

Mabel username id:

Please write id shown on letter
if different from id above

MABEL

Medicine in Australia: Balancing Employment and Life

2010

Doctor Enrolled in a Specialty Training Program (Specialist Registrar)

enquiries@mabel.org.au www.mabel.org.au Telephone: 03 8344 2600

MABEL has been endorsed by:

Royal Australian College of General Practitioners	Australian General Practice Training
Royal Australasian College of Physicians	Australian General Practice Network
Royal Australasian College of Surgeons	General Practice Registrars Australia
Royal College of Pathologists of Australasia	Australian Society of Anaesthetists
Royal Australian and New Zealand College of Ophthalmologists	Australia and New Zealand Society of Palliative Medicine Inc
Royal Australian and New Zealand College of Radiologists	Australian and New Zealand Society for Geriatric Medicine
Australian and New Zealand College of Anaesthetists	Australian Society of Plastic Surgeons
Australasian College for Emergency Medicine	Australian and New Zealand Intensive Care Society
Australasian College of Sports Physicians	Australian and New Zealand Society of Nephrology
Australian College of Rural and Remote Medicine	Internal Medicine Society of Australia and New Zealand
Joint Faculty of Intensive Care Medicine	Australasian Society of Career Medical Officers
Australian Medical Council	Australian Healthcare and Hospitals Association
Confederation of Postgraduate Medical Education Councils	Australian Private Hospitals Association
Postgraduate Medical Council of Victoria	Medical Oncology Group of Australia Incorporated
Postgraduate Medical Council of South Australia	Australian Orthopaedic Association
Postgraduate Medical Education Council of Queensland	Australian Rheumatology Association
Postgraduate Medical Institute of Tasmania	Rural Doctors Association of Australia
NSW Institute of Medical Education and Training	Rural Health Workforce Australia



THE UNIVERSITY OF
MELBOURNE



MELBOURNE INSTITUTE®
of Applied Economic and Social Research



MONASH University
Medicine, Nursing and Health Sciences

Space is provided at the end of this survey to make additional written comments.
 Please write responses in boxes provided using a dark pen. Check boxes can be ticked or crossed.

A About your current situation

- Are you currently doing any clinical medical in Australia?
 - Yes – *If yes, please go to Section B below and complete the main survey*
 - No – *Continue*
- Are you permanently retired from all types of paid work?
 - Yes – *As you are permanently retired from all types of paid work you do not need to complete the rest of the survey. Please return this survey in the reply-paid envelope provided. Thank you for your participation.*
 - No – *Continue*
- Which of the following statements describe your current situation? (Tick all that apply)
 - Doing medical work in Australia that is non-clinical (e.g. medico-legal, teaching, research, committee work)
 - Maternity leave
 - Home duties/childcare
 - Enrolled as a student
 - Extended leave (e.g. sick leave, long service leave)
 - Working outside Australia in a clinical role
 - Working outside Australia in a non-clinical, but medical role
 - Working outside Australia in a non-medical role
 - Doing non-medical work in Australia. Please state job title:
- Do you intend to return to clinical medical work in Australia?
 - Yes – *Please go to Section G and complete the final two sections of the survey*
 - Unsure – *Please go to Section G and complete the final two sections of the survey*
 - No – *As you do not intend returning to clinical work in Australia you do not need to complete the rest of the survey. Please return this survey in the reply-paid envelope provided. Thank you for your participation.*

B About your job satisfaction

- Please indicate how satisfied or dissatisfied you are in the various aspects of your work as a doctor.

	Very Dissatisfied	Moderately Dissatisfied	Not Sure	Moderately Satisfied	Very Satisfied	N/A
Freedom to choose your own method of working	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Amount of variety in your work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Physical working conditions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Opportunities to use your abilities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your colleagues and fellow workers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Recognition you get for good work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your hours of work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your remuneration	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Amount of responsibility you are given	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Taking everything into consideration, how do you feel about your job?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

6. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
The balance between my personal and professional commitments is about right	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I have a poor support network of other doctors like me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The IT systems I use are very helpful in day-to-day practice	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
It is difficult to take time off when I want to	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My patients have unrealistic expectations about how I can help them	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The majority of my patients have complex health and social problems	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I have good support and supervision from qualified specialists	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
There is enough time for me to do personal study	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Research publications are important to progress my training	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The hours I work are unpredictable	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

7. Would you like to change your hours of work?

- 1 No
- 2 Yes, I'd like to increase my hours
- 3 Yes, I'd like to decrease my hours

