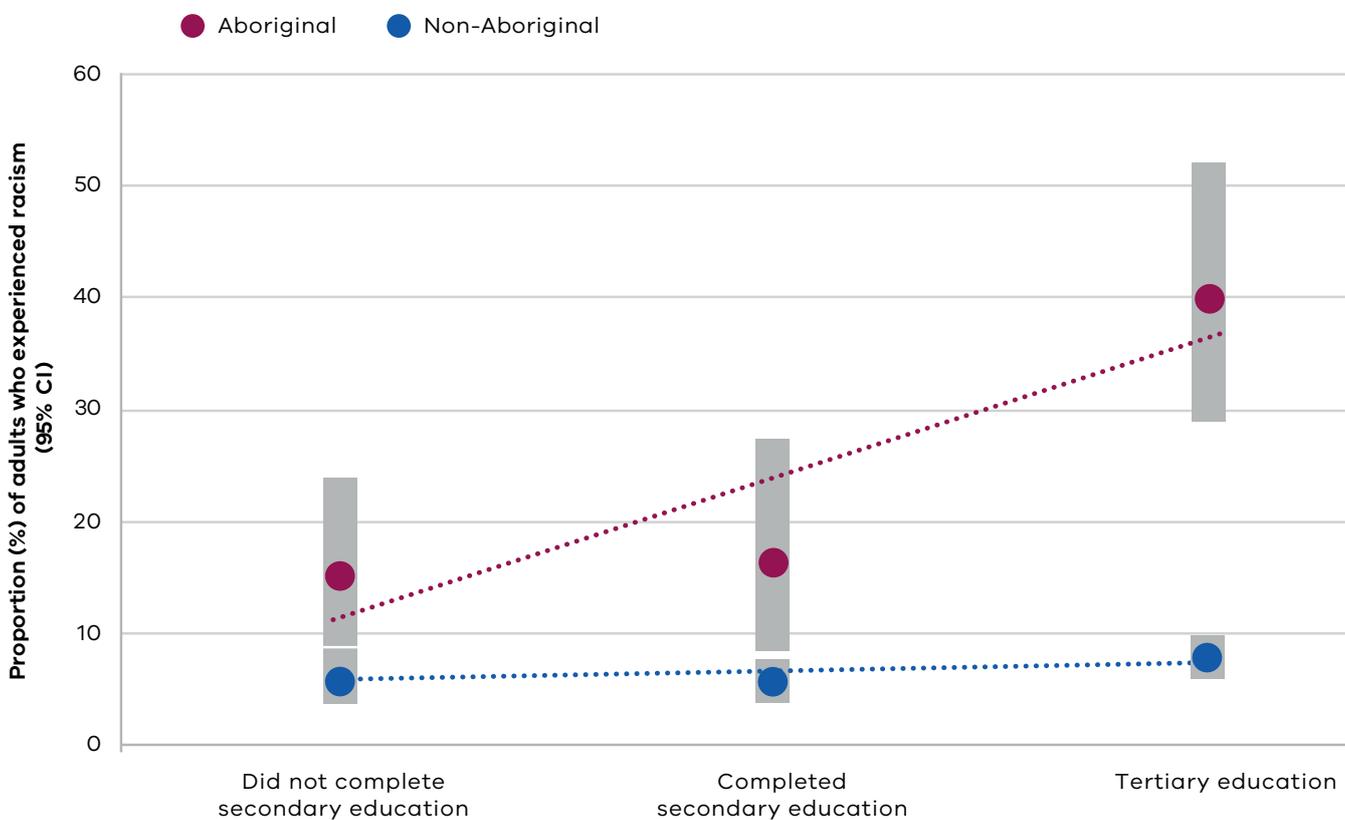
offered at TAFE span both the secondary and tertiary educational sectors, we determined the highest level of education attained as follows:

1. Did not complete secondary education – includes all survey participants who went to secondary school but did not complete Year 12, irrespective of whether or not they attended TAFE.
2. Completed secondary education – includes all survey participants who completed Year 12 but did not go to university, irrespective of whether or not they attended TAFE.
3. Tertiary – includes all survey participants who went onto university but not those who attended TAFE.

Appendix 2 Table 18 and Figure 3.13 show the relationship between experiences of racism and highest level of educational attainment. The key findings were:

- The proportion of adults who experienced racism increased with increasing level of educational attainment in both Aboriginal and non-Aboriginal adults.
- The proportion of Aboriginal adults who experienced racism was highest among those who were tertiary educated (39.9%), significantly higher than non-Aboriginal adults who were tertiary educated (8.0%) and significantly higher than Aboriginal adults who did not complete secondary education.

Figure 3.13: Proportion (%) of adults who experienced racism, by highest level of educational attainment and Aboriginal status, Victoria, 2017



Educational attainment, health and wellbeing

Most health and wellbeing outcomes exhibit strong gradients where the lower the level of educational attainment of an individual, the more likely the individual is to experience an adverse health or wellbeing outcome.

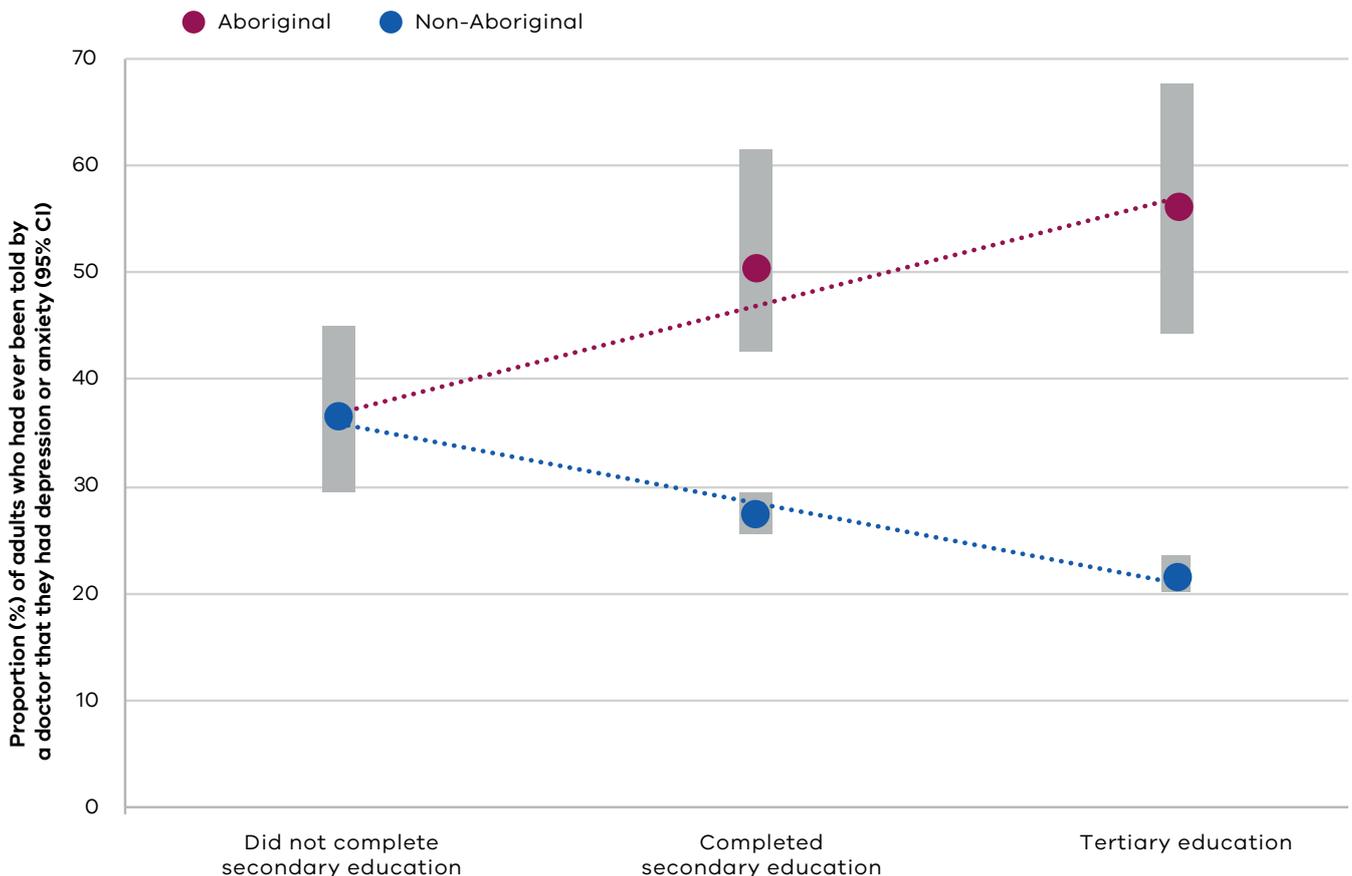
This section investigated the health and wellbeing of adults in Victoria by level of educational attainment. It is important to note in the context of this report that 'education' refers specifically to mainstream Western education.

Depression and anxiety

Appendix 2 Table 19 and Figure 3.14 show the proportion of adults who had ever been told by a doctor that they had depression or anxiety by highest level of educational attainment and Aboriginal status. The key findings were:

- The proportion of Aboriginal adults who had ever been told by a doctor that they had depression or anxiety increased with increasing level of education attainment – from 36.2% of Aboriginal adults who did not complete a secondary education to 55.5% of Aboriginal adults who were tertiary educated.
- In contrast, the proportion of non-Aboriginal adults who had ever been told by a doctor that they had depression or anxiety decreased with increasing level of educational attainment – from 36.5% of non-Aboriginal adults who did not complete a secondary education to 21.6% of non-Aboriginal adults who were tertiary educated.

Figure 3.14: Proportion (%) of adults who had ever been told by a doctor that they had depression or anxiety, by highest level of educational attainment and Aboriginal status, Victoria, 2017

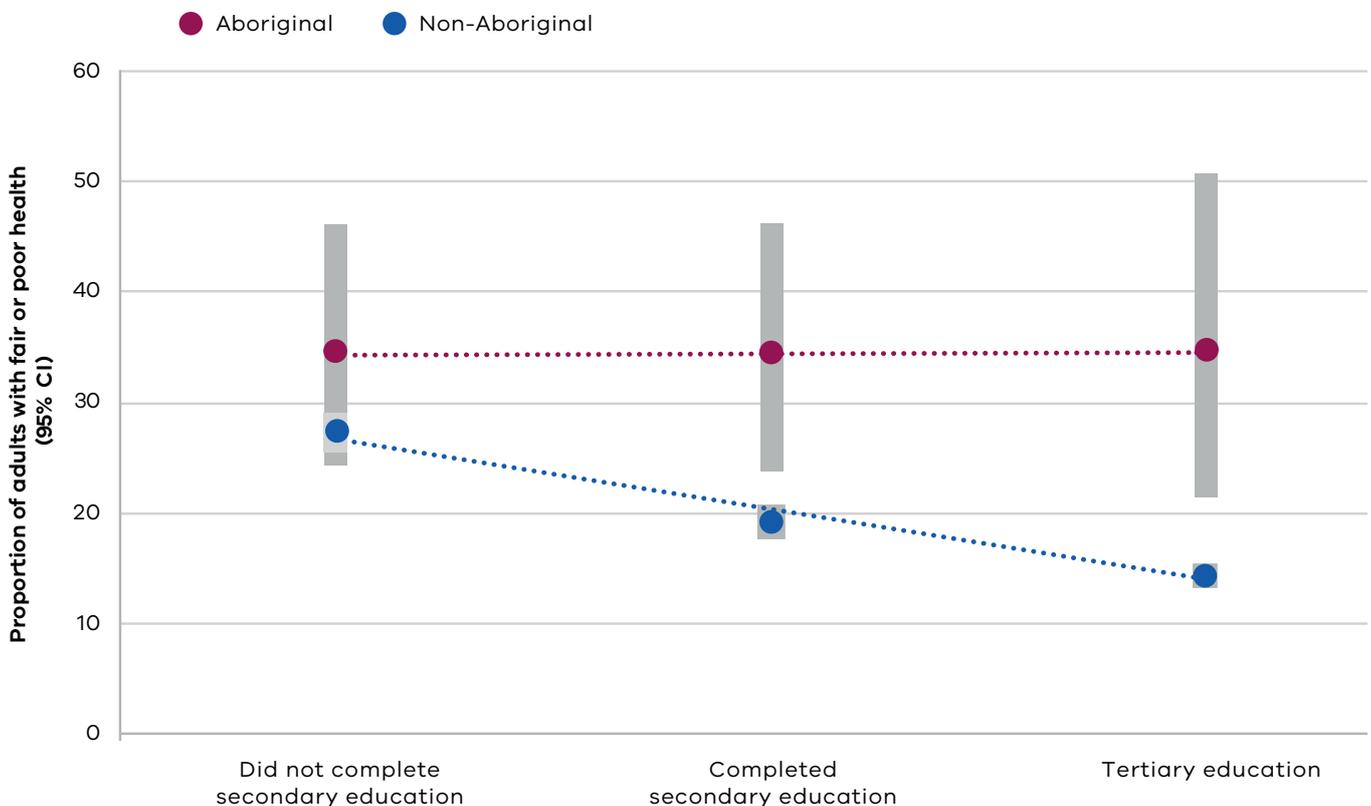


Overall health status

Appendix 2 Table 20 and Figure 3.15 show the relationship between self-reported health status and level of educational attainment, by Aboriginal status. The key findings were:

- There was no difference in the proportion of Aboriginal adults who reported being in fair or poor health by level of educational attainment – 34.5% of Aboriginal adults who did not complete secondary education reported being in fair or poor health compared with 34.7% of Aboriginal adults who were tertiary educated.
- In contrast, the proportion of non-Aboriginal adults who reported being in fair or poor health decreased with increasing level of educational attainment – from 27.3% of non-Aboriginal adults who did not complete secondary education to 14.3% of non-Aboriginal adults who were tertiary educated.

Figure 3.15: Proportion (%) of adults in fair or poor health, by highest level of educational attainment and Aboriginal status, Victoria, 2017



Discussion

Almost 1 in 5 (18.8%) Aboriginal adults who live in Victoria reported experiencing racism in the 12 months preceding the survey interview, but this is highly likely to be an underestimate. This is because the international literature consistently shows that experiences of racism are under-reported (Krieger 2014).

Studies show that people are more likely to report experiences of racism if the question is phrased to ask about the experiences of the ethnic group

to which they belong, rather than their personal experiences (Hausmann et al. 2010; Taylor et al. 1994). Evidence suggests this may be due to the psychologically protective effect associated with minimising personal experiences of racism (Hodson & Esses 2002; Ruggiero & Taylor 1997).

Moreover, multi-item measures of experiences of racism tend to be more reliable than single-item measures as was used in this report (Krieger et al. 2005). For example, the 2014–15 National Aboriginal

and Torres Strait Islander Social Survey, which is a population-representative national survey that used a multi-item measure, reported that 34% of Indigenous Australians had experienced racism in the 12 months prior to the survey (Australian Bureau of Statistics 2016b). In contrast, the Localities Embracing and Accepting Diversity (LEAD) survey, conducted in 2011 in four localities of Victoria, reported that 97% of Indigenous participants experienced racism in the 12 months preceding the survey (Ferdinand et al. 2012). Therefore, the estimate of the prevalence of experiences of racism reported here should be considered highly conservative.

This report found that the most common setting in which Aboriginal adults experienced racism was in public, followed by the healthcare sector, at home, by neighbours, or in someone else's home, and applying for work or at work.

Racism perpetuated by doctors, nurses and other health staff is well documented and results in poorer health outcomes (Moore et al. 2014; Paradies et al. 2014).

It is important to note that the estimates of the proportion of Aboriginal adults who experienced racism by setting is also likely to be underestimated because not all adults may have had exposure to every setting in the 12 months preceding the survey interview. For example, while 53.0% of Aboriginal adults who experienced racism reported that their experience did not occur in a healthcare setting, some of these adults may not have had contact with a healthcare setting in the 12 months preceding the survey. Moreover, given the existence of Aboriginal community-controlled health organisations (ACCHOs), some of those who did not experience racism in a healthcare setting may have exclusively sought medical attention from an ACCHO. ACCHOs were created in part to provide culturally safe health care, free from racism and discrimination. Therefore, the estimates of the proportions of Aboriginal adults who experienced racism by any given setting should be interpreted as the 'minimum' estimate.

The findings of strong associations of experiences of racism with psychological distress, depression and anxiety, and fair or poor self-reported health

status, are consistent with the wealth of literature that suggests a causal link between experiences of racism and poor health (Paradies et al. 2015; Pascoe & Smart Richman 2009; Priest et al. 2011; Priest et al. 2013; Schmitt et al. 2014).

The finding that higher socioeconomic status, measured by level of educational attainment, was not associated with better self-reported health status in Aboriginal adults is concerning, given that education theoretically should offer a path out of socioeconomic disadvantage. 'Education' in this context refers to Western education, which as Boughton (2000) notes is one of the main ways in which societies reproduce themselves with their understanding of the social and political roles and responsibilities of their citizens, and how power is distributed and exercised.

