

The Australian Longitudinal Study on Women's Health

Women and Mental Health in Australia

1 POOR MENTAL HEALTH IS COMMON AT ALL STAGES OF LIFE

Mental health is one of Australia's National Health Priorities. The World Health Organization has identified depression as the second largest cause of disability-adjusted life years lost worldwide. The cost of depression, and of other forms of mental health problems, is high in personal, social, health care and economic terms.

Self-reports of poor mental health suggest that it is much higher among Younger than among Mid-age or Older women. However, there is less of an age difference in diagnosis of depression or anxiety, and use of prescribed medications is lowest among the youngest women (see Figure 1). This suggests a degree of under-diagnosis among young women, which is a cause for concern.

Suicide prevention is a major mental health issue, and Figure 2 shows that both Younger and Mid-aged Australian women report suicide-related thoughts and behaviours.

Figure 1. Indicators of Poor Mental Health Among Australian Women

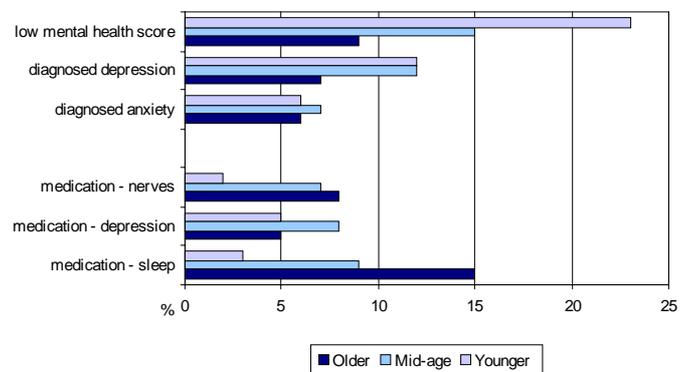
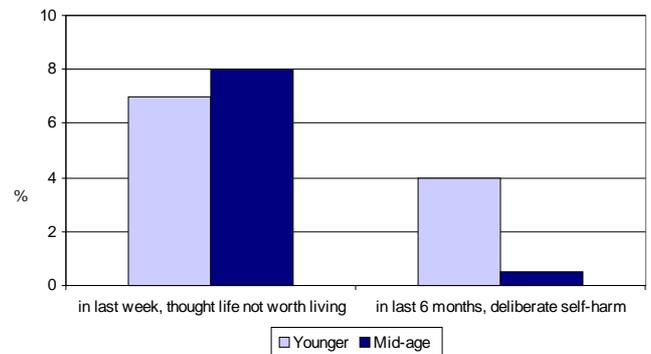


Figure 2. Suicide-Related Thoughts and Actions Among Australian Women



"You can't talk to anyone who hasn't been through this themselves..."



Most women with mental health symptoms do not seek professional help, and many feel embarrassed about asking for help. While mild to moderate levels of distress may appear unimportant to others, they are widespread and are strong predictors of clinical depression and other major psychiatric illness. The identification, treatment and prevention of minor but common mental health problems can prevent major illness.

Further information is available in the technical report *Women and Mental Health in Australia*

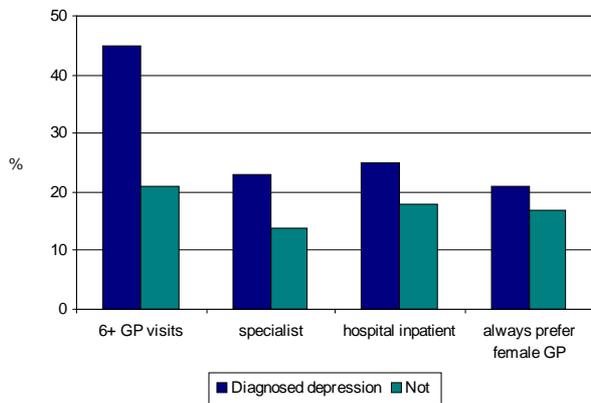


2 WOMEN WITH POOR MENTAL HEALTH ARE HIGH USERS OF HEALTH SERVICES

Women with poor mental health are high users of health services. For example, Figure 3 shows that young women with depression are much more likely than others to see a GP six or more times in a year, and more likely to see a specialist or to be hospitalised.

Depressed women are also more likely to prefer female GPs. This can be problematic, particularly in rural and remote areas where female GPs are often unavailable.

Figure 3. Health Service Use and Depression - Younger Women



Women with mental health problems use health services as heavily as women with major physical problems such as heart disease, cancer and diabetes.

Of Mid-aged women with depression, anxiety, or low mental health, over 40% are high GP users. This is similar to the rates for women with major physical diseases, and much higher than the overall figure of 18% of Mid-aged women (see Figure 4).

The story is similar for Older women, with over half of those with mental health problems being high GP users, higher than the rate for women with major physical diseases.