8. What is the likelihood that you will:

	Very Unlikely	Unlikely	Neutral	Likely	Very Likely
Leave direct patient care (primary or hospital) within FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Leave medical work entirely within FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Reduce your clinical workload in the next FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

9. This and the following question ask about any workplace aggression directed toward you in the last 12 months whilst you were working in medicine (i.e. any circumstance or location in which you performed your role as a medical practitioner), including:

- *Verbal or written abuse, threats, intimidation or harassment* – such as ridicule, abusive email, racism, bullying, contemptuous treatment and non-physical threats or intimidation;
- *Physical threats, intimidation, harassment or violence* – such as a raised hand or object, unwanted touching, damage to property and sexual or other physical assault.

For each potential source of aggression, please tick the box that most closely matches how often you experienced each type of aggression in the past 12 months.

	Frequently (once or more each week)	Often (a few times each month)	Occasionally (a few times each 6 months)	Infrequently (a few times in 12 months)	Not at all
A. Aggression from patients					
<i>Verbal or written</i> abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical</i> threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
B. Aggression from relatives or carers of patients					
<i>Verbal or written</i> abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical</i> threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C. Aggression from any workplace co-worker					
<i>Verbal or written</i> abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical</i> threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
D. Aggression from any other person external to the workplace					
<i>Verbal or written</i> abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical</i> threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

10. Please indicate whether or not the following actions to prevent or minimise aggression have been implemented in your main workplace.

	Yes	No	Unsure	
Policies, protocols and/or procedures for aggression prevention and management	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Warning signs in reception and patient / public waiting areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Alerts to high risk of aggression (e.g. on patient record)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Restricting or withdrawing access to services for aggressive persons	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Incident reporting and follow-up	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Education and training (for self and other staff)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Duress alarms in consultation and treatment areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Clinician escape optimised in consultation / treatment rooms (e.g. seated closer to door than patient, two exits in rooms)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Optimised lighting, noise levels, comfort and waiting times in patient / public waiting areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Patient / public access restrictions (e.g. advisory signs, locked doors to treatment and storage areas)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Building security systems (e.g. burglar alarms, deadlocks, window bars, surveillance cameras, security personnel)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Safety and security measures for after hours or on-call work, or home visits (e.g. security escort to external areas at night, movement register, working in pairs, satellite phones)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/> Not applicable
Other (please specify)	<input type="text"/>			

C About the places where you work

11. Excluding on-call, for how many HOURS in your MOST RECENT USUAL WEEK at work did you undertake work in each of the following settings? (Include ALL of the work you do as a doctor) (If none, write 0)

	Actual hours per week	hrs/wk
Public hospital (including psychiatric hospital)	<input type="text"/>	hrs/wk
Private hospital	<input type="text"/>	hrs/wk
Private medical practitioner's rooms or surgery	<input type="text"/>	hrs/wk
Residential/aged care health facility (nursing/residential home, hospice etc.)	<input type="text"/>	hrs/wk
Tertiary education institution	<input type="text"/>	hrs/wk
Other	<input type="text"/>	hrs/wk
TOTAL HOURS WORKED	<input type="text"/>	hrs/wk

12. Approximately how many hours per week do you work as a hospital locum? (If zero, write 0)

13. What is the main hospital in which you work (i.e. spend most time)?

Hospital name

Postcode

14. How long have you worked at this hospital?

No. of months

No. of years

D About your workload

15. Excluding on-call, how many HOURS in your MOST RECENT USUAL WEEK at work did you spend on the following activities? (Include ALL of the work you do as a doctor in ALL jobs/workplaces) (If none, write 0)

TOTAL HOURS WORKED PER WEEK (Should equal the TOTAL in question 11) hrs/wk
 Direct patient care (face-to-face, phone consultations, home visits) hrs/wk
 Indirect patient care (medical notes, reports, phone calls, meeting patients' families) hrs/wk
 Education activities (academic research, continuing medical education) hrs/wk
 Management and administration hrs/wk
 Other hrs/wk

16. In your most recent USUAL week at work, for around HOW MANY patients did you provide care? (Include face-to-face, out-of-hours and telephone consultations in ALL SETTINGS)

17. Do you do any on-call yourself? (Including public holidays, weekends and weekdays outside of 8am to 6pm)

- ¹ Yes
² No—Go to question 20

18. In your last usual week at work: (If none, write 0)

How many HOURS were you rostered or listed for on-call? hrs/wk
 How many HOURS were actually spent in direct patient care? hrs/wk
 How many TIMES were you actually called out? times/wk

19. In your most recent usual month, what was your on-call ratio? (For example, if it is 1 in 8, write 8 in the box provided.)

