“And they’re OFF”
Industry Health Promotion Investigation in Victorian Thoroughbred Participants

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EXECUTIVE SUMMARY

The Swinburne Centre for Social Impact partnered with Racing Victoria to collect health, psychological health and well-being data, using an online, anonymous survey method. We recruited members of the horse racing industry visiting a “Well-being Lounge” during the annual yearling sales at Oakland Junction, Victoria, early 2017; and by targeted email in mid-2017. The aim of this research was to gain evidence about the mental health and well-being of personnel working in the Victorian horse racing industry. These include occupational groups of horse trainers, jockeys, horse owners, stable supervisors, stable hands and others.

The survey used standardised questionnaires to obtain data on demographic details, sleep habits, mental health and well-being. While the survey identified well-being issues amongst this general community, this data cannot be traced back to individual people and is only used in aggregate form. The project relied upon people agreeing to participate, it did not pre-identify people with health or well-being issues. Trained psychologists were on hand at the Yearling sales, and support information available, in case the survey triggered any concerns for participants. We used the K10 (a measure of psychological distress) and PSQI (sleep behaviour) standardised surveys, which were self-administered by participants via iPads or paper at the yearling sales. A second round of recruitment was made from Racing Victoria horse trainer email lists in mid-2017. The results of the research provide evidence of the mental health status and well-being of people in the horse racing community, and of Victorian horse racing trainers specifically.

We suggest a further round of qualitative interviews to explore reasons for identified mental health scores of racing trainers; evidence which could be used to inform strategies for mental ill-health prevention and support for those with well-being issues. This would assist Racing Victoria in its goals to optimize well-being of those in the racing industry.
1. INTRODUCTION

The Swinburne Centre for Social Impact partnered with Racing Victoria to collect health, psychological health and well-being data, using an online, anonymous survey method.

The aim of this research was to gain evidence about the mental health and well-being of people working in the horse racing industry. These include occupational groups such as horse trainers, jockeys, horse owners, stable supervisors, and stable hands with racehorse trainers being our primary focus.

We recruited members of the horse racing industry visiting a “Well-being Lounge” at the annual yearling sales in early 2017. Participants were recruited over four days using a combination of paper-based and iPad-based surveys. Data collected included demographic and well-being information, including responses to the Kessler Psychological Distress Scale (K10) - a measure of psychological distress (K10; Kessler et al., 2002) and Pittsburgh Sleep Quality Index (PSQI) - a measure of sleep behaviour (PSQI; Buysse et al., 1988). K10 and PSQI are established, widely used, standardised surveys. After analysis of resulting data, a further round of surveys was emailed out by Racing Victoria, to Victorian race horse trainers using Racing Victoria’s existing email list. This was to increase the number of respondents and thus ensure survey findings were as reliable as possible.

2. BACKGROUND

In Victoria, there are around 937 (2016-17 season) thoroughbred horse trainers (including restricted and pre-trainers). Of these, 235 are female trainers (25%) and 701 are male trainers (75%). The total number of participants in the racing industry in Victoria is estimated at around 3,000 including a range of stable-based employees (e.g. assistant trainers, stable supervisors, stable hands and track riders).

Little is known about the occupational health of these employees. A Racing Victoria survey of nearly 10 years ago found that of 303 horse trainers surveyed, 72% were male, with an average age of 50 years, and worked an average of 46 hours per week (with a range of 4-110 hours) (Speed et al., 2008). All horse trainers worked at least six days per week and 98% worked seven days per week. The horse trainers reported that they rarely took annual leave due to a concern about a lack of trustworthy replacement staff. Other common problems reported were issues with developing social networks outside the industry, physical health issues (due to ongoing fatigue, lack of respite, labour intensive work), mental health issues caused by constant high mental pressure, and feeling unrecognised in their work, unless their horses win (Speed 2008:24-26).
The 2008 study indicated that, while the majority of trainers felt happy and satisfied with their work (70-75%), a significant number felt anxious (31%) or depressed (22%), and 9% felt unable to cope. A small number reported panic attacks (5%) and thoughts of self-harm or suicide (4%). Survey authors concluded that:

“...in terms of the actual numbers of people who experience these feelings, or of the consequences of experiencing these feelings, the implications of these statistics are substantial. For example, 25 trainers often, very often or always feel unable to cope, and 10 trainers often, very often or always experience thoughts of suicide or self-harm, that are in some way related to their work or businesses as horse trainers. Remember, only 24% of trainers responded to the survey. When we project these numbers to the (trainer) population at large (multiply these numbers by 4.0), then the significance of these findings becomes alarming”.