However, the literature has failed to find a clear and consistent relationship between health and Western education among Aboriginal Australians, in contrast to what has been observed in non-Aboriginal Australians where Western education has been consistently found to be health-promoting (Dunbar & Scrimgeour 2007).

Malin (2003) hypothesised that the positive effects of Western education on health that are seen in other populations may not be seen in Aboriginal populations in Australia due to the negative impact of social exclusion in the classroom on their social and emotional health and wellbeing (Malin 2003).

This is supported by consistent findings that Aboriginal school and university students across Australia experience racism and discrimination from both students and teachers (Berger et al. 2017; Priest et al. 2012; Priest et al. 2019). This report also found that 22.8% of Aboriginal adults who experienced racism in the 12 months preceding the survey interview experienced it in an educational setting. Again this is likely to be an underestimate because not all Aboriginal adults who reported experiencing racism would have had exposure to an educational setting.

Therefore, the finding that educational attainment was not associated with better overall health status in Aboriginal adults may be explained by a greater exposure to the health-damaging effects of

racism due to greater exposure to an educational setting that is necessary for higher educational attainment. Greater exposure to racism may therefore counteract or cancel the health-promoting benefits of mainstream Western education that are consistently observed for non-Aboriginal people.

This is supported by the finding in this report that the proportion of Aboriginal adults who were ever told by a doctor that they had depression or anxiety increased with increasing level of educational attainment. Depression and anxiety are not only debilitating conditions in their own right but are also significant risk factors for a range of physical illnesses such as cardiovascular disease, and this is independent of other risk factors such as smoking and hypertension (Dhar & Barton 2016).

The implication of this finding is that more needs to be done to eradicate systemic and interpersonal racism within our education system because racism may be a barrier to the health-promoting effect of mainstream Western education.

This report finds that Aboriginal adults in Victoria are frequently the targets of racism in its many forms and, consistent with the literature, confirms that racism may be a key determinant of the health and wellbeing of Aboriginal Victorians.

Food insecurity

What is food insecurity?

Food security is defined as access by all people at all times to enough food for an active, healthy life and includes at a minimum: a) the ready availability of nutritionally adequate and safe foods, and b) the assured ability to acquire acceptable food in socially acceptable ways (e.g. without resorting to emergency food supplies, scavenging, stealing, and other coping strategies) (Radimer 2002, p. 861).

In contrast, food insecurity exists 'whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable food in socially acceptable ways is limited or uncertain' (Radimer 2002, p. 861).

As is implicit in the definition, food insecurity is not a binary concept; it exists along a continuum. When people at risk of food insecurity use coping strategies such as relying on nutritionally inadequate low-cost food and/or skipping meals, they are food insecure without hunger. When people go without food because they have none left and cannot access more, they are food insecure with hunger.

How was food insecurity measured?

We report on two measures of food insecurity. The first measure is a measure of food insecurity with hunger and is based on asking the survey participants the following question: 'In the last 12 months, were there any times that you ran out of food and couldn't afford to buy more?' If a survey respondent answered in the affirmative, they were deemed to have experienced food insecurity with hunger.

The second is a measure of food insecurity without hunger and is based on asking the survey participants the following question: 'In the last 12 months did you have to rely on a restricted range of low-cost food for your children because you were running out of money to buy food?' If a survey respondent answered in the affirmative, they were deemed to be food insecure without hunger.

How does food insecurity affect health?

Food insecurity is associated with an increased risk of some birth defects, anaemia, malnutrition, cognitive problems, aggression, anxiety, behavioural problems, depression, suicide ideation, being hospitalised and asthma in children (Gundersen & Seligman 2017). In adults, food insecurity is associated with an increased risk of malnutrition, mental health problems, diabetes, hypertension, hyperlipidaemia, being in fair or poor health and poor sleep (Gundersen & Seligman 2017).

Food insecurity is also associated with obesity. Although an association between obesity and food insecurity may seem counterintuitive, it is in fact well documented across the world, referred to as 'the food insecurity–obesity paradox' (Dinour et al. 2007; Franklin et al. 2012).

Obesity can occur as a physiological adaptation to cyclical food restriction. It may develop as an adaptive physiological response to periodic episodes of food insecurity, leading to compensatory over-eating when food is plentiful that in turn is associated with an increase in body fat, decrease in muscle mass and rapid weight gain (Seligman et al. 2010). Moreover, foods that are high in sugar and fat tend to be energy-dense, obesogenic and considerably cheaper than their healthy alternatives (Drewnowski 2017).

Since food insecurity in the developed world is primarily due to a lack of economic resources with which to purchase food, food-insecure people often have no choice but to rely on foods that are high in sugar and fat because they are cheaper than healthy foods. Kettings and Sinclair (2009) costed a healthy food basket for a family of four in Victoria and found that the cost represented 31% of a welfare-dependent household income in 2014. They also determined

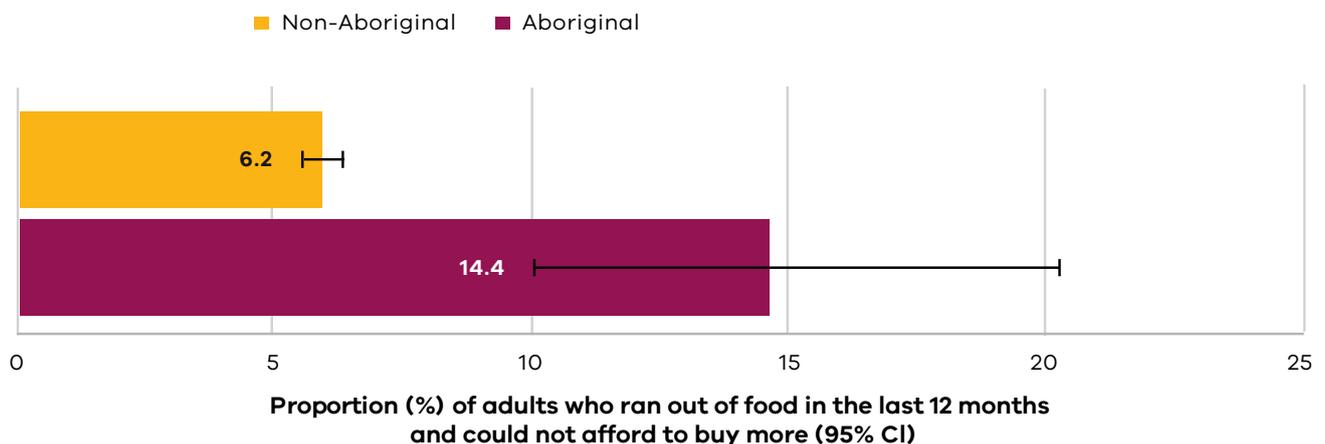
that welfare-dependent families constituted one-fifth (20%) of the Australian population at that time (Kettings & Sinclair 2009). The authors concluded that ‘healthy food habits are a fiscal challenge to welfare dependent families’ (Kettings & Sinclair 2009, p. 566). Therefore, food insecurity is a significant risk factor for obesity as well as other chronic diseases such as type 2 diabetes.

Proportion of adults who experienced food insecurity

Appendix 2 Table 21 and Figure 3.16 show the proportion of adults who experienced food insecurity with hunger by Aboriginal status. The key finding was:

- Approximately 1 in 7 (14.4%) Aboriginal adults in Victoria ran out of food and could not afford to buy more at least once in the 12 months preceding the survey interview – significantly higher than non-Aboriginal adults (6.2%).

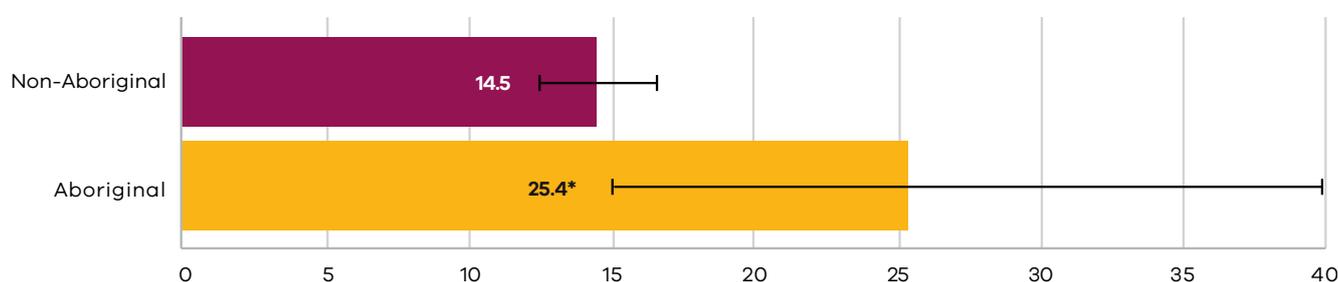
Figure 3.16: Proportion (%) of adults who experienced food insecurity with hunger, by Aboriginal status, Victoria, 2017



Appendix 2 Table 22 and Figure 3.17 show the proportion of adults who experienced food insecurity without hunger, by Aboriginal status. The key finding was:

- Approximately 1 in 4 (25.4%) Aboriginal parents sometimes or always relied on a restricted range of low-cost food for their children in order to avoid running out of money to buy food – higher than non-Aboriginal parents (14.5%).

Figure 3.17: Proportion of adults who experienced food insecurity without hunger, by Aboriginal status, Victoria, 2017



* Relative standard error >25% and <50% – therefore must be interpreted with caution

Proportion (%) of parents who relied on a restricted range of low-cost food for their children to avoid running out of money to buy food (95% CI)

Health and wellbeing of adults who experienced food insecurity

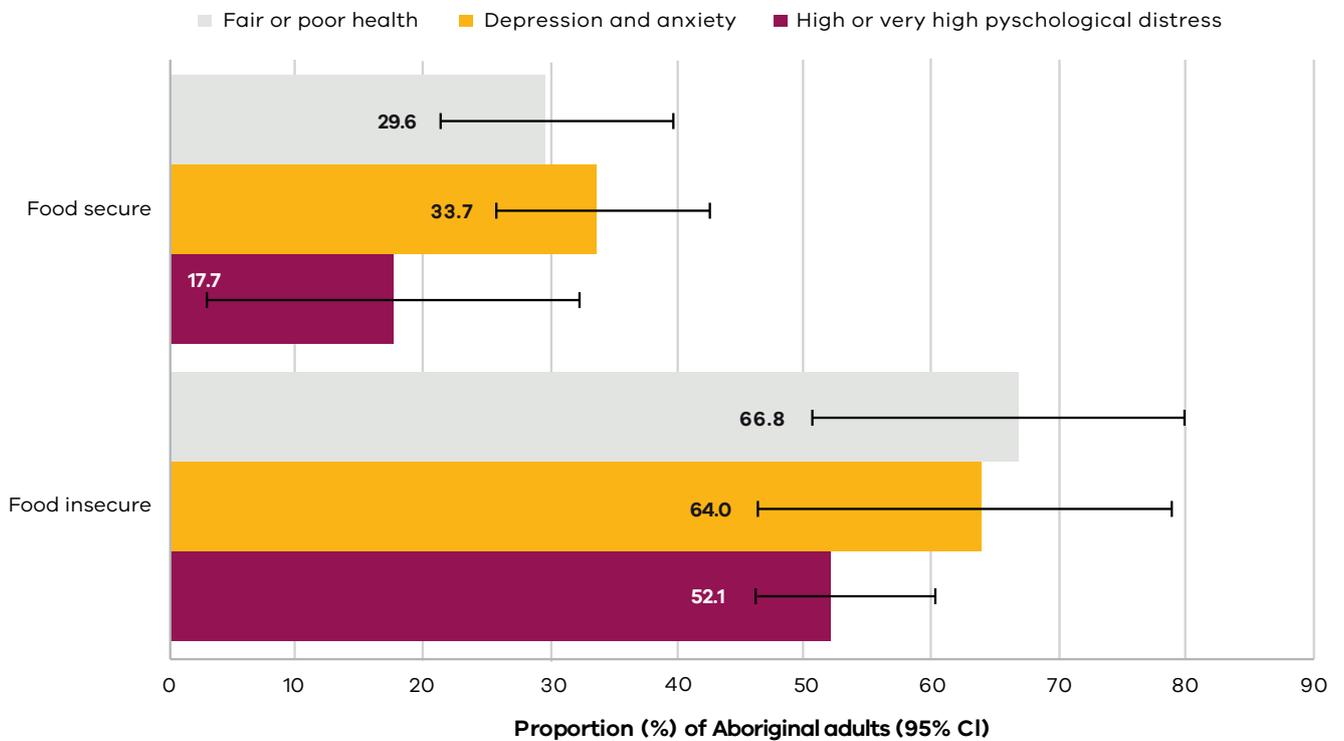
Appendix Tables 23–25 and Figure 3.18 show the proportion of Aboriginal adults who experienced food insecurity with hunger by various measures of health and wellbeing. The key findings were:

- Just over one-half (52.1%) of Aboriginal adults who experienced food insecurity with hunger in the 12 months preceding the survey had high or very high psychological distress compared with 17.7% of Aboriginal adults who did not experience food insecurity with hunger.
- Almost two-thirds (64.0%) of Aboriginal adults who experienced food insecurity with hunger had ever been told by a doctor that they had depression or anxiety compared with 33.7% of Aboriginal adults who did not experience food insecurity with hunger.

- Approximately two-thirds (66.8%) of Aboriginal adults who experienced food insecurity with hunger had fair or poor health compared with 29.6% of Aboriginal adults who did not experience food insecurity with hunger.
- Food insecurity is associated with poorer social and emotional wellbeing and poorer physical health.

Given that food insecurity is a significant risk factor for obesity, the substantially higher prevalence of food insecurity experienced by Aboriginal adults in Victoria may explain, at least in part, the higher prevalence of obesity that is consistently observed among Aboriginal Australians and Victorians compared with their non-Aboriginal counterparts (Department of Health and Human Services 2017a).

Figure 3.18: Proportion (%) of Aboriginal adults who ran out of food in the 12 months preceding the survey and couldn't afford to buy more, by health and wellbeing outcome, Victoria, 2017



Financial stress

How was financial stress measured?

Financial stress was measured by asking the question: 'If you needed to, could you raise \$2,000 within 2 days in an emergency?'

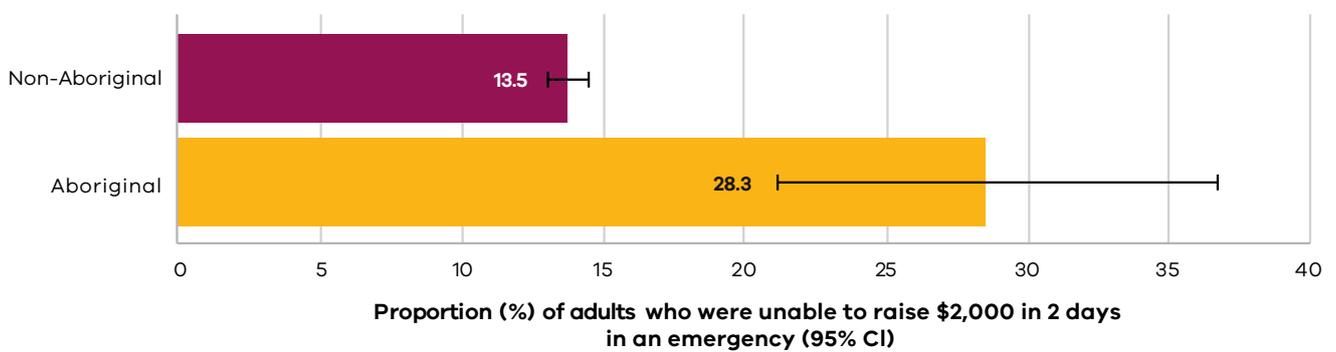
This included accessing savings, borrowing money, or using a credit card. If a survey respondent answered in the negative, they were deemed to be financially stressed.

Proportion of adults who experienced financial stress

Appendix 2 Table 26 and Figure 3.19 show the proportion of adults who were financially stressed, by Aboriginal status. The key finding was:

- The proportion of adults who were financially stressed was significantly higher among Aboriginal (28.3%) than non-Aboriginal adults (13.5%).