1 in
 Not Applicable (Tick one box)

20. Turning to time spent away from work: (If none, write 0)

How many WEEKS holiday did you take in the past year? weeks
 How many WEEKS of parental or maternity leave did you take in the past year? weeks
 Approximately how many DAYS off work due to illness did you have in the past year? days
 Approximately how many DAYS off work did you have for other reasons in the past year? days

E About your finances

The following information will be used to examine the effect of financial issues on your work–life balance and will remain strictly confidential.

21. What are your (approximate) **TOTAL** personal earnings from **ALL** of the work you do as a doctor? (If possible, base this on your last personal income tax return or payslip) Please write in **ONE COLUMN** where you have the most accurate information and can best remember.

	Annual	OR	Fortnightly
Before tax (gross earnings) \$			
After tax (net earnings) \$			

22. In addition to this, did you receive any ongoing 'in kind' benefits or subsidies as part of your current job/s (e.g. car, house, school fees, salary packaging)?

¹ Yes
² No

23. What is the approximate annual total value in dollars of these benefits?

(If zero, write 0)

24. What is the total level of financial debt that you currently have as a result of your medical education and training? (Give dollar amount; include HECS debt, other debt associated with training and living expenses) (If zero, write 0)

\$
 Don't Know (Tick box)

25. Do you (or your employer) regularly contribute to a superannuation scheme?

¹ Yes
² No

26. Please indicate the degree to which you agree with the following statement: "Given my current financial situation and prospects, I believe I will have enough to live on when I retire". (Tick one box)

¹ Strongly Disagree
² Disagree
³ Neutral
⁴ Agree
⁵ Strongly Agree

27. How much (in dollars) did you pay for professional medical liability, or malpractice, insurance premiums in the last year?

(If this was provided by someone else on your behalf, write 0)

28. Do you have other sources of personal income apart from your medical work? (Profit from other business interests, dividend income, bank interest, rental income etc.)

¹ Yes
² No

29. What is your total gross and net **HOUSEHOLD** income? (Include your and your partner's earnings, income from other business interests, dividends, interest etc.) The figures below should be equal to or greater than your personal earnings provided in question 21. Please write in **ONE COLUMN ONLY**, where you have the most accurate information or can best remember.

	Annual	OR	Fortnightly
Before tax (gross household income) \$			
After tax (net household income) \$			

F About your geographic location

30. Where is your main place of work?

Town/Suburb

Postcode

31. How long have you been working in or close to this geographic location?

No. of months

No. of years

32. Where do you live?

Town/Suburb

Postcode

33. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I don't have many friends or family members in my current work location	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
It is easy to pursue my hobbies and leisure interests in my current work location	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
My partner does not have many friends or family members in this work location	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
There are good employment opportunities for my partner in this work location	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
The choice of schools for our children is adequate in this work location	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>

34. Are you subject to restrictions on where you practise?

- 1 Yes—I am required to work in an Area of Need
- 2 Yes—I am required to work in a District of Workforce Shortage
- 3 No—Go to question 36

35. Please indicate the reason/s for these restrictions.

- I hold a Permanent Resident Visa
- I hold a Temporary Resident Visa
- I am undertaking a return of service period for a Medical Rural Bonded Scholarship or Bonded Medical Place
- I am undertaking a compulsory rural placement as part of my training
- Other

G About your family circumstances

36. Are you currently living with a partner or spouse?

- ¹ Yes ² No

37. What is the employment status of your partner/spouse?

- ¹ Not in the labour force (e.g. caring for dependents, studying)
² Currently seeking work
³ Full-time employment
⁴ Part-time employment
⁵ Not Applicable

38. Is your partner/spouse also a medical doctor?

- ¹ Yes
² No
³ Not Applicable

39. For how many years did your partner/spouse live in a rural area up until the age he/she left secondary school? (If none, write 0)

Don't know (Tick box)

Not Applicable (Tick box)

40. Please indicate the main rural area where your partner/spouse lived up until school leaving age.

Town

State

Don't know (Tick box)

Not Applicable (Tick box)