Similar rates of mental health were reported for stable employees, both male and female (ibid: 138).

Compared with the general population, it is possible that participants in the horse racing industry may experience particular stresses due to long and unsociable working hours, pressures to succeed in a competitive industry, and financial pressures. There may also be environment-related stresses (such as flood, fire, effects of climate change) that could impact mental health, as has been reported for farmers in other parts of Australia (Hart et al, 2011). Some issues could be associated with the male-dominated nature of the racing industry. Men are typically very low users of preventative health services in Australia. They have poorer health outcomes than women, and men in regional and rural communities are more likely to be smokers, drink alcohol in large quantities, and be overweight or obese, and less physically active than their metropolitan counterparts. In response, in 2013 the Australian government launched a national male health policy identifying priorities for the improvement of all aspects of male health (Lynch, W, 2013).

One of the tactics used by Racing Victoria to address health issues, is to deploy “Health PitStops” at key events (in our research this was a “Well-being Lounge” at the annual yearling sales. Originally, the concept of a PitStop was intended to appeal to men - drawing analogies between car parts and men’s health concerns, encouraging men to check their engines e.g., oil pressure (blood pressure), chassis (hip to waist ratio), fuel additive (alcohol consumption), exhaust (smoking) and shock absorbers (coping skills), amongst others. (Chambers, D, 2006).

Health PitStops have been deployed throughout Australia and overseas, including to target rural and remote workers such as farmers (Kuhns, S 2009.). They have been used by Royal Flying Doctor Service (Harvey et al, 2006) and others (Russell, et al 2006). In this research, we collected some survey data at a Health PitStop (Well-being Lounge) run by Racing Victoria.
Due to a general gap in research about racing industry staff health, trainer health in particular, reasons underpinning anecdotal reports of relatively poor mental health and well-being and a lack of strategies to improve health, this study was commissioned by Racing Victoria. A contemporary, focused and intensive dataset on the mental health and well-being of people living and working in the rural horse racing community in Victoria, was sought. Findings could be compared with other industries and with racing industry personnel of other geographical locations. Findings might inform future study and pilot work around health and health improvement strategies.

3. AIMS

The aims of this research were to:

• Obtain health and well-being data about those working in the Victorian horse racing sector, particularly trainers, using an online, anonymous survey method.
• Compare data found with those for the general Australian population.
• Raise awareness of the pressures, stress, and mental health issues associated with the horse racing community through the dissemination of aggregate results and findings.
• Use data to consider how best to support people associated with the horse racing community.

4. METHODOLOGY

Racing Victoria commissioned this research. The research is concerned with investigating the mental health and well-being of people working with and training thoroughbred racehorses in Victoria. Permissions to undertake the research were sought from, and granted by, Swinburne University of Technology Ethics Committee (2016/320).

4.1 Data collection phase 1 – iPad and paper-based survey

A survey form was produced that incorporated an introduction, demographic and brief standardised survey forms, the K10 and PSQI (see later sections and appendix for further information). The survey was uploaded and tested on iPads. The survey was found to be straightforward, easy to use, and could be completed in around ten minutes. The survey was designed to collect data about the mental health and well-being of people attending the Inglis Melbourne Premier Yearling Sale (Oakland Junction), potentially across six consecutive days in February 2017.

Racing Victoria hosted researchers and participants at a dedicated marquee central to the sales. The marquee served as a health ‘Well-being Lounge’ for people attending the yearling sales to have basic health checks (e.g. skin checks, weight and diabetes risk checks etc.) completed for them, as well as an opportunity to rest and collect Racing Victoria memorabilia. Racing Victoria
supported recruitment to the survey in ways including providing incentives (e.g. water, rest, and free merchandise), advertising the event on social media and on the Racing Victoria website.

4.2 The procedure

Researchers verbally introduced themselves to people visiting the marquee, and in quiet times opportunistically approached people in other spaces around the yearling sales (e.g. at café, on grass areas) asking them if they would take part. Participants self-completed the anonymous online survey on iPads. The survey was delivered through Qualtrics software (see- https://www.qualtrics.com/au/) and securely automatically uploaded to the Swinburne University server. Many surveys were completed by hand on paper after the first day. This was due to respondent preference, extreme heat at the event that caused iPads to overheat (temperatures reached above 34 degrees Celsius), and internet connectivity issues. Paper copies were placed in a sealed box, stored securely, and entered into the server manually by researchers. The survey was anonymous - although researchers met respondents face to face, they were unknown to them, and no names or identifying data were recorded.