Figure 3.19: Proportion (%) of adults who were financially stressed, by Aboriginal status, Victoria, 2017

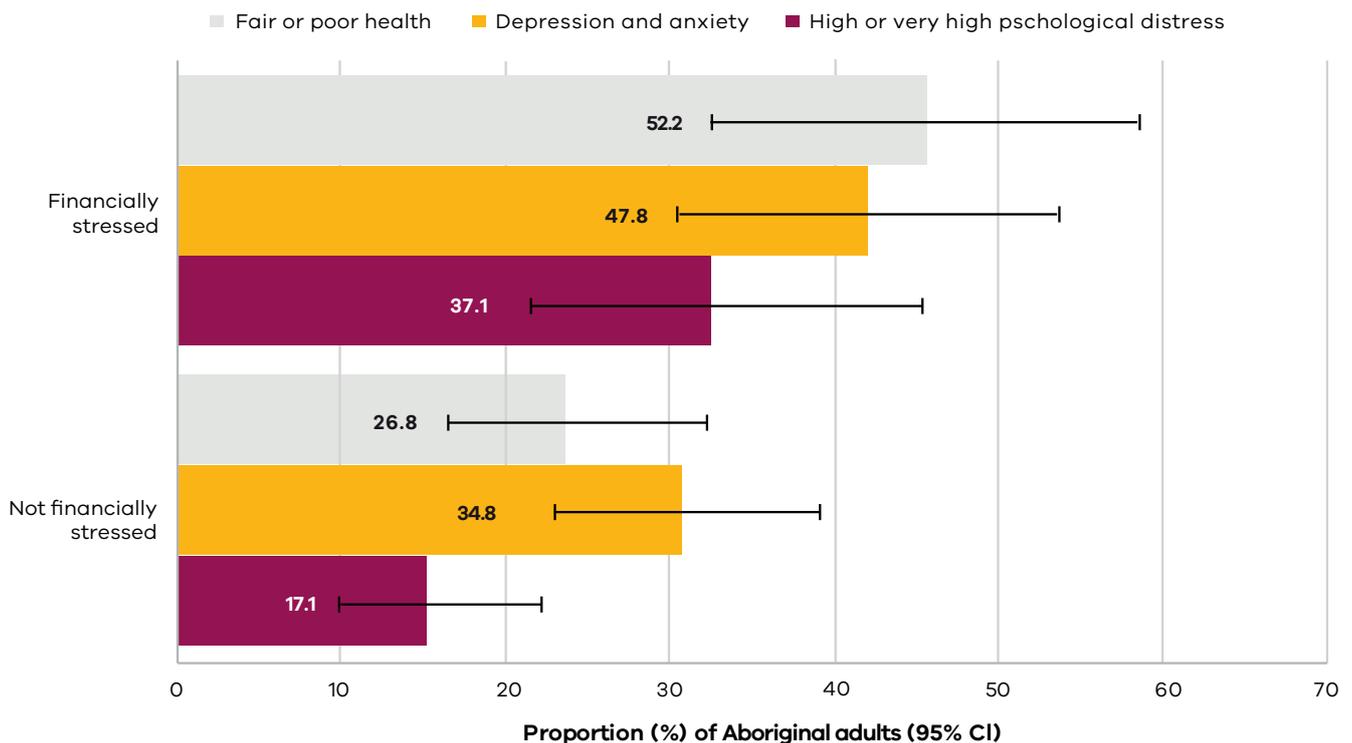


Health and wellbeing of adults who experienced financial stress

Appendix 2 Tables 27–29 and Figure 3.20 show the proportion of Aboriginal adults who were financially stressed, by various measures of health and wellbeing. The key findings were:

- A little over one-third (37.1%) of Aboriginal adults who were financially stressed had high or very high psychological distress compared with 17.1% of Aboriginal adults who were not financially stressed.
- Just under one-half (47.8%) of Aboriginal adults who were financially stressed had ever been told by a doctor that they had depression or anxiety compared with 34.8% of Aboriginal adults who were not financially stressed.
- Just over one-half (52.2%) of Aboriginal adults who were financially stressed were in fair or poor health compared with 26.8% of Aboriginal adults who were not financially stressed.
- Financial stress is associated with poorer social and emotional wellbeing and poorer physical health.

Figure 3.20: Proportion (%) of Aboriginal adults who were financially stressed, by health and wellbeing outcome, Victoria, 2017



Family violence

What is family violence?

According to the *Family Violence Protection Act 2008 (Vic)*, family violence is behaviour by a person towards a family member of that person that is: physically abusive; sexually abusive; emotionally or psychologically abusive; economically abusive; threatening; coercive; or in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person. It is also family violence when a child witnesses or is exposed to any of those behaviours.

How was family violence measured?

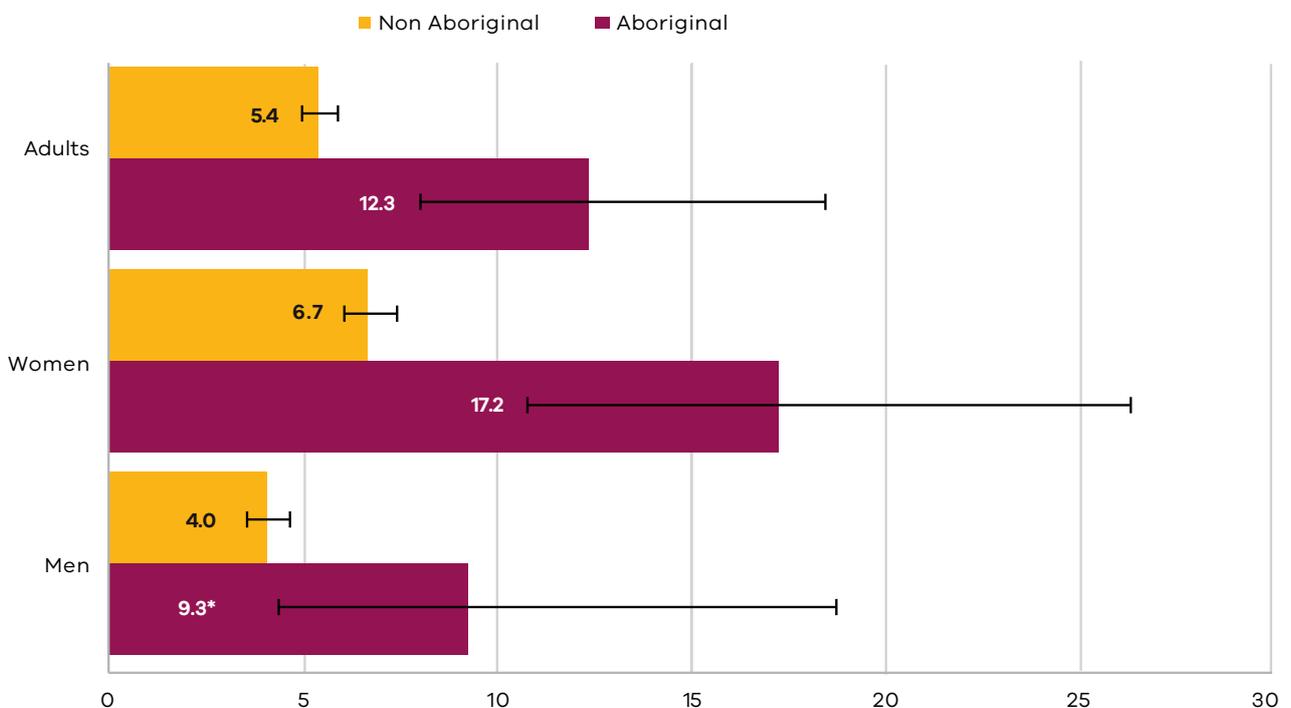
Survey participants were asked whether they had experienced family violence in the 2 years preceding the survey interview.

Proportion of adults who experienced family violence

Appendix 2 Table 30 and Figure 3.21 show the proportions of adults who experienced family violence in the 2 years preceding the survey, by gender and Aboriginal status. The key findings were:

- A significantly higher proportion of Aboriginal adults in Victoria (12.3%) experienced family violence in the 2 years preceding the survey compared with 5.4% of non-Aboriginal adults.
- A significantly higher proportion of Aboriginal women (17.2%) experienced family violence compared with 6.7% of non-Aboriginal women.
- Twice as many Aboriginal adults (9.9%) refused to answer the questions on family violence as their non-Aboriginal counterparts (4.8%).

Figure 3.21: Proportion of adults who experienced family violence in the 2 years preceding the survey, by Aboriginal status and gender, Victoria, 2017



* Relative standard error >25% and <50% – therefore must be interpreted with caution

Proportion (%) of adults who experience family violence (95% CI)

For more information see the report entitled *Family violence in Victoria – findings from the Victorian Population Health Survey 2017* located at <https://www.bettersafecare.vic.gov.au/reports-and-publications/vphs2017-family-violence-in-victoria>.

Social capital

What is social capital?

There is no universally agreed definition of social capital because it is a concept that traverses many disciplines such as sociology, economics, political science, psychology and population health. However, a simple definition of social capital is the ‘resources that are accessed by individuals as a result of their membership of a network or a group’ (Berkman et al. 2014).

Social capital is further classified into bonding, bridging, and linking social capital. Bonding social capital describes close connections that are based on trusting cooperative relationships between members of a network who see themselves as similar – that is, relations between relatively homogenous groups such as families and ethnic groups. Bonding social capital is considered good for ‘getting by’ in life.

Bridging social capital describes the weaker but more cross-cutting connections consisting of trusting, cooperative relationships between members of a network who do not see themselves as similar. For example, they might differ by age, socioeconomic status or ethnicity. Bridging social capital is considered good for ‘getting ahead’ in life.

Linking social capital describes connections with people in positions of power, consisting of trusting, cooperative relationships between people within a hierarchy with different levels of power. In other words, linking social capital is connections across social strata that are good for accessing support from formal institutions. Linking social capital thereby brings state–society relations and considerations of power into the social capital framework.

In the context of Aboriginal communities, bonding social capital refers to relationships within the Aboriginal community, bridging social capital to relationships between the Aboriginal and non-Aboriginal communities, and linking social capital to relationships between the Aboriginal community and the formal institutions of power such as governments (Mignone 2009).

Does social capital affect health?

Research shows that higher levels of social capital are associated with higher productivity of individuals and groups, higher educational achievement, lower crime rates, and better health outcomes (Ikeda & Kawachi 2010). Higher levels of social capital have consistently been shown to be associated with a lower incidence of, and mortality due to, cardiovascular disease, as well as a better prognosis when survival is the endpoint being considered (Ikeda & Kawachi 2010). There is also strong evidence of a protective effect of social capital on cognitive decline (Ikeda & Kawachi 2010).

The findings with cancer are mixed, with some studies showing a protective effect while others not. Overall, a dose-response relationship between all-cause mortality and the level of social capital has been observed, where the higher the level of social capital an individual has, the lower their risk of mortality (Ikeda & Kawachi 2010).

However, not all social capital is good. For example, strong bonding social capital can exclude outsiders, restrict individual freedoms, confer excessive and burdensome responsibilities on some members of the group, and drive the downward-levelling of social norms (Kawachi et al. 2008).

How was social capital measured in this report?

Social capital was measured in the 2017 VPHS by asking survey participants several questions about their ability to obtain social support and their level of social and civic trust. Social support is conceptualised as bonding social capital, while social and civic trust are conceptualised as bridging and linking social capital, respectively.

Trust is essential within social systems to enable cooperative and altruistic behaviours that enhance collective wellbeing and the attainment of collective goals. Trust in our civic institutions, such as our healthcare system, and the people who run them is essential to maximise an individual’s health and wellbeing (Kramer 1999). Trust is probably the main component of social capital, and social capital is a necessary condition for social integration, economic efficiency and democratic stability (Newton 2001).

Proportion of adults by level of bonding social capital

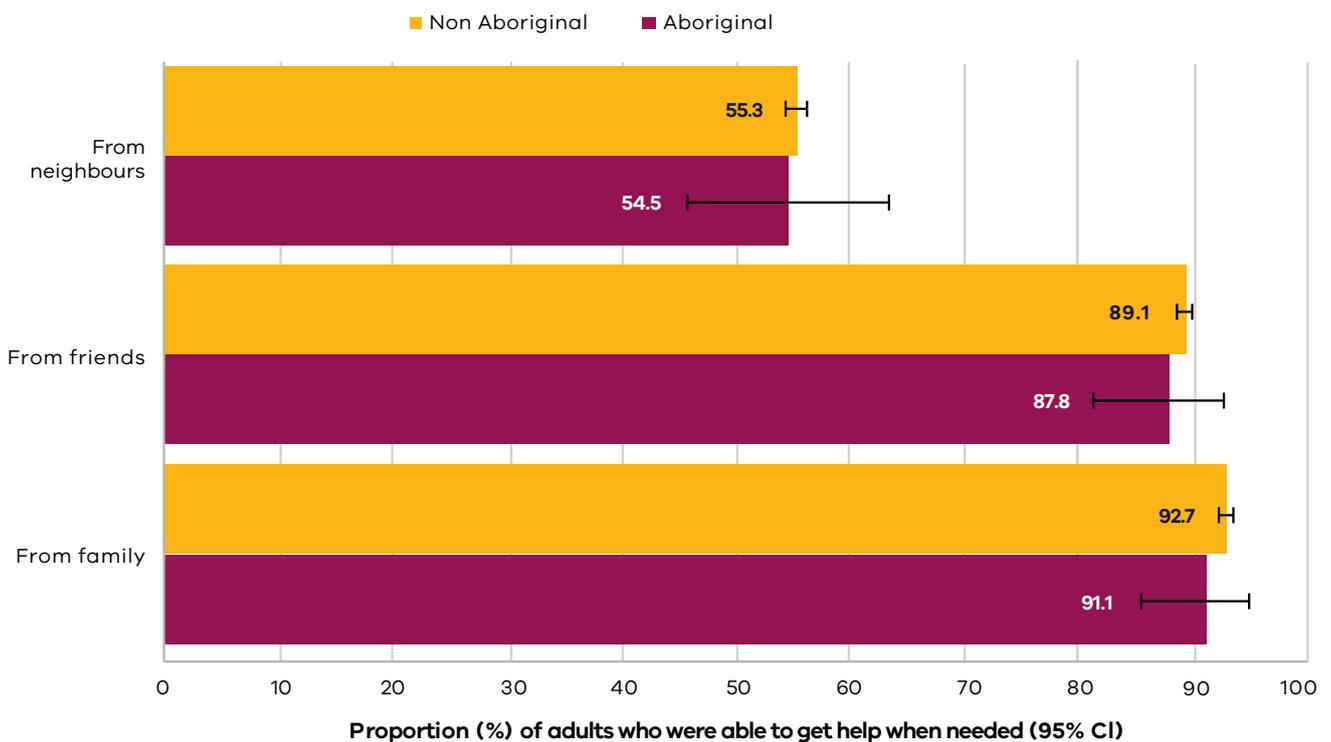
Bonding social capital was measured by asking survey participants three questions: 'If needed could you get help from (1) family, (2) friends, and/or (3) neighbours?'

Appendix 2 Table 31 and Figure 3.22 show the proportions of adults who were able to get help from family, friends and/or neighbours if needed.

The key findings were:

- Most adults were able to get help from family if needed and there was no statistical difference between Aboriginal (91.1%) and non-Aboriginal adults (92.7%).
- Most adults were able to get help from friends if needed and there was no difference between Aboriginal (87.9%) and non-Aboriginal adults (89.1%).
- Just over one-half of adults in Victoria were able to get help from their neighbours and there was no difference between Aboriginal (54.5%) and non-Aboriginal adults (55.3%).
- Therefore, there were no differences in the levels of bonding social capital of Aboriginal and non-Aboriginal adults in Victoria.

Figure 3.22: Proportion (%) of adults with a high level of bonding social capital, by Aboriginal status, Victoria, 2017



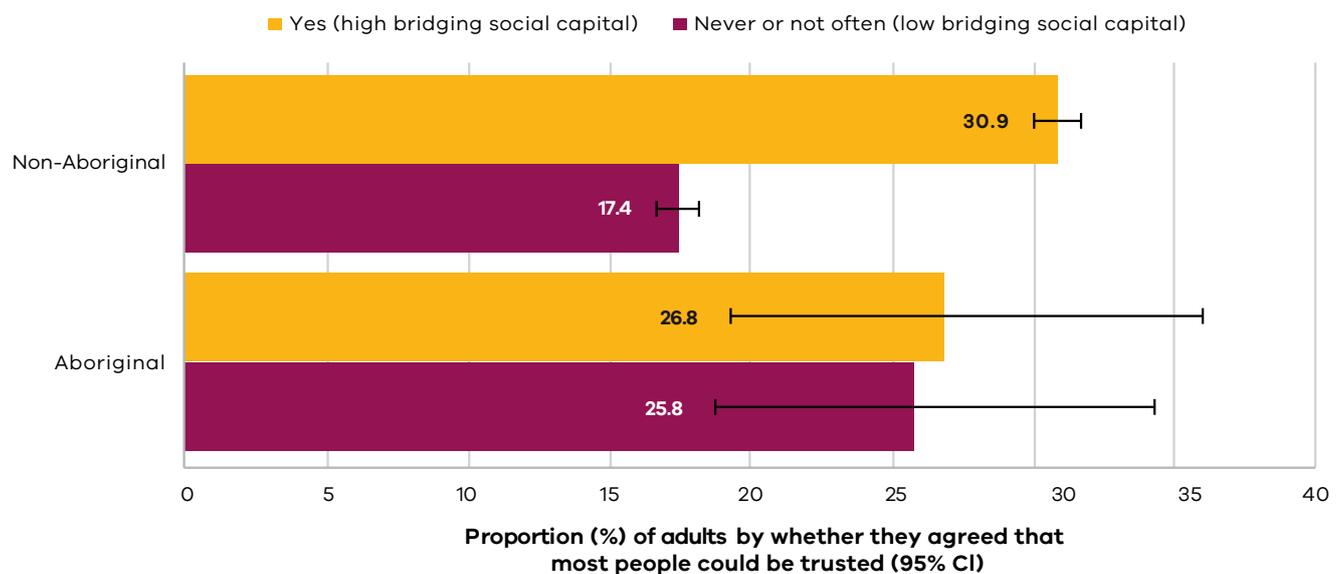
Proportion of adults by level of bridging social capital

'Social trust' refers to trust among casual acquaintances or strangers in everyday social interactions and is a measure of bridging social capital, which reflects the relationship between Aboriginal and non-Aboriginal communities and individuals.