41. How many dependent children do you have? (If none, write 0)

42. What is the age in years of each dependent child?

Not Applicable (Tick box)

Child 1

Child 2

Child 3

Child 4

Child 5

Child 6

43. Which of the following forms of childcare are you using for your children of pre-school age? (Please tick all that apply)

- Relatives or friends
 Nannies
 Childcare at work (i.e. provided by an employer)
 Other day care (childcare centre, family day care, kindergarten etc.)
 Not Applicable

44. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I am restricted in my employment and/or the time and hours I work due to a lack of available childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My partner is restricted in his/her employment and/or the time and hours worked due to a lack of available childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My partner is overqualified for his/her current job due to the limited availability of suitable jobs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

H About you

45. Have you completed the AMC Certificate examination since the last time you did the MABEL survey?

- 1 Yes
 2 No
 3 Not Applicable

46. Do you have medical qualifications from overseas which are NOT recognised in Australia?

- 1 Yes
 2 No
 3 Unsure

47. Which specialty training program are you enrolled in?

- 1 Paediatrics and Child Health
 2 Palliative Medicine
 3 Rehabilitation Medicine
 4 Dermatology
 5 Medical Administration
 6 Ophthalmology
 7 Psychiatry
 8 Surgery
 9 Internal medicine (adult medicine)
 10 Occupational Medicine
 11 Public Health Medicine
 12 Anaesthesia
 13 Emergency Medicine
 14 Intensive Care Medicine
 15 Obstetrics and Gynaecology
 16 Pathology
 17 Radiology

48. In what year do you expect to complete the program and become a qualified specialist?

49. What is your residency status? (Tick one box)

- 1 Unchanged since I last completed the MABEL survey
 2 Australian citizen
 3 Permanent resident
 4 Temporary resident

50. What type of medical registration do you have?

- 1 Unchanged since I last completed the MABEL survey
 2 Full (unconditional) medical registration
 3 Conditional medical registration
 4 Other (please specify)

51. In general, would you say your health is: (Tick one box)

- 1 Excellent
 2 Very good
 3 Good
 4 Fair
 5 Poor

52. All things considered, how satisfied are you with your life in general? (Tick one box)

Completely Dissatisfied											Completely Satisfied
1	2	3	4	5	6	7	8	9	10		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

53. Please answer each of the following questions using a 1 to 7 point scale, where 1 means 'Strongly disagree' and 7 means 'Strongly agree'.

	Strongly disagree 1	2	3	4	5	6	Strongly agree 7
I have little control over the things that happen to me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
There is really no way I can solve some of the problems I have	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>	11 <input type="checkbox"/>	12 <input type="checkbox"/>	13 <input type="checkbox"/>	14 <input type="checkbox"/>
There is little I can do to change many of the important things in my life	15 <input type="checkbox"/>	16 <input type="checkbox"/>	17 <input type="checkbox"/>	18 <input type="checkbox"/>	19 <input type="checkbox"/>	20 <input type="checkbox"/>	21 <input type="checkbox"/>
I often feel helpless in dealing with the problems of life	22 <input type="checkbox"/>	23 <input type="checkbox"/>	24 <input type="checkbox"/>	25 <input type="checkbox"/>	26 <input type="checkbox"/>	27 <input type="checkbox"/>	28 <input type="checkbox"/>
Sometimes I feel that I'm being pushed around in life	29 <input type="checkbox"/>	30 <input type="checkbox"/>	31 <input type="checkbox"/>	32 <input type="checkbox"/>	33 <input type="checkbox"/>	34 <input type="checkbox"/>	35 <input type="checkbox"/>
What happens to me in the future mostly depends on me	36 <input type="checkbox"/>	37 <input type="checkbox"/>	38 <input type="checkbox"/>	39 <input type="checkbox"/>	40 <input type="checkbox"/>	41 <input type="checkbox"/>	42 <input type="checkbox"/>
I can do just about anything I really set my mind on doing	43 <input type="checkbox"/>	44 <input type="checkbox"/>	45 <input type="checkbox"/>	46 <input type="checkbox"/>	47 <input type="checkbox"/>	48 <input type="checkbox"/>	49 <input type="checkbox"/>

54. Thank you for completing the survey. Please provide any further comments below.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

In case of loss of included reply-paid envelope, please forward survey to:
 Melbourne Institute of Applied Economic and Social Research – MABEL Survey
 Reply Paid 84574
 UNIVERSITY OF MELBOURNE VIC 3010