4.3 Psychological support

Two qualified psychologists were available in case respondents expressed mental health concerns. While some people chose to talk about personal matters with the researchers, none actively sought professional counselling. Several respondents reported that they were pleased that Racing Victoria had commissioned the research which was viewed as being ‘much needed’ and timely.

4.4 Data collection phase 2 – targeted email

The yearling sales yielded 267 fully-completed survey responses (plus 11 that were excluded from analysis due to incomplete data). Twenty of the respondents at the yearling sales identified as trainers. Many people present at the yearling sales were engaged in activities (e.g. eating, caring for horses, watching sales, and bidding) and could not be disturbed to ask them to participate in the survey. Data collection at the yearling sales was labour-intensive requiring three researchers to attend during five days. Therefore, in consultation with Racing Victoria, we sought a further method for additional participant recruitment, to gain a larger pool of respondents.

The second phase involved approach via a targeted email sent by Racing Victoria to the Racing Victoria list of horse trainers. An extension to ethical permission was sought from Swinburne University Ethics Committee and granted for this second phase in late April 2017.

A covering letter and standalone email were generated and distributed by Racing Victoria using pre-existing lists of Victorian horse trainers. Respondents were requested not to complete the
survey if they had already done so at the yearling sales. Survey responses were completed via an embedded link in the email sent. Data were securely captured via Qualtrics, and held on university servers, thus preserving anonymity and a separation between Racing Victoria and survey respondents. A reminder was sent at two weeks after the original email.

One hundred and two (102) surveys were returned at Round 2; of these, 91 were fully completed (62 in response to the original email to trainers (plus eight not complete) and 29 in response to the reminder email (plus three not complete). Of those who completed the Round 2 survey, 71 out of 91 (78%) identified as trainers.

The overall response – following yearling sales data collection and the email phase - was 358 respondents after deduction of incomplete surveys, and those that had not ticked the ‘consent’ box. Overall, 91 fully completed responses were from trainers. It is estimated that this final sample represents 9.7% of all registered trainers in Victoria, as recorded on Racing Victoria email lists.

5. MEASURES

The data are presented in aggregate form, presenting a group case study of people working in the racing community in Victoria, Australia. The primary group of interest are the horse trainers, but other groups working in this industry are also considered. The data are analysed in terms of the primary demographic categories e.g. gender, age bands, occupational groups, household income (for comparison of socio-economic groups) and urban/rural location, as identified by postcode. Aggregate data are compared with Australian published norms for the instruments used; and average Australian data reported by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.

**Psychological distress** was measured using the Kessler Psychological Distress Scale 10-item checklist (K10; Kessler et al., 2002). The K10 is a widely used community screening measure of anxiety and depression. It is a self-report questionnaire that yields a global measure of distress based on questions about symptoms of anxiety and depression experienced in the most recent 4-week period. Subscales of anxiety and depression can be calculated as well as an overall distress score. The K10 cannot be used as an indicator of anxiety and depressive disorder diagnoses, and as such, there are no designated cut-off scores. In Australia, scores above 22 (out of 30) are considered ‘high to very high’ levels of psychological distress (Australian Bureau of Statistics, 2012).

**Sleep quality** was measured using the Pittsburgh Sleep Quality Index (PSQI; Buysse et al., 1988). The PSQI is a widely-used 9-item questionnaire that measures various aspects of sleep over the previous month, including duration, time to fall asleep (latency), level of sleep disturbance, level of daytime dysfunction due to sleepiness, sleep efficiency, sleep quality, and use of medications to aid sleep. A total scale score can be calculated from these aspects of sleep with higher scores
indicating worse sleep. An empirically derived cut-off score of > 5 distinguishes poor sleepers from good sleepers and indicates that a subject reports severe difficulties in at least two areas, or moderate difficulties in more than three areas. Good sleepers will typically score below 3 and people with diagnosable insomnia will typically score higher than 11.