The VPHS asked one question that measured bridging social capital: 'Do you agree that most people can be trusted?' Appendix 2 Table 32 and Figure 3.23 show the proportions of adults by level of bridging social capital and Aboriginal status. The key findings were:

- One-quarter of Aboriginal adults in Victoria (25.8%) did not agree that most people can be trusted – significantly higher than non-Aboriginal adults (17.4%).
- Aboriginal adults have significantly lower levels of bridging social capital than their non-Aboriginal counterparts, consistent with the findings of other studies conducted in other states of Australia (Brough et al. 2006; Brough et al. 2007; Browne-Yung et al. 2013).

Figure 3.23: Proportion (%) of adults, by level of bridging social capital and Aboriginal status, Victoria, 2017



Proportion of adults by level of linking social capital

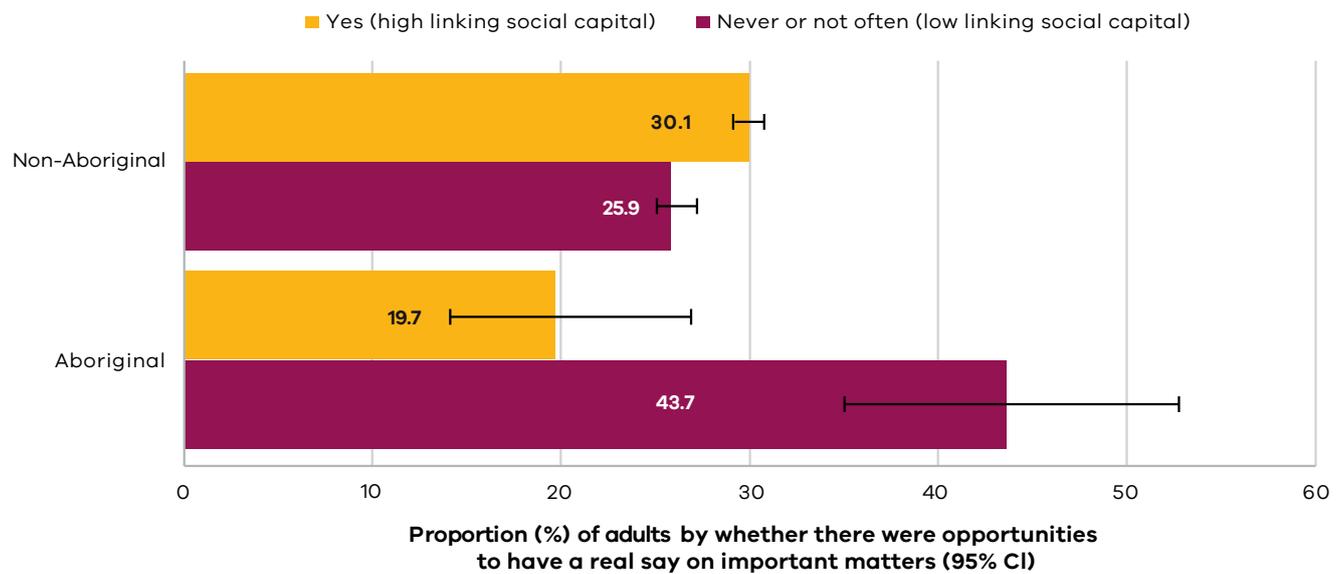
'Civic trust' refers to trust in public institutions and the respect that citizens are given in their relationships with those institutions. Civic trust is a measure of linking social capital.

Civic trust was measured by asking survey participants the question: 'Do you feel there are opportunities to have a real say on issues that are important to you?'

Appendix 2 Table 33 and Figure 3.24 show the proportions of adults with low linking social capital by Aboriginal status. The key findings were:

- A little under one-half (43.7%) of Aboriginal adults in Victoria did not feel there were opportunities to have a real say on issues that were important to them – significantly higher than non-Aboriginal adults (25.9%).
- Aboriginal adults have significantly lower levels of linking social capital than their non-Aboriginal counterparts, consistent with the findings of other studies conducted in other states of Australia.

Figure 3.24: Proportion (%) of adults, by level of linking social capital and Aboriginal status, Victoria, 2017



Discussion

This report shows that while Aboriginal adults in Victoria enjoy strong bonding social capital, they experience low bridging and linking social capital. These findings are consistent with the literature, which has also found strong bonding social capital among Aboriginal communities across Australia but low bridging social capital and low or absent linking social capital (Baum 2007; Brough et al. 2006; Browne-Yung et al. 2013).

Baum (2007), Brough et al. (2006) and Browne-Yung et al. (2013) provided evidence that racism towards Aboriginal Australians is a significant barrier to building bridging social. Baum (2007), in reviewing the literature, suggested that tackling racism may be an important means of building bridging and linking social capital for Aboriginal people and communities, noting that the reconciliation movement aims to build bridging social capital between Aboriginal and non-Aboriginal Australians.

Therefore, successfully addressing racism in all its forms may reap multiple benefits that not only reduce the direct health-damaging effects of racism but may also remove a major barrier to developing bridging and linking social capital. In turn, building bridging and linking social capital may not only improve Aboriginal health and wellbeing but may also reinforce and sustain changes in the beliefs and attitudes that were once used to justify racism.

4. ABORIGINAL AND TORRES STRAIT ISLANDER PATIENT IDENTIFICATION

Introduction

The Council of Australian Governments (COAG) recognises that in order to close the gap in health between Aboriginal and non-Aboriginal Australians, measures are needed that specifically target the needs of Aboriginal people. In order to do this, the national data collections need to accurately identify and record Aboriginal status. This includes administrative datasets that collect data on hospitalisations and attendance at emergency departments such as the Victorian Admitted Episodes Dataset (VAED) and the Victorian Emergency Minimum Dataset (VEMD). Box 3 (in Appendix 1) shows the current national standard question used to determine Aboriginal and/or Torres Strait Islander status.

Because GPs are often the access point to the healthcare system, they too must have processes in place to seek the Aboriginal status of their patients. However, there is no specific national data collection covering the general practice sector, and the private ownership and autonomy of general practices also contribute to the diversity of clinical information systems used.

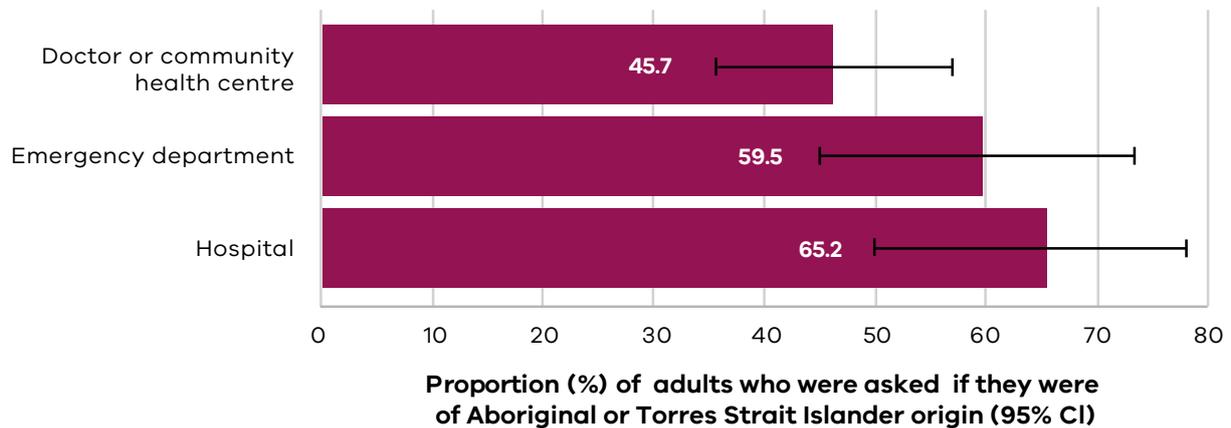
Aboriginal survey participants of the 2017 VPHS were asked if they had been admitted to a hospital, attended an emergency department and/or attended a doctor, GP or community health centre in the past 12 months. If they responded 'yes', they were asked if the healthcare provider asked them if they were of Aboriginal or Torres Strait Islander origin.

Results

Appendix 2 Table 34 and Figure 3.25 show the proportions of Aboriginal patients by whether or not they were asked if they were of Aboriginal or Torres Strait Islander origin if they had sought health care in the 12 months preceding the survey, by type of healthcare service. The key findings were:

- While most Aboriginal adults in Victoria who were admitted to hospital in the 12 months preceding the survey were asked if they were of Aboriginal or Torres Strait Islander status (65.2%) – almost one-third were not asked (31.7%).
- A little over one-half of Aboriginal adults who attended an emergency department in the 12 months preceding the survey were asked if they were of Aboriginal or Torres Strait Islander status (59.5%) – 34.7% were not asked and 5.8% did not know or refused to say.
- Just under one-half (45.7%) of Aboriginal adults who attended a doctor, GP or community health centre in the 12 months preceding the survey were asked if they were of Aboriginal or Torres Strait Islander origin – 52.3% were not asked and 2.0% did not know or refused to say.

Figure 3.25: Proportion of Aboriginal adults who attended a hospital, emergency department or went to a doctor, general practitioner or community health centre in the 12 months preceding the survey, and were asked if they were of Aboriginal or Torres Strait Islander origin, Victoria, 2017



Discussion

A study conducted by the Australian Institute of Health and Welfare (2010) to determine the proportion of patients correctly identified as Aboriginal in public hospitals in 2007–08 reported that 84% of Aboriginal patients were correctly identified in Victoria. The study interviewed a sample of admitted patients in public hospitals about their Aboriginal status and then compared the patient’s responses with the hospital admission records.

Given that the 84% reported in the Australian Institute of Health and Welfare study is much higher than the 65% reported in the 2017 VPHS raises some important questions. Does the substantial difference between the two studies reflect a decrease in the determination of Aboriginal status over time, a difference in methodologies, and/or that some of the survey participants may have attended a private hospital?

Irrespective, the almost one-third of Aboriginal adults who were admitted to a hospital but not asked about their Aboriginal status represents a substantial under-reporting of Aboriginal status.

Similarly, the one-third of Aboriginal adults who attended an emergency department but were not asked about their Aboriginal status represents a substantial under-reporting of Aboriginal status.

The poor identification of Aboriginal people by GPs and community health centres is concerning. Many Aboriginal adults in Victoria may be missing out on culturally safe care, preventative health checks, targeted programs and follow-up services.

The data suggest that more needs to be done to ensure key datasets are systematically and accurately capturing Aboriginal status.

APPENDIX 1: METHODS

Introduction

The Victorian Population Health Survey (VPHS) was first undertaken in 2001 and is an ongoing source of high-quality information on the health of Victorians aged 18 years or older. The information collected in the survey is used to inform and support planning, implementation and evaluation of adult population health and health programs in Victoria.

This report is the second population-based report on the health and wellbeing of Aboriginal people in the state of Victoria. It is based on the responses of 33,654 randomly selected adults aged 18 years or older in the 2017 VPHS.

In 2017, under the new methodology, enough adults who identified as Aboriginal were recruited to produce this second report on the health and wellbeing of Aboriginal Victorians. The questions about connection to culture, identification and health service use that were developed for the 2011 VPHS were included in the 2017 VPHS and the findings are reported here.

The 2017 survey used an overlapping dual-frame design, with half of the total interviews obtained from a random digit dial (RDD) landline frame and the other half from a mobile frame (60/40 RDD mobile and 40% listed mobile).

The VPHS was undertaken using computer-assisted telephone interviewing. In the early years of the VPHS, an 'eligible prefix file' maintained by the Department was used to generate the RDD numbers. A form of RDD has been used in the most recent iterations of the survey, based on the 'register of numbers' maintained by the Australian Communications and Media Authority (ACMA) and purchased from the commercial sample providers 'Sampleworx' (2010 to 2012) and 'SamplePages' (2013 onwards).

The target population for the VPHS is defined as all non-institutionalised Victorian residents aged 18 years or older, excluding residents of 'Unincorporated Victoria', as defined by the Australian Bureau of Statistics (ABS).

The respondent is selected using the 'most recent birthday' method for the landline sample and the phone answerer for the mobile sample.

For the 2017 VPHS, 33,654 interviews (16,946 landline and 6,926 listed mobile, 9,782 RDD mobile) were completed, including 642 in languages other than English and 1,288 converted refusals.

The average interview length was 24.2 minutes.

Interviewing was conducted between 28 November 2017 and 30 May 2018. The within-survey response rate for the 2017 VPHS was 66%.

Sample

The target sample size for the 2017 VPHS was 426 interviews in each of the 79 Victorian local government areas (LGAs), totalling 33,654 interviews. As for previous surveys in the series, the target was not treated as a hard quota per se. The focus for the VPHS was on completing the call cycle for all sample records initiated, resulting in excess interviews in some LGAs and a small shortfall in others, relative to the target.

The decision to use a dual-frame design and to incorporate mobile RDD into the frame was driven mainly by a desire to address the increasing under-coverage of traditional landline RDD sample frames, particularly for young people.

Based on sample availability by LGA, the overlapping dual-frame design used in 2017 assumed 17,389 interviews with residents of Victoria aged 18 or older using landline RDD sample, 6,504 interviews conducted using mobile-listed sample and 9,761 interviews conducted using mobile RDD sample, bringing the total number of interviews under the dual-frame design to 33,654, including 293 adults who identified as being of Aboriginal and Torres Strait Islander origin.

Sample frame

The starting point for both landline and mobile RDD sample generation is the 'Register of Numbers' published and regularly updated by ACMA. This register contains all the number ranges (i.e. prefixes) allocated by ACMA to various telecommunication providers and contains the number range and quantity for both landlines and mobiles.

The RDD sample for the 2010 and 2011–12 VPHS was purchased from a commercial list provider, where the process was to generate RDD numbers and allocate them to a pool of numbers (approximately 7 million) to be drawn down as required, where numbers are purportedly re-tested every 12 months. Testing of this method of generating RDD sample, ahead of the 2011–12 VPHS, found a substantial under-coverage of the Victorian population (19%), with under coverage rates much higher (up to 70%) in infrequently sampled areas such as small LGAs.

For the 2013 VPHS and subsequent surveys in the series, a customised approach to RDD sample generation was agreed with another commercial list provider, whereby RDD numbers are generated and tested at the time of each request, rather than being drawn from a pre-existing (and potentially ageing) pool of numbers. Internal testing conducted in advance of the 2013 VPHS suggested that the new approach to RDD number generation offered a marginally better contemporary coverage of the population accessible by landline phone, since it offered improved coverage of new connections, and yielded a slightly higher proportion of interviews with people new to their neighbourhood, a higher proportion of renters and fewer interviews with people aged 75 years or older. This process assigns a 'best estimate' of postcode to each landline number at the number generation and testing stage, based on information available about the geographic area serviced by each individual telephone exchange.

A two-step process was used to attempt to assign a mailing address for use in approach letter mailing to the randomly generated landline numbers. The

first step was to wash the landline RDD telephone numbers against the 'Australia on Disk' 2015 listings, to source name and address information, where available. The second stage was to use Sensis's 'MacroMatch' service to identify those name–address–telephone number combinations that remain current, with reference to the online version of the White Pages directory, which is updated daily. This is a proven method of enhancing the overall efficiency of the approach letter mailing. Selections where the surname and address remained the same but the phone number had changed were included in the sample for approach letter mailing, as well as those records where the surname and the phone number remained the same but the address had changed. For the letter sample, where a postcode and locality were associated with the selected telephone number, locality was used in combination with postcode for the a priori allocation of the sample record to the LGA.

Questionnaire design

The 2017 statewide VPHS questionnaire was based on that used in 2016, with some additional sections and questions included for the first time, some questions reinstated from previous surveys, and some questions deleted. The questionnaire included five new sections: (1) palliative care (2) family violence (3) LGBTIQ+ (4) Aboriginal cultural participation and connection to culture (Box 1) and (5) discrimination (Box 2). Support details for any participants who reported having experienced family violence or who have provided support to someone who was terminally ill or dying were provided at the end of the interview.

A pilot test of 160 interviews using dual-frame sample was conducted between 13 and 24 November 2017. While the primary purpose of the pilot test was to test the questionnaire, procedures relating to the sending of primary approach text messages and follow-up activity following the first non-contact attempt were also tested as part of the pilot test program.

Box 1: Questions about connection to culture

1. In the last 12 months have you gone to or been involved in any of the following Aboriginal or Torres Strait Islander cultural activities or ceremonies?
 1. Ceremonies
 2. NAIDOC Week activities
 3. Sports carnivals (excluding NAIDOC Week activities)
 4. Festivals or carnivals involving Aboriginal or Torres Strait Islander arts, craft, music or dance (excluding NAIDOC Week activities)
 5. Been involved with any Aboriginal or Torres Strait Islander organisations
 6. Funerals/sorry business

2. How important is it for you to be able to attend Aboriginal or Torres Strait Islander cultural events, ceremonies, carnivals or do any of the activities just mentioned?
 1. It matters a lot
 2. It matters a bit
 3. It doesn't matter much
 4. It doesn't matter at all
 5. (Don't know)

3. In the last 12 months, how often did you talk with older relatives or Elders about Aboriginal or Torres Strait Islander history or culture?
 1. Never
 2. Rarely
 3. Sometimes
 4. Often
 5. Very often
 6. (Don't know)

Box 2: Questions asked about experiences of discrimination

1. In the past 12 months, do you feel that you have experienced discrimination or have been treated unfairly by others?
2. Thinking about your most recent experience of discrimination in Australia, do you think it was because of any of the following?
 1. You are Aboriginal and/or a Torres Strait Islander
 2. Your skin colour
 3. Your nationality, race or ethnic group
 4. The language you speak
 5. The way you dress or your appearance
 6. Your gender
 7. Your gender identity
 8. Your age
 9. A disability or health issue
 10. Being overweight or obese
 11. Your marital status
 12. Your family status
 13. Your sexual orientation
 14. Your intersex status
 15. Your occupation
 16. Your religious beliefs
 17. Your political position
 18. Any other reason (SPECIFY)
 19. (None of the above)
 20. (Can't say)
3. Thinking about your experiences of discrimination overall in Australia in the last 12 months, please indicate whether you experienced discrimination in the following situations.
 1. Applying for work, or when at work or on the job
 2. At home, by neighbours or at somebody else's house
 3. At school, university, a training course or other educational setting
 4. While doing any sporting, recreational or leisure activities
 5. By the police, security people, lawyers or in a court of law
 6. By doctors, nurses or other staff at hospitals or doctors' surgeries
 7. By staff of government agencies
 8. When seeking any other services
 9. By members of the public
 10. Any other situations (SPECIFY)
 11. (None of the above)
 12. (Don't know)

Box 2: Questions asked about experiences of discrimination /...continued

4. Thinking about your experiences of discrimination in Australia in the last 12 months, did you report or make a complaint about one or more of these instances of discrimination to anyone? Does not include informally telling a family member and/or friend.

1. Yes, reported experience(s)
2. Yes, reported some, not all, experiences
3. No, did not report any experiences
4. (Don't know)

Box 3: The national standard Indigenous identification question

'Are you [is the person] of Aboriginal or Torres Strait Islander origin?'

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander.

Source: The Indigenous status data element METeOR, AIHW:
meteor.aihw.gov.au/content/index.phtml/itemid/291036

Interviewer briefing

All interviewers selected to work on the VPHS attended a comprehensive 4-hour briefing session, which was delivered by the project management team. A total of 228 interviewers were briefed on the project, including 16 bilingual interviewers. A core team of 103 interviewers conducted 70% of the interviews.

Fieldwork quality control procedures

The in-field quality monitoring techniques applied to the VPHS were consistent with existing ISO 20252 procedures and included:

- monitoring (by remote listening) of each interviewer within their first three shifts, whereby the supervisor listened in on at least 75% of the interview and provided comprehensive feedback on data quality issues and respondent liaison technique
- validation via remote monitoring of 1,683 interviews (or approximately 5% of each interviewer's work) covering the interviewer's approach and commitment-gaining skills, as well as the conduct of the interview
- field team debriefing after the first shift, and thereafter whenever there was important information to impart in relation to data quality, consistency of interview administration, techniques to avoid refusals, appointment-making conventions or project performance
- maintenance of a 'question and answer' log, addressing issues raised by interviewers to clarify survey administration and definitional issues in the questionnaire
- a mid-survey debriefing
- examination of verbatim responses to 'other specify' questions
- monitoring the interview-to-refusal ratio by interviewer
- an end-of-survey debriefing.

Refusal conversion activity

A reason for refusal to participate in the 2017 VPHS was collected from refusing households or, if the refusal took place after respondent selection or in the case of the mobile sample, from the selected individual. Where the reason for refusal related directly to another (non-refusal) call outcome code (such as too old / frail / unable to do the survey, business number, non-Victorian resident, or language difficulty) the call result was amended accordingly, and the refusal was excluded from the denominator for the response rate calculation. As in previous studies in the series, refusals classified as 'soft – possible conversion' by the interviewer, where the reason for refusal was recorded as 'no comment – just hung up', 'too busy' or 'not interested' (17,842 in total) were regarded as the pool for potential refusal conversion.

Analysis of reason for refusal

Reason for refusal was captured for 16,299 cases and was used to inform strategies for refusal avoidance. As can be seen in Appendix 1 Table 1, immediate refusal outcomes where the sample members perceived lack of salience (not interested, 39.6%) and just hung up (30.2%) were among the most common reasons for refusal. This is similar to other surveys in the series.

Refusals encountered on RDD mobile were more likely to involve the phone answerer hanging up without comment and less likely to respond that they weren't interested in comparison with landline and listed mobile numbers.

Appendix 1 Table 1: Reason for refusal

	Total n	Landline %	RDD mobile %	Listed mobile %
Total	16,299	9,206	4,992	2,101
Not interested	39.6	41.1	35.5	42.7
No comment / just hung up	30.2	27.9	36.1	26.3
Too busy	8.1	7.2	8.7	10.6
Never do surveys	3.0	3.7	1.8	2.3
Don't trust surveys/government	2.1	2.0	2.1	2.1
Don't believe surveys are confidential / privacy concerns	2.5	2.7	2.6	1.7
Too personal/intrusive	2.0	2.4	1.5	1.6
Remove number from list (place on do not call register)	1.9	1.2	2.6	2.8
Get too many calls for surveys / telemarketing	1.2	1.2	0.9	1.8
Silent number	0.9	1.3	0.5	–
Interview length is too long	2.3	2.6	1.8	2.2
Don't like subject matter	0.4	0.4	0.3	0.5
Letter put me off	0.1	0.1	< 0.1	–
Other (specified)	5.7	6.0	5.5	5.3

Note: Does not include opt-outs to the text message because the reason for opting out is unknown.

Languages other than English

In total, 3,043 sample members were recorded as having a language difficulty. Of these, 2,119 spoke one of the nine foreign languages (Arabic, Cantonese, Croatian, Greek, Italian, Mandarin, Serbian, Turkish and Vietnamese) for follow-up. An interview was achieved in 30.3% (39.2% landline, 40.7% listed mobile and 26.6% RDD mobile) of cases where a language difficulty relating to one of the nine foreign languages was encountered. Of the 924 cases where a language difficulty was encountered that did not relate to one of the nine target languages, the preferred language was identified in 99.6% of cases. The languages in most demand included Macedonian (73), Korean (69), Spanish (65), Khmer (54), Russian (48) and Thai (46), with almost all cases for Korean sourced from the mobile sample.

Achieved age and gender distribution

The age and gender profile of survey participants was compared with that of the Victorian population to provide an indication of the extent, if any, of non-response bias.

While the analysis showed that the achieved sample continues to under-represent males and young people (under 35 years), it has improved the profile of both young people and males since the last LGA-level survey in 2014. The weighting strategy for the VPHS addressed imbalances in age and gender.

Sample composition

The composition of the achieved sample is provided in Appendix 1 Table 2. While males and young people have historically been under-represented in the achieved sample, the inclusion of a mobile sample from 2015 increased the overall proportion of males to levels not seen before in the history of the VPHS and improved –the representation of younger people (under 34 years) back to levels not seen since 2006/2007. It has also increased the representation of other difficult to reach groups including the proportion of participants who have lived in their current neighbourhood for less than 5 years, the proportion who are ‘de facto’ or ‘never married’ along with those in ‘group households’.

Appendix 1 Table 2: Sample composition

Measure	Characteristic	2017	% change (2016 to 2017)
Gender	Male	42.9	0.1
	Female	57.1	-0.1
Age group	18–24 years	4.3	-2.7
	25–34 years	8.4	-2.8
	35–44 years	11.1	-2.3
	45–54 years	15.8	0.1
	55–64 years	21.1	1.4
	65+ years	39.2	6.2
	Marital status	Married	54.9
Widowed		10.5	0.9
Divorced		8	0
Separated		3.7	0.3
Never married		12.7	-3.5
Other		10.1	1.8
Country	Born in Australia	77.9	8.8
Labour force status	Employed	50.2	-2.1
	Unemployed	3	-0.7
	Not in labour force	44.9	1
Length of tenure	1 year or less	5.4	-2.5
	> 1 up to 5 years	19	0.3
	> 5 up to 10 years	14.6	-0.7
	> 10 years	60.8	2.9
Household type	Couple only	36.7	6.3
	Couple with dependent children	16	-2.9
	Couple with non-dependent children	5.2	-2.4
	One-parent family with dependent children	2.6	0
	One-parent family with non-dependent children	2.6	-0.7
	Group household	6.8	-0.3
	One-person household	21.1	1.6

Weighting

For the 2017 LGA-level VPHS survey the weights were designed to combine the processes for the previous LGA-level VPHS (2014) and the most recent dual-frame statewide VPHS in 2016. For both surveys, this was a two-stage process. The first stage involved calculating an initial design weight to adjust for differing probabilities of selection caused by the sample design. In the second stage this design weight was adjusted so that the final weight conformed to population benchmarks obtained from ABS data.

The strength of the weighting approach – which incorporates design weights together with generalised raking to multiple benchmarks – is that it ensures estimates are robust and as representative as possible of the target population. For the 2016 survey, design weights were calculated as the inverse probability of selection obtained from the formula:

$$p = \frac{S_{LL}LL}{U_{LL}AD_{LL}} + \frac{S_{MP}MP}{U_{MP}}$$

where:

S_{LL} is the number of survey respondents contacted by landline

U_{LL} is the population of the universe of landline numbers

LL indicates whether the respondent owns a landline

AD_{LL} is the number of in-scope adults in the respondent's household (limited to a maximum of four)

S_{MP} is the number of survey respondents contacted by mobile

U_{MP} is the population of the universe of mobile numbers

MP indicates whether the respondent owns a mobile phone.

For the 2017 VPHS, S_{LL} , U_{LL} , S_{MP} and U_{MP} were all calculated at the LGA level. The final weighting solution would then adjust the design weights to match ABS benchmarks also at the LGA level. Prior to finalising the data, a weighting review was undertaken to compare possible weighting strategies. *Weight 1* adjusted for sex and age as per previous LGA surveys. *Weight 2* added an adjustment for telephone status, with benchmarks calculated at the capital city or rest-of-state level and applied at the LGA level. *Weight 3* included sex by age, telephone status, age by education and country of birth and was more methodologically comparable to previous statewide VPHS surveys. Weight 3 was chosen as the most appropriate weighting strategy. The final data was weighted by sex by age, telephone status, age by education and country of birth. Target population statistics were based on ABS 2016 Estimated Residential Population estimates of sex by age (18–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years and 65 years or older) within each LGA.

Statistical analysis

The survey data was analysed using the Stata statistical software package (Version 14.2, StatCorp LP, College Station Texas).

Prevalence

Prevalence is simply the proportion of people in a given population who have a certain characteristic in a specified period of time. Therefore, the statement 'the prevalence of high or very high psychological distress in Aboriginal men was 20.8%' should be interpreted as '20.8% of Aboriginal men in Victoria experienced high or very high psychological distress in the 4 weeks preceding the survey'. 'Four weeks' refers to the fact that the questions on psychological distress asked about the respondent's feelings during the 4 weeks immediately prior to the survey.

Standard error

The standard error is a measure of the variation in an estimate produced by sampling a population. The standard error can be used to calculate confidence intervals and relative standard errors, providing the likely range of the true value of an estimate and an indication of the reliability of an estimate.

Relative standard error

A relative standard error (RSE) provides an indication of the reliability of an estimate. Estimates with RSEs less than 25% are generally regarded as 'reliable' for general use. The percentages presented in tables and graphs in this report have RSEs less than 25%, unless otherwise stated. Rates that have an RSE between 25 and 50% have been marked with an asterisk (*) and should be interpreted with caution. For the purposes of this report, percentages with RSEs higher than 50% were not considered reliable estimates and have not been presented. A double asterisk (**) has been included in tables and graphs where the percentage would otherwise appear, indicating the relevant RSE was higher than 50%.

Point estimates and 95% confidence intervals

We report that the overall prevalence of depression or anxiety among Aboriginal adults in Victoria was 39% (95% confidence interval: 30.0–48.7%). The figure of '39%' is referred to as the 'point estimate' because it is drawn from a sample of adults in Victoria as opposed to every adult in Victoria. Since a point estimate is essentially a best guess, there is always uncertainty associated with any estimate and it is very important to measure the level of uncertainty around the point estimate. To do this we calculate a 95% confidence interval around the point estimate.

A 95% confidence interval means that if we were to draw 20 random samples from the same population, 19 of every 20 (95%) confidence intervals calculated for each sample would contain the true population estimate of the characteristic we are trying to measure and one of every 20 (5%) would not. Ninety-five per

cent confidence intervals are reported for all estimates throughout the report and used to ascertain statistical significance (see below). The width of a confidence interval also indicates the precision of an estimate; the wider the interval the less the precision.

The 95% confidence interval contains the range of possible values of the true prevalence of the indicator we are measuring, with the point estimate being the most likely estimate of the true prevalence of family violence in Victoria. Therefore, the prevalence of depression or anxiety among Aboriginal adults in Victoria lies between 30.0% and 48.7%, with 39% being the most likely estimate.

We strongly encourage readers not to focus on the point estimate alone because this can be misleading when comparing with another point estimate without their respective 95% confidence intervals being considered, potentially resulting in incorrect conclusions being drawn.

Effect size

Effect size is the size of the difference between two groups (Sullivan 2012). The effect size is the most important finding as it helps to determine whether the effort, time and cost of an intervention are justified by the magnitude of the effect. The effect size is independent of the sample size.

Statistical significance

Statistical significance provides an indication of how likely a result is due to chance. It is not used to describe practical or clinical significance – the relative importance of a particular finding and whether it has a real, palpable, noticeable effect on daily life. Both types of significance are important.

In general, statisticians have historically determined that statistical significance exists when there is less than or equal to a 5% probability ('*p*') the results occurred by chance – referred to as $p \leq 0.05$. For example, if the difference between two estimates from two different populations is associated with a *p*-value of ≤ 0.05 , then the interpretation is that the estimates from two different populations are statistically

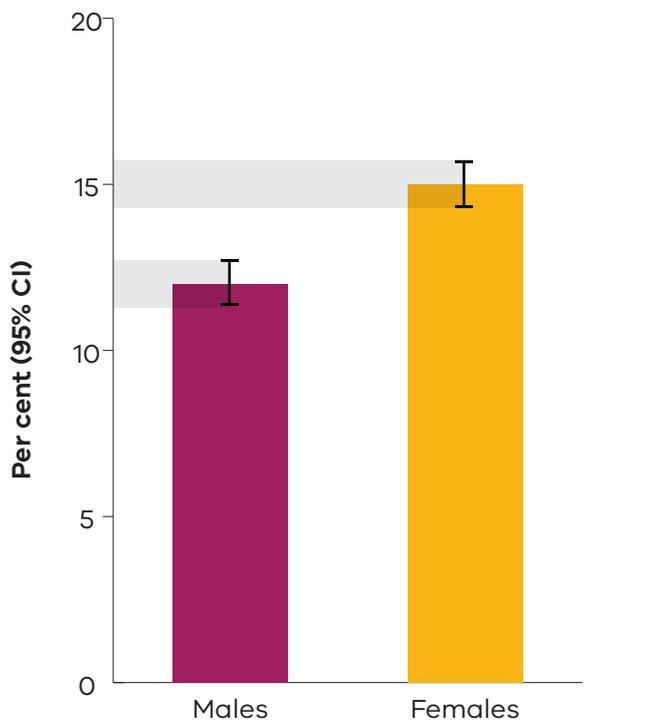
significantly different from each other. There is no scientific basis for choosing the $p \leq 0.05$ as the cut-off for determining statistical significance and many argue it is too low and should be increased to $p \leq 0.001$.

Conversely, however, if the p -value is greater than 0.05, this does not mean that there is no difference between the two groups being compared. It simply means there is 'insufficient evidence' to determine whether or not the estimates from two different populations are statistically significantly different from each other. This is an important point to understand because statistical significance

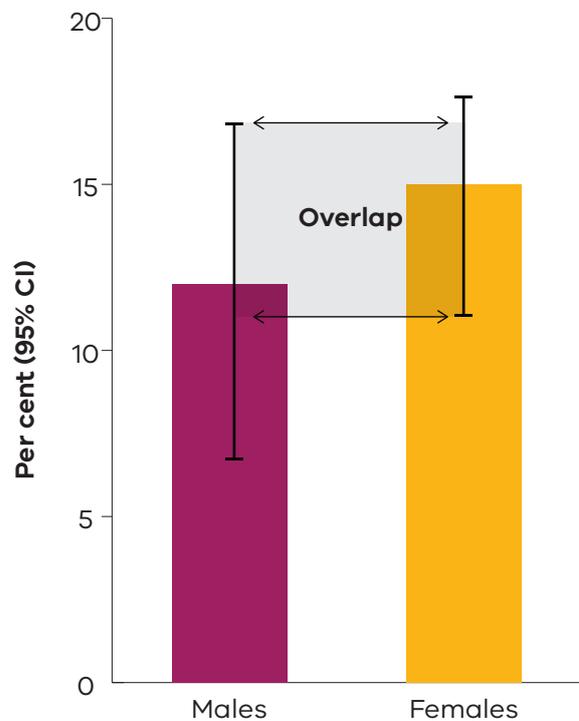
is highly sensitive to sample size – the higher the sample size the lower the p -value and the smaller the sample size the higher the p -value.