6. SAMPLE

A total sample of 358 people completed the survey, with 91 (25.4%) identifying themselves as horse trainers. Sixty-four percent of the trainers were men, slightly below the industry numbers provided by Racing Victoria (75%). The average age of the trainers in the sample was 51 years, which is again consistent with industry statistics that show the average age of all Victorian horse trainers is 55 years. In comparison to others (“non-trainers”) in the sample, horse trainers were significantly older ($M = 51$ years, $SD = 13$ years vs. $M = 46$ years, $SD = 15$ years), $p < .05$. The proportion of men in the trainer sample (63.7%) was greater than the proportion of men in the non-trainer sample (53.6%), however this difference was not statistically significant ($p = .11$).
7. RESULTS

Participants in the survey were asked “Given your current needs and financial responsibilities, would you say that you and your family are: Prosperous, Very Comfortable, Reasonably Comfortable, Just Getting Along, Poor, Very Poor” in order to assess financial well-being.¹ As shown in Figure 1, a significantly lower percentage of trainers rated themselves as at least “Reasonably comfortable” and above compared to non-trainers (48% vs. 76%, respectively).

![Figure 1. Proportion of trainers and non-trainers selecting each category of financial well-being](image)

The regional distribution of trainers and non-trainers was assessed using the Accessibility/Remoteness Index of Australia and is calculated using participants’ self-reported postcode.² A higher percentage of trainers (57.8%) than non-trainers (30.2%) live in Inner Regional areas (see Figure 2).

¹ Categories of financial prosperity were based on those used in the Government-run HILDA (Household, Income and Labour Dynamics in Australia) Survey.

² By way of example, Geelong is considered a Major City, Colac is considered Inner Regional, and Horsham is considered Outer Regional.
7.1 Psychological Distress

Figure 3 shows that trainers reported significantly higher psychological distress scores on the K10 compared to non-trainers ($p < .001$). The pattern of differences was the same for both men and women. Women reported slightly higher psychological distress than men, but the differences were not statistically significant.
Applying the categories recommended by the Australian Bureau of Statistics, we can see in Figure 4 that there is a significantly higher percentage of trainers than non-trainers in all categories of distress except Low distress. There were no statistically significant differences between trainers in the sample and population percentages. It is worth noting that population scores displayed in Figure 4 were based on data derived from the Swinburne Well-being Monitor (2014), N = 900. Population scores on the K10 from the Swinburne Well-being Monitor are known to be higher than previous population surveys that have used the K10. For example, in the National Health Survey 2014-15 run by the Australian Bureau of Statistics, the percentage of the adult population experiencing Low distress was 68%, a percentage more closely aligned to what is shown in Figure 4 for the non-trainer sample, and much higher than the 40% found in the Swinburne Well-being Monitor sample. The reasons for these higher scores in the latter sample are currently under investigation, but for current purposes it is suggested that differences in levels of psychological distress between the trainers and the population may be more pronounced than what is shown in Figure 4.
Figure 4. Comparison between trainers and non-trainers on K10 categories

Total K10 scores can also be broken down into subscales of anxiety (6 items) and depression (4 items). Figure 5 shows that trainers reported significantly higher levels of anxiety (p < .01) and depression (p < .001) than non-trainers. It is worth noting that higher anxiety scores than depression scores are due to the fact that more K10 items contribute to the anxiety subscale score (6) than the depression subscale score (4). The highest possible score for the anxiety subscale is 30, whereas the highest possible score for the depression subscale is 20. The higher scores for anxiety do not therefore mean that it is more of a problem in this sample than depression, they contribute equally to overall psychological distress.
Figure 5. Comparison between trainers and non-trainers on total K10 anxiety and depression subscale scores

7.2 Sleep quality

Figure 6 shows a statistically significant difference in PSQI total score between trainers and non-trainers ($p < .01$) and between trainers and population ($p < .01$).\(^3\) A cut-off score of $> 5$ distinguishes poor sleepers from good sleepers. Almost two-thirds of trainers (62.64%) scored above this cut-off compared to 45.15% of non-trainers.

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\(^3\) Population score for comparison based on Magee, Caputi, Iverson, and Huang (2008), $N = 364$, Australian sample, age range 18-59 years
Investigating scores on the subscales of the PSQI reveals the main reasons for worse scores among trainers, with a statistically significant difference between trainers and non-trainers on sleep duration and daytime dysfunction, both $p < .01$ (see Figure 7). Worse sleep duration is perhaps not surprising in this sample given the normal working hours of horse trainers. The higher level of daytime dysfunction reported by trainers compared to non-trainers is more concerning. Scores for the daytime dysfunction subscale are calculated on the basis of responses to two items in the PSQI that refer to a) “having trouble staying awake while driving, eating meals, or engaging in social activity” and b) “having problems keeping up enough enthusiasm to get things done”. Trainers are reporting difficulties in these two areas.