There are many ways to determine the p -value. Ninety-five per cent confidence intervals can be used to determine statistical significance. Where the 95% confidence intervals for two groups do not overlap, this roughly corresponds to a p -value of ≤ 0.05 .

The following figure shows how 95% confidence intervals can be used to determine statistical significance.



Confidence intervals do not overlap, therefore, estimates are statistically different



Confidence intervals overlap, therefore, estimates are **not** statistically different

Statistically significant differences can reflect either important or non-important differences between two point estimates, which is why one should always ask the question: 'But is this statistically significant difference practically or clinically meaningful?'

Statistical significance also does not give any information about the effect size. Sometimes there can be a large effect size or difference between two estimates that is not statistically different because the sample size of one or both estimates is too small to be able to detect a statistically significant difference.

Therefore, if one solely relied on the presence of a statistically significant difference to determine whether there was a difference between two groups, one can sometimes erroneously conclude there is no difference between two estimates when in reality there is. This is referred to as a type 2 error. Small sample sizes make it hard to detect real differences between two groups and are a source of type 2 error (Kirkwood & Sterne 2003). By increasing the sample size, we can reduce the probability of making a type 2 error.

Conversely, very large sample sizes, as seen with big data, are a source of type 1 error – the opposite problem. Type 1 error is where one finds statistically significant differences between two estimates when in reality there is no real difference between the two estimates (Kirkwood & Sterne 2003). This is why solely relying on statistical significance is not recommended.

Crude and age-standardised (age-adjusted) estimates of prevalence

A crude estimate of prevalence is the proportion of a population that experiences a specific event over a specified period of time and is calculated by dividing the number of events recorded for a given period by the number of people in the population at risk of the event during the time period specified. Crude estimates are useful for service planning purposes.

However, in making comparisons between the Aboriginal and non-Aboriginal populations of Victoria, it is necessary to take into consideration the different age structures of the two populations. The Aboriginal population is a much younger population than the non-Aboriginal population. If one does not take into account the different age structures, any difference between the two populations in the prevalence of an indicator of interest may just reflect the different age structures rather than a real difference.

Age standardisation

Age-standardised estimates, also known as age-adjusted estimates, were calculated using the direct method of standardisation. The direct age-standardised estimates that are presented in this report are based on the weighted sum of age-specific rates applied to a standard population – the 2011 estimated resident population of Victoria, using 10-year age groups.

Interpretation of the data

In the field of statistics, there is no single correct way to interpret data. In 2016, the American Statistical Association released a position statement in which they stated: 'Scientific conclusions and business or policy decisions should not be based only on whether a p -value passes a specific threshold' (Wasserstein & Lazar 2016, p. 131).

The position statement goes on to say:

Practices that reduce data analysis or scientific inference to mechanical 'bright-line' rules (such as ' $p < 0.05$ ') for justifying scientific claims or conclusions can lead to erroneous beliefs and poor decision making. A conclusion does not immediately become 'true' on one side of the divide and 'false' on the other. Researchers should bring many contextual factors into play to derive scientific inferences, including the design of a study, the quality of the measurements, the external evidence for the phenomenon under study, and the validity of assumptions that underlie the data analysis. Pragmatic considerations often require binary, 'yes-no' decisions, but this does not mean that p -values alone can ensure that a decision is correct or incorrect. The widespread use of 'statistical significance' (generally interpreted as ' $p \leq 0.05$ ') as a license for making a claim of a scientific finding (or implied truth) leads to considerable distortion of the scientific process (Wasserstein & Lazar 2016, p. 131).

Due to the small number of adults who identified as being of Aboriginal origin in the 2017 VPHS, this report will differ from other VPHS reports in how the data are interpreted. Interpretation of the data in this report will take into consideration both effect size (the difference between any two groups) and statistical significance. This is because effect size is not affected by sample size, whereas statistical significance is.

In this report, where comparisons are made between two groups and a large effect size is observed, regardless of whether it reaches statistical significance at the $p \leq 0.05$ level, the interpretation will be that there may be a true difference. Therefore, where there is statistical significance between two groups, this will be indicated by the use of the term 'significantly'. Where there is no statistical significance between two groups, but the effect size is notably large, this will be indicated by the use of terms 'higher' or 'lower' without the concomitant use of the qualifying term 'significantly'.

APPENDIX 2: TABLES

Appendix 2 Table 1: Proportion (%) of adults, by level of psychological distress, gender and Aboriginal status, Victoria, 2017

Aboriginal status	Psychological distress level													
	Mild (K10 <16)			Moderate (K10 16-21)			High or very high (K10 22+)			Did not know or refused to say				
	%	95% CI		%	95% CI		%	95% CI		%	95% CI			
		LL	UL		LL	UL		LL	UL		LL	UL		
Men														
Aboriginal	53.7	41.5	65.4	25.6	16.1	38.1	18.3	12.0	26.9		**			
Non-Aboriginal	58.2	56.8	59.5	23.5	22.4	24.7	12.7	11.8	13.6	5.6	5.0	6.3		
Did not know or refused to say	47.6	31.0	64.8	28.4	15.5	46.2	16.1	*	7.6	31.1	7.8	*	2.9	19.3
All Victorian men	58.1	56.8	59.4	23.5	22.4	24.7	12.8	11.9	13.7	5.6	5.0	6.3		
Women														
Aboriginal	24.7	17.1	34.2	36.2	27.1	46.3	30.8	21.3	42.3	8.4	*	4.4	15.5	
Non-Aboriginal	50.3	49.0	51.6	25.6	24.5	26.7	18.0	16.9	19.1	6.1	5.4	6.9		
Did not know or refused to say	27.4	17.6	40.1	38.5	24.5	54.8	19.2	*	9.9	33.9	14.9	*	7.3	28.0
All Victorian women	50.0	48.7	51.3	25.8	24.7	26.9	18.1	17.0	19.1	6.1	5.5	6.9		
All adults														
Aboriginal	41.7	33.3	50.5	29.8	22.5	38.4	23.2	17.4	30.3	5.3	*	2.5	10.6	
Non-Aboriginal	54.1	53.2	55.1	24.6	23.8	25.4	15.4	14.7	16.1	5.9	5.4	6.4		
Did not know or refused to say	39.5	29.1	51.0	32.1	21.1	45.5	17.2	*	10.2	27.6	11.2	*	5.7	20.6
All Victorian adults	53.9	53.0	54.9	24.7	23.9	25.5	15.5	14.8	16.2	5.9	5.4	6.4		

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults', by gender, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

K10 = Kessler 10 Psychological Distress Scale.

Appendix 2 Table 2: Proportion (%) of adults who had ever been told by a doctor that they had depression or anxiety, by gender and Aboriginal status, Victoria, 2017

Aboriginal status	Ever been diagnosed by a doctor with depression or anxiety?								
	Yes			No			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Men									
Aboriginal	29.5	21.2	39.5	70.5	60.5	78.8	0.0	.	.
Non-Aboriginal	21.0	19.9	22.0	78.6	77.5	79.7	0.4	0.3	0.6
Did not know or refused to say	21.1 *	10.6	37.7	78.7	62.2	89.3	**		
All Victorian men	21.1	20.1	22.2	78.5	77.4	79.5	0.4	0.3	0.6
Women									
Aboriginal	49.8	37.4	62.3	49.3	36.8	61.8	**		
Non-Aboriginal	33.5	32.3	34.7	66.2	65.0	67.4	0.3	0.2	0.4
Did not know or refused to say	47.0	30.9	63.9	53.0	36.1	69.1	0.0	.	.
All Victorian women	33.6	32.4	34.8	66.1	64.9	67.3	0.3	0.2	0.4
All adults									
Aboriginal	38.3	30.9	46.2	61.2	53.2	68.7	**		
Non-Aboriginal	27.3	26.5	28.2	72.3	71.5	73.1	0.3	0.3	0.5
Did not know or refused to say	33.2	21.9	46.7	66.7	53.2	78.0	**		
All Victorian adults	27.5	26.7	28.3	72.2	71.4	73.0	0.3	0.3	0.5

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults', by gender, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 3: Proportion (%) of adults, by subjective wellbeing (life is worthwhile rating) and Aboriginal status, Victoria, 2017

Overall, to what extent do you feel that the things you do in your life are worthwhile, on a scale from 0 to 10 - where 0 is not worthwhile at all and 10 is completely worthwhile?															
Aboriginal status	Not at all worthwhile (0-4)			Somewhat worthwhile (5-6)			Worthwhile (7-8)			Completely worthwhile (9-10)			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL		LL	UL
Aboriginal	8.2	5.1	12.9	10.5 *	6.3	16.9	40.7	32.3	49.7	37.8	29.2	47.2	2.9 *	1.1	7.3
Non-Aboriginal	3.9	3.6	4.3	12.7	12.1	13.4	46.3	45.3	47.2	34.1	33.2	34.9	3.0	2.7	3.4
Did not know or refused to say	7.7 *	3.4	16.7	11.5 *	6.1	20.5	41.6	29.6	54.6	33.5	22.7	46.3	5.8 *	2.5	12.7
Victorian adults	4.0	3.6	4.4	12.7	12.1	13.4	46.2	45.3	47.1	34.1	33.2	34.9	3.0	2.7	3.4

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

Appendix 2 Table 4: Proportion (%) of adults, by subjective wellbeing (life satisfaction rating) and Aboriginal status, Victoria, 2017

Aboriginal status	How satisfied are you with your life overall, on a scale from 0 to 10 - where 0 is not satisfied at all and 10 is completely satisfied?														
	Not at all satisfied (0-4)			Somewhat satisfied (5-6)			Satisfied (7-8)			Completely satisfied (9-10)			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL		LL	UL
Aboriginal	10.1	6.2	16.1	17.1	11.6	24.4	45.4	36.8	54.3	24.4	18.2	32.0	**		
Non-Aboriginal	5.1	4.7	5.6	15.2	14.5	15.9	51.0	50.1	52.0	27.0	26.2	27.8	1.6	1.4	1.8
Did not know or refused to say	7.3 *	3.3	15.4	19.4	12.1	29.7	38.2	27.1	50.6	29.8	19.6	42.5	5.3 *	2.1	13.0
Victorian adults	5.2	4.8	5.6	15.3	14.6	16.0	51.0	50.0	51.9	27.0	26.2	27.8	1.6	1.4	1.8

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 5: Proportion (%) of adults, by self-reported health status, gender and Aboriginal status, Victoria, 2017

Aboriginal status	Self-reported health status											
	Excellent or very good			Good			Fair or poor			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Men												
Aboriginal	21.4	13.6	32.0	45.4	35.1	56.2	33.2	22.8	45.6	0.0	.	.
Non-Aboriginal	42.1	40.8	43.4	37.8	36.6	39.1	19.5	18.5	20.6	0.6	0.4	0.8
Did not know or refused to say	52.6	37.7	67.0	22.5	13.9	34.3	24.9 *	13.6	41.1	0.0	.	.
All Victorian men	41.8	40.5	43.1	37.9	36.7	39.2	19.7	18.7	20.8	0.6	0.4	0.8
Women												
Aboriginal	41.9	29.7	55.1	23.4	15.8	33.2	34.6	24.7	46.2	**	.	.
Non-Aboriginal	41.5	40.3	42.8	37.3	36.1	38.6	20.6	19.6	21.7	0.5	0.3	0.8
Did not know or refused to say	28.0 *	16.1	44.2	37.1	22.4	54.8	34.8	21.2	51.5	0.0	.	.
All Victorian women	41.5	40.2	42.7	37.2	36.0	38.5	20.8	19.8	21.8	0.5	0.3	0.7
Adults												
Aboriginal	30.3	22.5	39.3	35.2	27.6	43.5	34.5	26.5	43.6	**	.	.
Non-Aboriginal	41.8	40.9	42.7	37.6	36.7	38.5	20.1	19.4	20.9	0.5	0.4	0.7
Did not know or refused to say	35.6	24.5	48.5	32.9	22.4	45.3	31.6	21.6	43.6	0.0	.	.
All Victorian adults	41.6	40.7	42.5	37.6	36.7	38.5	20.3	19.6	21.0	0.5	0.4	0.7

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults', by gender, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 6: Proportion (%) of adults, by self-reported dental health status, gender and Aboriginal status, Victoria, 2017

Aboriginal status	Self-reported dental health status														
	Excellent or very good			Good			Fair or poor			Not applicable (no natural teeth)			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL		LL	UL
Men															
Aboriginal	15.8	10.3	23.5	23.2	15.3	33.4	37.6	27.4	49.0	23.2	15.2	33.9	**		
Non-Aboriginal	33.7	32.4	34.9	35.8	34.5	37.1	26.2	25.1	27.5	3.8	3.4	4.3	0.5	0.3	0.7
Did not know or refused to say	25.0 *	14.5	39.6	42.4	28.1	58.1	27.3 *	14.3	45.9	4.8 *	2.2	10.4	**		
All Victorian men	33.5	32.3	34.7	35.7	34.5	37.0	26.4	25.3	27.6	3.9	3.5	4.4	0.5	0.3	0.7
Women															
Aboriginal	34.2	25.6	44.0	29.0	20.5	39.2	31.3	21.9	42.6	5.5 *	3.0	9.9	**		
Non-Aboriginal	41.0	39.8	42.3	32.3	31.1	33.6	22.3	21.3	23.5	3.9	3.6	4.4	0.3	0.2	0.5
Did not know or refused to say	26.3 *	15.0	41.8	40.7	25.8	57.4	25.8 *	14.6	41.4	7.3 *	2.9	17.3	0.0	.	.
All Victorian women	40.9	39.6	42.1	32.4	31.2	33.6	22.4	21.4	23.5	4.0	3.6	4.4	0.3	0.2	0.5
Adults															
Aboriginal	24.8	18.3	32.7	26.0	19.7	33.5	35.7	27.9	44.5	13.3 *	7.6	22.1	**		
Non-Aboriginal	37.4	36.5	38.3	34.0	33.2	34.9	24.3	23.5	25.1	3.9	3.6	4.2	0.4	0.3	0.6
Did not know or refused to say	25.7	16.6	37.5	46.3	34.2	58.9	22.6	14.1	34.1	5.0 *	2.5	9.8	**		
All Victorian adults	37.2	36.3	38.1	34.0	33.1	34.9	24.4	23.6	25.2	4.0	3.7	4.3	0.4	0.3	0.5

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults', by gender, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 7: Proportion of Aboriginal adults who attended an Aboriginal cultural event in the 12 months preceding the survey, by gender and type of event, Victoria, 2017

Gender	Attended an Aboriginal cultural event in last 12 months?					
	%	Yes		No or did not know [#]		
		95% CI		%	95% CI	
		LL	UL		LL	UL
Attended at least one cultural event *						
Men	48.1	34.2	62.4	51.7	37.5	65.7
Women	58.3	44.3	71.2	41.7	28.8	55.7
Adults	52.3	41.9	62.6	47.6	37.4	58.1
Attended an Aboriginal ceremony						
Men	32.4	20.9	46.4	67.6	53.6	79.1
Women	23.7	14.4	36.5	76.3	63.5	85.6
Adults	28.8	20.8	38.5	71.2	61.5	79.2
Attended a NAIDOC Week event						
Men	34.3	22.3	48.7	65.7	51.3	77.7
Women	35.2	23.5	49.0	64.8	51.0	76.5
Adults	34.7	25.8	44.8	65.3	55.2	74.2
Attended a sports carnival						
Men	20.6	11.9	33.4	79.4	66.6	88.1
Women	19.3	10.1	33.7	80.7	66.3	89.9
Adults	20.1	13.3	29.2	79.9	70.8	86.7
Attended an arts festival or carnival involving Aboriginal arts, crafts, music or dance						
Men	30.5	19.6	44.2	69.5	55.8	80.4
Women	34.9	23.0	49.1	65.1	50.9	77.0
Adults	32.3	23.9	42.1	67.7	57.9	76.1
Involved with an Aboriginal organisation						
Men	33.4	22.3	46.8	66.5	53.1	77.6
Women	49.1	35.1	63.3	50.9	36.7	64.9
Adults	39.8	30.4	50.2	60.1	49.8	69.6
Attended a funeral or sorry business						
Men	29.3	18.5	43.2	70.6	56.8	81.5
Women	27.2	17.4	39.9	72.1	59.4	82.0
Adults	28.5	20.6	37.9	71.2	61.7	79.1

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

[#] Only 1 respondent did not know if they had attended an arts festival or carnival involving Aboriginal arts, crafts, music or dance; 1 respondent did not know if they were involved with an Aboriginal organisation; and 3 respondents did not know if they had attended a funeral or sorry business.

* Does not include attending a funeral or sorry business

Appendix 2 Table 8: Proportion (%) of Aboriginal adults, by the importance of attending an Aboriginal cultural event and gender, Victoria, 2017

Gender	How important is it to you to be able to attend Aboriginal cultural events?														
	It matters a lot			It matters a bit			It doesn't matter much			It doesn't matter at all			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL		LL	UL
Men	32.4	21.2	46.0	17.5 *	8.9	31.7	23.1	13.9	35.8	24.0 *	12.1	42.1		**	
Women	41.6	28.8	55.7	22.0	13.5	33.8	24.0	11.6	43.0	10.9 *	5.6	20.3		**	
Adults	36.2	27.4	46.0	19.4	12.7	28.4	23.5	15.5	33.9	18.7 *	10.7	30.5	2.3 *	0.9	6.0

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 9: Proportion (%) of Aboriginal adults, by how often they spoke with an Elder or older relative about Aboriginal history or culture in the 12 months preceding the survey and gender, Victoria, 2017

In the last 12 months, how often did you talk with older relatives or an Elder about Aboriginal history or culture?															
Gender	Never or rarely			Sometimes			Often or very often			Sometimes, often or very often			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL		LL	UL
Men	40.1	26.5	55.5	23.8 *	13.8	37.9	36.1	24.0	50.1	59.9	44.5	73.5	0.0	.	.
Women	40.3	27.8	54.2	27.4 *	14.9	45.0	31.2	20.1	44.9	58.6	44.7	71.2	**		
Adults	40.2	30.4	50.9	25.3	16.9	36.0	34.1	25.4	44.0	59.4	48.7	69.2	**		

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 10: Proportion (%) of Aboriginal adults, by attendance of at least one Aboriginal cultural event in the 12 months preceding the survey and self-reported health status, Victoria, 2017

Attended at least one Aboriginal cultural event in last year?	Self-reported health status											
	Excellent/Very Good			Good			Fair/Poor			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Yes	30.6	19.3	44.8	40.2	28.4	53.3	29.2	19.8	40.8	**	.	.
No	23.1 *	12.8	38.2	36.3	22.1	53.3	40.6	24.6	58.9	0.0	.	.
Did not know	**			**			62.1 *	14.3	94.1	0.0	.	.
Total	27.3	19.0	37.5	38.5	29.0	48.8	34.2	24.9	44.9	**		

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Cultural events include: ceremonies; NAIDOC week activities; sports carnivals; festivals or carnivals involving Aboriginal arts, craft, music or dance; or involvement with an Aboriginal organisation.

Appendix 2 Table 11: Proportion (%) of Aboriginal adults, by how often they spoke with an Elder or older relative about Aboriginal history or culture in the 12 months preceding the survey and self-reported health status, Victoria, 2017

Frequency of talking with an Elder or older relative about Aboriginal history or culture	Self-reported health status											
	Excellent/Very Good			Good			Fair/Poor			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Never or rarely	22.1 *	12.4	36.2	37.9	23.8	54.4	40.0	23.9	58.6	0.0	.	.
Sometimes	29.7 *	12.1	56.6	41.4 *	22.3	63.5	28.9 *	14.7	48.9	0.0	.	.
Often or very often	31.3	18.7	47.5	37.5	23.2	54.3	31.2	19.1	46.4	**	.	.
Did not know or refused to say	**	.	.	0.0	.	.	**	.	.	0.0	.	.
Total	27.3	19.0	37.5	38.5	29.0	48.8	34.2	24.9	44.9	**	.	.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 12: Proportion (%) of adults, by experiences of racism in the 12 months preceding the survey and ethnicity, Victoria, 2017

Ethnicity	Discriminated against in the last 12 months due to Aboriginal status, skin colour, nationality, race, or ethnic group?								
	Yes			No			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal	18.8	13.8	25.0	80.4	74.2	85.4	**		
Non-Aboriginal / English only / born in Australia	2.7	2.4	3.2	96.6	96.2	97.1	0.6	0.5	0.8
Non-Aboriginal / English only / born overseas	8.9	7.2	11.0	89.3	87.1	91.2	1.8	1.1	2.9
Non-Aboriginal / spoke a European language	9.4	7.5	11.8	89.4	87.1	91.4	1.1	0.6	1.9
Non-Aboriginal / spoke a non-European language	14.0	12.5	15.6	83.8	82.0	85.4	2.2	1.6	3.0
All Victorian adults	6.7	6.2	7.2	92.1	91.6	92.6	1.2	1.0	1.5

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for all adults are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

****** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 13: Proportion (%) of adults who experienced racism in the 12 months preceding the survey, by place of experience or perpetrator, and ethnicity, Victoria, 2017

Ethnicity	Discriminated against in the last 12 months due to Aboriginal status, skin colour, nationality, race, or ethnic group?					
	%	Yes		No, don't know or refused to say		
		95% CI		%	95% CI	
		LL	UL		LL	UL
By a doctor, nurse, or other staff at a hospital or doctor's surgery						
Aboriginal	47.0	31.7	62.9	53.0	37.1	68.3
Non-Aboriginal / English only / born in Australia	16.6	11.3	23.7	83.4	76.3	88.7
Non-Aboriginal / English only / born overseas	7.3 *	3.7	14.0	92.7	86.0	96.3
Non-Aboriginal / spoke a European language	14.2 *	8.4	23.1	85.8	76.9	91.6
Non-Aboriginal / spoke a non-European language	11.1 *	6.2	19.2	88.9	80.8	93.8
All Victorian adults	11.3	9.1	14.0	88.7	86.0	90.9
Applying for work or when at work						
Aboriginal	36.1	23.2	51.4	63.9	48.6	76.8
Non-Aboriginal / English only / born in Australia	43.0	36.3	50.0	57.0	50.0	63.7
Non-Aboriginal / English only / born overseas	58.0	49.4	66.1	42.0	33.9	50.6
Non-Aboriginal / spoke a European language	58.1	48.9	66.8	41.9	33.2	51.1
Non-Aboriginal / spoke a non-European language	47.3	41.4	53.2	52.7	46.8	58.6
All Victorian adults	49.2	45.5	52.9	50.8	47.1	54.5
At home, by neighbours, or at someone else's home						
Aboriginal	36.6	23.3	52.4	63.4	47.6	76.7
Non-Aboriginal / English only / born in Australia	21.1	16.2	27.0	78.9	73.0	83.8
Non-Aboriginal / English only / born overseas	22.8	15.3	32.5	77.2	67.5	84.7
Non-Aboriginal / spoke a European language	21.3	14.2	30.6	78.7	69.4	85.8
Non-Aboriginal / spoke a non-European language	17.3	11.6	25.0	82.7	75.0	88.4
All Victorian adults	20.9	17.3	25.1	79.1	74.9	82.7
At a school, university, training course, or other educational setting						
Aboriginal	22.8 *	12.9	37.3	77.2	62.7	87.1
Non-Aboriginal / English only / born in Australia	16.0	11.8	21.3	84.0	78.7	88.2
Non-Aboriginal / English only / born overseas	26.9	18.9	36.7	73.1	63.3	81.1
Non-Aboriginal / spoke a European language	12.6 *	7.3	20.7	87.4	79.3	92.7
Non-Aboriginal / spoke a non-European language	17.0	12.8	22.3	83.0	77.7	87.2
All Victorian adults	18.1	15.1	21.6	81.9	78.4	84.9
While doing any sporting, recreational or leisure activity						
Aboriginal	21.7 *	12.1	36.0	78.3	64.0	87.9
Non-Aboriginal / English only / born in Australia	15.8	11.3	21.6	84.2	78.4	88.7
Non-Aboriginal / English only / born overseas	24.7	17.1	34.3	75.3	65.7	82.9
Non-Aboriginal / spoke a European language	14.5 *	8.6	23.4	85.5	76.6	91.4
Non-Aboriginal / spoke a non-European language	10.9	7.8	15.0	89.1	85.0	92.2
All Victorian adults	16.4	13.4	19.9	83.6	80.1	86.6

continued.../

.../continued

Appendix 2 Table 13: Proportion (%) of adults who experienced racism in the 12 months preceding the survey, by place of experience or perpetrator, and ethnicity, Victoria, 2017

Ethnicity	Discriminated against in the last 12 months due to Aboriginal status, skin colour, nationality, race, or ethnic group?						
	Yes			No, don't know or refused to say			
	%	95% CI		%	95% CI		
		LL	UL		LL	UL	
By police, security people, lawyers, or in a court							
Aboriginal	22.8 *	12.8	37.4	77.2	62.6	87.2	
Non-Aboriginal / English only / born in Australia	10.4	6.9	15.4	89.6	84.6	93.1	
Non-Aboriginal / English only / born overseas	16.4	10.3	25.1	83.6	74.9	89.7	
Non-Aboriginal / spoke a European language	14.6 *	8.1	25.0	85.4	75.0	91.9	
Non-Aboriginal / spoke a non-European language	12.4	9.0	16.9	87.6	83.1	91.0	
All Victorian adults	13.3	11.0	16.1	86.7	83.9	89.0	
By staff of a government agency							
Aboriginal	16.6 *	7.9	31.4	83.4	68.6	92.1	
Non-Aboriginal / English only / born in Australia	19.0	14.0	25.3	81.0	74.7	86.0	
Non-Aboriginal / English only / born overseas	14.7	9.1	22.8	85.3	77.2	90.9	
Non-Aboriginal / spoke a European language	12.2 *	6.8	20.9	87.8	79.1	93.2	
Non-Aboriginal / spoke a non-European language	9.9	6.9	14.1	90.1	85.9	93.1	
All Victorian adults	13.4	11.1	16.1	86.6	83.9	88.9	
When seeking any other services							
Aboriginal	24.1 *	13.1	40.1	75.9	59.9	86.9	
Non-Aboriginal / English only / born in Australia	19.0	13.9	25.5	81.0	74.5	86.1	
Non-Aboriginal / English only / born overseas	20.3	13.3	29.6	79.7	70.4	86.7	
Non-Aboriginal / spoke a European language	12.0	7.4	18.9	88.0	81.1	92.6	
Non-Aboriginal / spoke a non-European language	19.5	13.8	26.8	80.5	73.2	86.2	
All Victorian adults	18.1	15.0	21.7	81.9	78.3	85.0	
By members of the public							
Aboriginal	70.2	60.6	78.3	29.8	21.7	39.4	
Non-Aboriginal / English only / born in Australia	54.7	47.1	62.0	45.3	38.0	52.9	
Non-Aboriginal / English only / born overseas	61.4	51.5	70.5	38.6	29.5	48.5	
Non-Aboriginal / spoke a European language	44.5	34.3	55.2	55.5	44.8	65.7	
Non-Aboriginal / spoke a non-European language	50.7	42.8	58.6	49.3	41.4	57.2	
All Victorian adults	52.2	48.0	56.3	47.8	43.7	52.0	

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for all adults are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

Appendix 2 Table 14: Proportion (%) of adults who experienced racism and reported the incident or made a complaint, by ethnicity, Victoria, 2017

Sub-population	In the last 12 months, did you report or make a complaint about one or more incidents of racism (not including to a friend or family member)?								
	Yes, reported some or all experiences			No, did not report any experience			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal	31.3	19.4	46.4	68.7	53.6	80.6	0.0	.	.
Non-Aboriginal / only spoke English / born in Australia	21.0	15.8	27.2	79.0	72.8	84.2	0.0	.	.
Non-Aboriginal / only spoke English / born overseas	19.2	12.6	28.2	80.8	71.8	87.4	**		
Spoke a European language	28.0	19.3	38.9	71.1	60.2	80.0	**		
Spoke a non-European language	13.7	9.1	20.0	86.3	79.9	90.9	**		
All Victorian adults who experienced racism	19.0	16.1	22.3	80.8	77.5	83.7	**		

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

****** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 15: Proportion (%) of adults, by level of psychological distress, experiences of racism and Aboriginal status, Victoria, 2017

	Psychological distress												
	Mild (K10 <16)			Moderate (K10 16-21)			High or very high (K10 22+)			Did not know or refused to say			
	%	95% CI		%	95% CI		%	95% CI		%	95% CI		
		LL	UL		LL	UL		LL	UL		LL	UL	
Discriminated against in the last 12 months, due to Aboriginal status, skin colour, nationality, race, or ethnic group													
Aboriginal	29.9	17.5	46.2	29.1	18.4	42.6	39.8	26.1	55.4	**			
Non-Aboriginal	38.6	34.5	42.8	28.5	25.0	32.2	24.0	20.5	28.0	8.9	6.5	12.2	
Did not know or refused to say	**		0.0	.	.	45.6	43.6	47.7	0.0	.	.		
All Victorian adults	38.2	34.2	42.3	28.3	24.8	31.9	24.8	21.3	28.7	8.7	6.4	11.9	
Not discriminated against													
Aboriginal	44.7	34.9	54.8	31.3	23.1	40.9	18.3	12.5	26.2	5.7	*	2.6	12.2
Non-Aboriginal	55.5	54.6	56.5	24.3	23.5	25.2	14.7	14.0	15.4	5.5	5.0	6.0	
Did not know or refused to say	42.0	31.1	53.7	33.0	21.5	46.9	12.5	*	6.5	22.9	12.6	6.4	23.2
All Victorian adults	55.4	54.4	56.3	24.4	23.6	25.3	14.7	14.0	15.4	5.5	5.0	6.0	

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 16: Proportion (%) of adults, by whether or not they had ever been told by a doctor that they had depression or anxiety, experiences of racism and Aboriginal status, Victoria, 2017

Aboriginal status	Ever been diagnosed by a doctor with depression or anxiety?									
	%	Yes		%	No		Did not know or refused to say			
		95% CI			95% CI		95% CI			
		LL	UL		LL	UL	LL	UL		
Discriminated against in the last 12 months, due to Aboriginal status, skin colour, nationality, race, or ethnic group										
Aboriginal	65.5	51.5	77.3	30.7	19.6	44.7	**			
Non-Aboriginal	30.6	26.7	34.7	68.8	64.6	72.7	0.6 *	0.3	1.3	
Did not know or refused to say	46.5	46.5	46.5	0.0	.	.	0.0	.	.	
All Victorian adults	31.7	27.9	35.8	67.6	63.5	71.5	0.7 *	0.3	1.4	
Not discriminated against										
Aboriginal	32.1	24.3	41.0	67.8	58.9	75.6	**			
Non-Aboriginal	27.2	26.4	28.1	72.5	71.6	73.3	0.3	0.2	0.4	
Did not know or refused to say	30.0	18.5	44.7	69.8	55.2	81.3	**			
All Victorian adults	27.2	26.4	28.1	72.5	71.6	73.3	0.3	0.2	0.4	

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 17: Proportion (%) of adults, by self-reported health status, experiences of racism and Aboriginal status, Victoria, 2017

Aboriginal status	Self-reported health status											
	Excellent or very good			Good			Fair or poor			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Discriminated against in the last 12 months, due to Aboriginal status, skin colour, nationality, race, or ethnic group												
Aboriginal	24.0 *	13.4	39.2	24.8 *	14.5	39.1	51.2	37.0	65.2	0.0	.	.
Non-Aboriginal	31.7	28.0	35.6	39.1	34.9	43.5	29.0	25.2	33.2	**	.	.
Did not know or refused to say	0.0	.	.	**	.	.	41.9	34.6	49.6	0.0	.	.
All Victorian adults	31.4	27.8	35.3	38.8	34.7	43.2	29.6	25.8	33.7	**	.	.
Not discriminated against												
Aboriginal	29.9	21.2	40.3	38.5	30.0	47.9	31.5	22.9	41.7	**	.	.
Non-Aboriginal	42.8	41.9	43.8	37.4	36.5	38.3	19.3	18.5	20.1	0.5	0.4	0.7
Did not know or refused to say	36.2	24.7	49.5	33.1	22.0	46.4	30.7	20.6	43.2	0.0	.	.
All Victorian adults	42.6	41.7	43.6	37.4	36.5	38.4	19.4	18.7	20.2	0.5	0.4	0.7

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 18: Proportion (%) of adults, by experiences of racism, highest level of educational attainment and Aboriginal status, Victoria, 2017

Highest level of educational attainment	Discriminated against in the last 12 months due to Aboriginal status, skin colour, nationality, race, or ethnic group								
	Did not experience racism			Experienced racism			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal									
Did not complete secondary education	84.0	76.5	89.5	15.1	9.8	22.6			**
Completed secondary education	82.9	72.8	89.7	16.3	*	9.7	26.2		**
Tertiary education	57.4	46.9	67.2	39.9		29.9	50.8		**
All Aboriginal adults	80.4	74.2	85.4	18.8	13.8	25.0			**
Non-Aboriginal									
Did not complete secondary education	92.7	91.2	93.9	5.9	4.8	7.3	1.4	1.0	2.1
Completed secondary education	93.2	92.3	94.0	5.8	5.1	6.7	1.0	0.6	1.5
Tertiary education	90.9	90.0	91.7	8.0	7.3	8.8	1.1	0.8	1.5
All non-Aboriginal adults	92.2	91.7	92.8	6.6	6.1	7.1	1.2	1.0	1.5