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4 Recall that higher scores on the PSQI scale and subscales indicate worse sleep
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Figure 7. Comparison between trainers and non-trainers on PSQI subscales

8. HIGHER DEPRESSION AND ANXIETY AMONGST TRAINERS

The direct arrows (called direct effects) between trainers and the two sleep behaviour variables in Figure 8 suggest that trainers tend to experience significantly more sleep disturbance and daytime sleep dysfunction than all others in the sample. They are also more likely to directly report higher depression. On average, sleep disturbance is .32 of a point higher and daytime sleep dysfunction is .55 of a point higher amongst trainers. Since these direct effect results are taking into account the gender, socioeconomic status and age of trainers we can be confident that these differences in sleep behaviours and depression are due to being a trainer rather than their demographic characteristics. In other words trainers have poorer sleep behaviours and increased depression regardless of their gender, socioeconomic status or age. The results also show that regardless of whether one is a trainer or not, those from lower socioeconomic backgrounds and younger people also experience significantly more daytime sleep dysfunction (but not sleep disturbance). Interestingly, once all other background variables are taken into consideration, there were no differences in sleep behaviours, depression or anxiety across gender.

While the direct effects between sleep disturbance and depression and anxiety were not significant, they were for daytime dysfunction. This suggests that it is increased daytime
dysfunction rather than sleep amount, that lead to increased depression and anxiety. The model also tests for the indirect effects of being a trainer on depression and anxiety through sleep behaviours. Both effects via daytime dysfunction were significant (at p<.05) implying that trainers have increased depression and anxiety because they also tend to experience greater daytime dysfunction due to their sleep. Because sleep disturbance did not significantly predict depression and anxiety, we can conclude that trainers are not at risk for increased depression and anxiety because of their greater tendency to have more disturbed sleep. It is therefore more about how their sleep distubs their day to day functioning. The direct arrow from trainers to depression suggests however, that trainers are also more depressed for reasons apart from daytime dysfunction. Thus trainers are more depressed because their sleep is more likely to result in daytime dysfunction (as indicated by the indirect effect) and for other reasons that are not assessed in this model. We suggest a need for further research to explore other possible reasons as to why trainers report significantly more depression than other members of the horse racing industry.

![Path model explaining the reasons for higher depression and anxiety amongst trainers.](image)

**Figure 8.** Path model explaining the reasons for higher depression and anxiety amongst trainers.

**Note:** Estimates are un-standardised regression weights. Only significant paths are shown. * = p<.01, all other paths p<.001. For Socioeconomic status (SES) lower scores = higher SES. Trainers = 1, Others = 0. Trainers more likely to be male, older and lower SES.
9. CONCLUSIONS

This report has presented important, relevant and timely information about the relationship between trainers in the Victorian horse racing industry - and their sleep, anxiety and rates of depression. We have found that Victorian horse trainers that responded to the survey are more depressed than other populations, even when we take into account their particular sleeping patterns which reflect industry norms. On the basis of the data presented in this report, and without any further investigation, we are unable to make any recommendations for specific interventions which might help. However there is certainly scope for further qualitative investigation (e.g. in-depth interviews, focus groups) to examine these relationships in more detail, and to determine why trainers are more depressed than other populations. In addition, there is scope to investigate interventions which might help support trainers, and by extension their families, colleagues and the horse racing industry more widely. A sleep hygiene psycho-educational program tailored specifically to the unique workplace conditions of trainers would appear to be an intervention worthy of investigation in this population.
10. REFERENCES


Chambers D. 'Apart from taking it down the pub here, it's about as masculine as you can get" - An evaluation of the Pit Stop men's health program in rural and remote Western Australia. Proceedings of the 16th National Health Promotion Conference; 2006 April 23-26; Alice Springs Convention Centre, Alice Springs, Northern Territory, Australia.