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for all adults, by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 19: Proportion (%) of adults who had ever been told by a doctor that they had depression or anxiety, by highest level of educational attainment and Aboriginal status, Victoria, 2017

Highest level of educational attainment	Ever told by a doctor that you have depression or anxiety?									
	Yes			No			Did not know or refused to say			
	%	95% CI		%	95% CI		%	95% CI		
		LL	UL		LL	UL		LL	UL	
Aboriginal										
Did not complete secondary education	36.2	26.1	47.7	63.1	51.5	73.3		**		
Completed secondary education	50.4	38.9	62.0	49.6	38.0	61.1	0.0			
Tertiary education	55.5	43.2	67.2	43.9	32.3	56.3		**		
All Aboriginal adults	38.3	30.9	46.2	61.2	53.2	68.7		**		
Non-Aboriginal										
Did not complete secondary education	36.5	34.4	38.6	63.1	60.9	65.1	0.4	*	0.2	0.8
Completed secondary education	27.4	26.0	28.8	72.3	70.9	73.7	0.3	*	0.2	0.5
Tertiary education	21.6	20.5	22.7	78.1	77.0	79.1	0.3		0.2	0.5
All non-Aboriginal adults	27.3	26.5	28.2	72.3	71.5	73.1	0.3		0.3	0.5

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for all adults, by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 20: Proportion (%) of adults, by self-reported health status, highest level of educational attainment and Aboriginal status, Victoria, 2017

Aboriginal status	Self-reported health status											
	Excellent or very good			Good			Fair or poor			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Aboriginal												
Did not complete secondary education	29.1	19.6	40.8	36.4	26.0	48.2	34.5	24.3	46.3	0.0	.	.
Completed secondary education	29.3	18.1	43.7	36.5	25.8	48.7	34.2	24.0	46.2	0.0	.	.
Tertiary education	31.1 *	17.4	49.3	34.0	24.3	45.2	34.7	21.5	50.7	**		
All Aboriginal adults	30.0	22.2	39.1	35.3	27.6	43.7	34.7	26.6	43.8	**		
Non-Aboriginal												
Did not complete secondary education	32.6	30.6	34.6	39.3	37.2	41.4	27.3	25.5	29.3	0.8	0.5	1.4
Completed secondary education	42.7	41.2	44.3	37.6	36.0	39.1	19.4	18.1	20.7	0.4	0.2	0.7
Tertiary education	49.6	48.3	51.0	35.7	34.4	37.0	14.3	13.4	15.3	0.4	0.2	0.6
All non-Aboriginal adults	41.9	41.0	42.8	37.6	36.7	38.5	20.0	19.3	20.8	0.5	0.4	0.7

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for all adults, by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 21: Proportion (%) of adults who experienced food insecurity with hunger, by Aboriginal status, Victoria, 2017

Aboriginal status	In the last 12 months, were there any times that you ran out of food, and couldn't afford to buy more?								
	Yes			No			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal	14.4	10.0	20.2	85.2	79.3	89.6	**		
Non-Aboriginal	6.2	5.7	6.7	93.4	92.9	93.9	0.4	0.3	0.5
All Victorian adults	6.2	5.8	6.7	93.3	92.8	93.8	0.4	0.3	0.6

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 22: Proportion (%) of parents who experienced food insecurity without hunger, by Aboriginal status, Victoria, 2017

Aboriginal status	In the last 12 months did you have to rely on a restricted range of low-cost food for your children because you were running out of money to buy food?								
	Never, or not often			Sometimes or yes, definitely			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal	49.6	37.4	61.9	25.4 *	15.0	39.8	0.0	.	.
Non-Aboriginal	84.6	82.2	86.6	14.5	12.5	16.8	1.0 *	0.5	1.8
All Victorian adults	84.3	81.9	86.4	14.8	12.7	17.1	0.9 *	0.5	1.8

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution

Appendix 2 Table 23: Proportion (%) of adults, by food insecurity with hunger, psychological distress and Aboriginal status, Victoria, 2017

Ran out of food in last 12 months and could not afford to buy more?	Psychological distress											
	Mild (K10 <16)			Moderate (K10 16-21)			High or very high (K10 22+)			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Aboriginal												
Yes (food insecure)	16.3 *	6.9	33.8	25.3 *	14.6	40.3	52.1	36.8	67.1		**	
No	45.9	36.7	55.5	32.1	24.2	41.1	17.7	12.0	25.3	4.3 *	1.8	9.8
All Aboriginal adults	41.7	33.3	50.5	29.8	22.5	38.4	23.2	17.4	30.3	5.3 *	2.5	10.6
Non-Aboriginal												
Yes (food insecure)	21.1	17.8	24.7	25.7	21.1	30.9	47.3	43.0	51.8	5.9	4.3	8.1
No	56.3	55.3	57.2	24.8	24.0	25.6	13.2	12.5	13.9	5.8	5.3	6.3
All non-Aboriginal adults	54.1	53.2	55.1	24.6	23.8	25.4	15.4	14.7	16.1	5.9	5.4	6.4

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'all adults' by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

K10 = Kessler 10 Psychological Distress Scale.

Appendix 2 Table 24: Proportion (%) of adults, by food insecurity with hunger, doctor-diagnosed depression or anxiety, and Aboriginal status, Victoria, 2017

Ran out of food in last 12 months and could not afford to buy more?	Ever been diagnosed by a doctor with depression or anxiety?								
	Yes			No			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal									
Yes (food insecure)	64.0	46.2	78.6	36.0	21.4	53.8	0.0	.	.
No	33.7	25.9	42.6	65.7	56.8	73.6	**		
All Aboriginal adults	38.3	30.9	46.2	61.2	53.2	68.7	**		
Non-Aboriginal									
Yes (food insecure)	62.5	57.8	66.9	37.0	32.6	41.7	0.5	*	0.2 1.4
No	25.0	24.2	25.9	74.6	73.8	75.4	0.3		0.2 0.4
All non-Aboriginal adults	27.3	26.5	28.2	72.3	71.5	73.1	0.3		0.3 0.5

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'all adults' by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 25: Proportion (%) of adults, by food insecurity with hunger, self-reported health and Aboriginal status, Victoria, 2017

Ran out of food in last 12 months and could not afford to buy more?	Self-reported health status											
	Excellent or very good			Good			Fair or poor			Did not know or refused to say		
	95% CI			95% CI			95% CI			95% CI		
	%	LL	UL	%	LL	UL	%	LL	UL	%	LL	UL
Aboriginal												
Yes (food insecure)	**			29.5 *	17.0	46.1	66.8	50.6	79.9	0.0	.	.
No	34.0	25.1	44.2	36.3	27.8	45.8	29.6	21.2	39.7	**		
All Aboriginal adults	30.0	22.2	39.1	35.3	27.6	43.7	34.7	26.6	43.8	**		
Non-Aboriginal												
Yes (food insecure)	19.1	16.2	22.2	34.5	30.8	38.4	46.0	42.0	50.2	**		
No	43.5	42.5	44.4	37.5	36.6	38.5	18.5	17.8	19.3	0.5	0.4	0.7
All non-Aboriginal adults	41.9	41.0	42.8	37.6	36.7	38.5	20.0	19.3	20.8	0.5	0.4	0.7

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'all adults' by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 26: Proportion (%) of adults, by financial stress and Aboriginal status, Victoria, 2017

Aboriginal status	If you needed to, could you raise \$2,000 within 2 days in an emergency?								
	Yes			No (financial stress)			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal	68.9	60.4	76.3	28.3	21.2	36.7	2.8 *	1.1	6.6
Non-Aboriginal	83.5	82.7	84.3	13.5	12.8	14.2	3.0	2.6	3.3
All Victorian adults	83.4	82.6	84.1	13.6	13.0	14.4	3.0	2.6	3.4

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 27: Proportion (%) of adults, by financial stress, psychological distress and Aboriginal status, Victoria, 2017

Able to raise \$2,000 within 2 days in an emergency?	Psychological distress								
	Mild (K10 <16)			Moderate (K10 16-21)			High or very high (K10 22+)		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal									
Yes	51.2	41.3	61.0	27.9	20.2	37.1	17.1	11.2	25.2
No (financial stress)	18.7 *	9.9	32.3	34.9	22.4	49.8	37.1	24.6	51.6
All Aboriginal adults	41.7	33.3	50.5	29.8	22.5	38.4	23.2	17.4	30.3
Non-Aboriginal									
Yes	58.4	57.4	59.4	24.7	23.8	25.5	12.1	11.4	12.7
No (financial stress)	31.4	28.8	34.1	24.0	21.7	26.5	35.0	32.3	37.8
All non-Aboriginal adults	54.3	53.4	55.2	24.5	23.7	25.3	15.3	14.6	16.0

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'all adults' by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

K10 = Psychological Distress Scale.

Appendix 2 Table 28: Proportion (%) of adults, by financial stress, doctor-diagnosed depression or anxiety, and Aboriginal status, Victoria, 2017

Able to raise \$2,000 within 2 days in an emergency?	Ever been diagnosed by a doctor with depression or anxiety?								
	Yes			No			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Aboriginal									
Yes	34.8	26.1	44.6	64.4	54.5	73.2	**		
No (financial stress)	47.8	34.7	61.3	52.2	38.7	65.3	0.0	.	.
All Aboriginal adults	38.3	30.9	46.2	61.2	53.2	68.7	**		
Non-Aboriginal									
Yes	24.9	24.1	25.8	74.8	74.0	75.7	0.2	0.2	0.3
No (financial stress)	43.6	40.9	46.3	55.5	52.8	58.2	0.9	*	0.5 1.5
All non-Aboriginal adults	27.3	26.5	28.2	72.3	71.5	73.1	0.3	0.3	0.5

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'all adults' by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 29: Proportion (%) of adults, by financial stress, self-reported health and Aboriginal status, Victoria, 2017

Able to raise \$2,000 within 2 days in an emergency?	Self-reported health status											
	Excellent or very good			Good			Fair or poor			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Aboriginal												
Yes	32.6	23.5	43.2	40.6	31.2	50.8	26.8	18.7	36.8		**	
No (financial stress)	21.5 *	10.6	38.5	26.3	16.0	40.1	52.2	37.1	66.9	0.0		
All Aboriginal adults	30.0	22.2	39.1	35.3	27.6	43.7	34.7	26.6	43.8		**	
Non-Aboriginal												
Yes	45.2	44.2	46.2	37.2	36.2	38.1	17.3	16.6	18.0	0.3	0.2	0.5
No (financial stress)	22.7	20.6	25.0	39.1	36.4	41.9	37.0	34.4	39.6	1.2 *	0.7	2.0
All non-Aboriginal adults	41.9	41.0	42.8	37.6	36.7	38.5	20.0	19.3	20.8	0.5	0.4	0.7

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'all adults' by Aboriginal status, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 30: Proportion (%) of adults, by experiences of family violence in the 2 years preceding the survey, gender and Aboriginal status, Victoria, 2017

Aboriginal status	Yes, experienced family violence			No, did not experience family violence			Refused to answer questions on family violence			
	%	95% CI		%	95% CI		%	95% CI		
		LL	UL		LL	UL		LL	UL	
Men										
Aboriginal	9.3 *	4.3	18.7	82.9	72.4	89.9	7.7 *	3.5	16.1	
Non-Aboriginal	4.0	3.5	4.6	91.4	90.6	92.2	4.4	3.8	5.1	
Did not know or refused to say	14.1 *	5.6	31.3	65.1	48.5	78.7	20.8 *	10.6	36.9	
All Victorian men	4.1	3.6	4.7	91.2	90.3	92.0	4.6	4.0	5.3	
Women										
Aboriginal	17.2	10.8	26.3	73.1	61.5	82.2	9.7 *	4.4	20.2	
Non-Aboriginal	6.7	6.0	7.4	88.1	87.2	89.0	5.2	4.6	5.8	
Did not know or refused to say	10.1 *	4.2	22.3	63.3	49.5	75.2	26.5	16.4	40.0	
All Victorian women	6.8	6.1	7.5	87.9	87.0	88.7	5.3	4.7	6.0	
Adults										
Aboriginal	12.3	8.0	18.4	77.7	69.7	84.1	9.9 *	5.7	16.6	
Non-Aboriginal	5.4	4.9	5.8	89.7	89.1	90.3	4.8	4.4	5.3	
Did not know or refused to say	10.2 *	5.3	18.8	63.3	50.0	74.9	26.4	16.3	39.6	
All Victorian adults	5.5	5.0	5.9	89.5	88.9	90.1	5.0	4.5	5.4	

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95% confidence interval.

Estimates that are (statistically) significantly different from the total corresponding estimate for all Victorian adults, by gender, are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error ÷ point estimate × 100; interpretation below:

* Estimate has an RSE between 25 and 50% and should be interpreted with caution.

** Estimate has an RSE greater than 50% and is not reported as it is unreliable for general use.

Appendix 2 Table 31: Proportion (%) of adults, by level of bonding social capital and Aboriginal status, Victoria, 2017

Aboriginal status	Able to get help from family, friends and/or neighbours when needed								
	Yes (high bonding social capital)			No (low bonding social capital)			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL
Able to get help from family?									
Aboriginal	91.1	85.2	94.7	7.4 *	4.2	12.9	**		
Non-Aboriginal	92.7	92.2	93.2	7.0	6.5	7.5	0.3	0.2	0.4
Victorian adults	92.7	92.2	93.2	7.0	6.5	7.5	0.3	0.2	0.5
Able to get help from friends?									
Aboriginal	87.8	81.3	92.3	10.7	6.5	17.1	**		
Non-Aboriginal	89.1	88.6	89.7	10.6	10.0	11.1	0.3	0.2	0.4
Victorian adults	89.1	88.5	89.7	10.6	10.0	11.2	0.3	0.2	0.5
Able to get help from neighbours?									
Aboriginal	54.5	45.6	63.1	44.0	35.5	52.9	**		
Non-Aboriginal	55.3	54.4	56.2	44.4	43.5	45.3	0.3	0.2	0.4
Victorian adults	55.2	54.3	56.1	44.4	43.5	45.4	0.3	0.2	0.5

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** Estimate has an RSE greater than 50% and is not reported as it is unreliable for general use.

Appendix 2 Table 32: Proportion (%) of adults, by level of bridging social capital and Aboriginal status, Victoria, 2017

Aboriginal status	Do you agree most people can be trusted?											
	Never or not often			Sometimes			Yes, definitely			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Aboriginal	25.8	18.7	34.3	46.4	37.7	55.2	26.8	19.2	36.0	**		
Non-Aboriginal	17.4	16.6	18.1	50.3	49.4	51.3	30.9	30.1	31.7	1.4	1.2	1.7
Did not know or refused to say	24.3	16.0	35.2	44.2	33.1	55.8	23.3	14.6	35.0	8.2	*	4.5 14.8
Victorian adults	17.5	16.8	18.3	50.2	49.3	51.1	30.8	30.0	31.6	1.4	1.2	1.7

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 33: Proportion (%) of adults, by level of linking social capital and Aboriginal status, Victoria, 2017

Aboriginal status	Do you feel there are opportunities to have a real say on issues that are important to you?											
	Never or not often			Sometimes			Yes, definitely			Did not know or refused to say		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
		LL	UL		LL	UL		LL	UL		LL	UL
Aboriginal	43.7	35.1	52.7	35.4	28.0	43.4	19.7	14.1	26.9	**		
Non-Aboriginal	25.9	25.1	26.7	41.2	40.3	42.1	30.1	29.2	30.9	2.9	2.5	3.3
Did not know or refused to say	34.6	23.4	47.9	32.0	21.6	44.7	18.1	11.2	27.8	15.3	*	7.8 27.7
Victorian adults	26.1	25.3	26.9	41.1	40.2	42.0	29.9	29.1	30.7	2.9	2.6	3.3

Data were age-standardised to the 2011 Victorian population.

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Estimates that are significantly different (statistically) from the corresponding estimate for 'Victorian adults' are identified by colour as follows: **above** or **below**.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

Appendix 2 Table 34: Proportion (%) of Aboriginal adults, by whether they were asked by a healthcare provider if they were of Aboriginal or Torres Strait Islander origin and type of health service, Victoria, 2017

Asked whether patient identified as Aboriginal or Torres Strait Islander	Accessed the following healthcare services in the past 12 months		
	%	95% CI	
		LL	UL
Admitted to hospital			
Yes	65.2	49.7	78.0
No	31.7	19.2	47.6
Did not know or refused to say		**	
Went to an emergency department of a hospital			
Yes	59.5	44.5	72.9
No	34.7	21.7	50.4
Did not know or refused to say	5.8	*	2.3 13.6
Attended a doctor, GP or community health centre			
Yes	45.7	35.2	56.6
No	52.3	41.4	63.0
Did not know or refused to say	2.0	*	0.9 4.5

LL/UL 95% CI = lower/upper limit of 95 per cent confidence interval.

Relative standard error (RSE) = standard error / point estimate * 100; interpretation below:

* RSE between 25 and 50 per cent; point estimate (%) should be interpreted with caution.

** RSE greater than, or equal to, 50 per cent; point estimate (%) is unreliable, hence not reported.

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