11. APPENDIX A - SURVEY

Survey

Demographic Questions

Age:_____
Gender:_____

Occupation:

☐ Trainer
☐ Owner
☐ Horse Breeder
☐ Jockey
☐ Stable Foreman
☐ Sales vendors
☐ Stablehand
☐ Racing enthusiast
☐ Other, please specify:__________

☐ Please tick this box if you are a family member of a trainer

Please enter your postcode:__________

Given your current needs and financial responsibilities, would you say that you and your family are... (choose one)

☐ Prosperous
☐ Very comfortable
☐ Reasonably comfortable
In the last 12 months did any of the following happen to you because of a shortage of money? (Cross one box for each line)

A  Could not pay electricity, gas or telephone bills on time
B  Could not pay the mortgage or rent on time
C  Pawned or sold something
D  Went without meals
E  Was unable to heat (or cool) home
F  Asked for financial help from friends or family
G  Asked for help from welfare/community organisations

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

   BED TIME _____________

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

   NUMBER OF MINUTES _____________

3. During the past month, what time have you usually gotten up in the morning?
4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF SLEEP PER NIGHT

For each of the remaining questions, check the one best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you . . .

a) Cannot get to sleep within 30 minutes
   - Not during the past month
   - Less than once a week
   - Once or twice a week
   - Three or more times a week

b) Wake up in the middle of the night or early morning
   - Not during the past month
   - Less than once a week
   - Once or twice a week
   - Three or more times a week

c) Have to get up to use the bathroom
   - Not during the past month
   - Less than once a week
   - Once or twice a week
   - Three or more times a week

d) Cannot breathe comfortably
   - Not during the past month
   - Less than once a week
   - Once or twice a week
   - Three or more times a week
e) Cough or snore loudly

Not during the past month
Less than once a week
Once or twice a week
Three or more times a week

f) Feel too cold

Not during the past month
Less than once a week
Once or twice a week
Three or more times a week

g) Feel too hot

Not during the past month
Less than once a week
Once or twice a week
Three or more times a week

h) had bad dreams

Not during the past month
Less than once a week
Once or twice a week
Three or more times a week

i) Have pain

Not during the past month
Less than once a week
Once or twice a week
Three or more times a week

j) Other reasons(s) please describe

_____________________________________________________________________________
_____________________________________________________________________________
How often during the past month have you had trouble sleeping because of this?

- Not during the past month
- Less than once a week
- Once or twice a week
- Three or more times a week

6. During the past month, how would you rate your sleep quality overall?

- Very good __________
- Fairly good __________
- Fairly bad __________
- Very bad __________

7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

- Not during the past month
- Less than once a week
- Once or twice a week
- Three or more times a week

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

- Not during the past month
- Less than once a week
- Once or twice a week
- Three or more times a week

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

- No problem at all
- Only a very slight problem
Somewhat of a problem  
A very big problem

These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been.

1. During the last 30 days, about how often did you feel tired out for no good reason?
   1. None of the time
   2. A little of the time
   3. Some of the time
   4. Most of the time
   5. All of the time

2. During the last 30 days, about how often did you feel nervous?
   1. None of the time
   2. A little of the time
   3. Some of the time
   4. Most of the time
   5. All of the time

3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?
   1. None of the time
   2. A little of the time
   3. Some of the time
   4. Most of the time
   5. All of the time

4. During the last 30 days, about how often did you feel hopeless?
   1. None of the time
   2. A little of the time
   3. Some of the time
4. Most of the time
5. All of the time

5. During the last 30 days, about how often did you feel restless or fidgety?
   1. None of the time
   2. A little of the time
   3. Some of the time
   4. Most of the time
   5. All of the time

6. During the last 30 days, about how often did you feel so restless you could not sit still?
   1. None of the time
   2. A little of the time
   3. Some of the time
   4. Most of the time
   5. All of the time

7. During the last 30 days, about how often did you feel depressed?
   1. None of the time
   2. A little of the time
   3. Some of the time
   4. Most of the time
   5. All of the time

8. During the last 30 days, about how often did you feel that everything was an effort?
   1. None of the time
   2. A little of the time
   3. Some of the time
   4. Most of the time
   5. All of the time

9. During the last 30 days, about how often did you feel so sad that nothing could cheer you up?
   1. None of the time
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2. A little of the time
3. Some of the time
4. Most of the time
5. All of the time

10. During the last 30 days, about how often did you feel worthless?

1. None of the time
2. A little of the time
3. Some of the time
4. Most of the time
5. All of the time

Thank you for completing this survey.