“Doctors don’t look beyond the initial problem. They don’t look into why you feel the way you feel.”

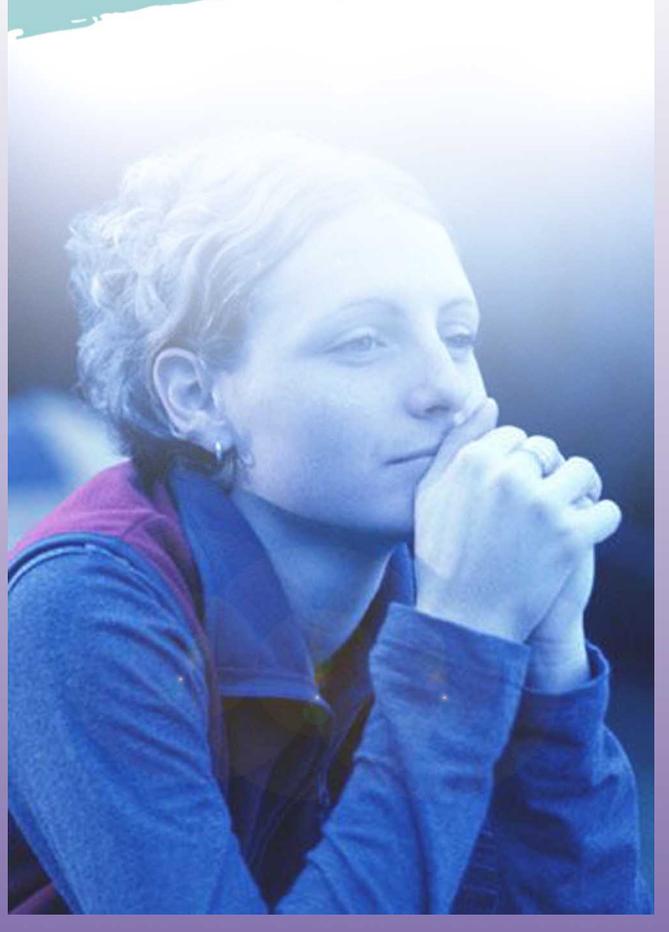
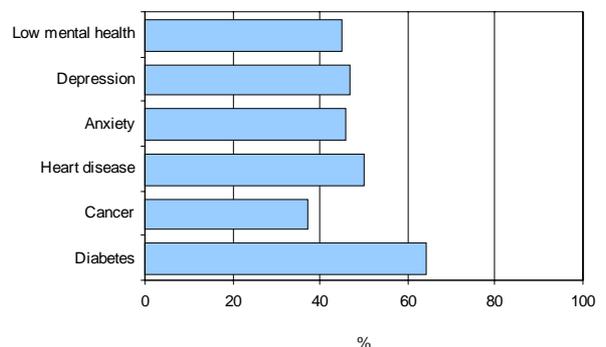


Figure 4. Frequent GP Visits by Major Conditions : Mid-aged Women



When one also considers the very high number of Mid-aged and Older women with mental health problems, compared with those with serious physical disease (for example, 15% of Mid-age women have low mental health scores, compared with 3% with diabetes), this shows that mental health problems are responsible for a high proportion of health service use.

3. WHO EXPERIENCES POOR MENTAL HEALTH ?

Around 12% of women have been diagnosed with mental health conditions, but over 20% report symptoms of poor mental health.

In all age groups, women with poor mental health tend to be:

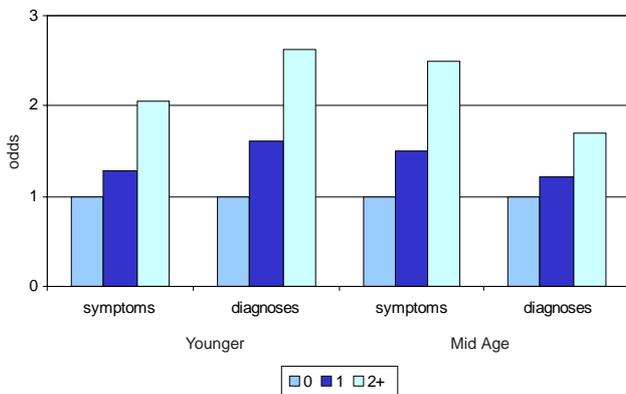
- single
- in financial difficulties
- in poor physical health
- likely to smoke
- likely to drink at risky levels
- likely to be sedentary
- likely to use illicit drugs

Poor mental health is part of a complex and reciprocally interacting set of factors. Cause and effect are not straightforward. Poor mental health causes and maintains social and personal problems, but these in turn cause and maintain poor mental health.

Life choices and health behaviours chosen by young women who are depressed or unhappy will have implications for their futures. Decisions about education, finances, fertility and relationships may make it more difficult for them to make positive life changes, again suggesting the importance of early intervention and prevention.

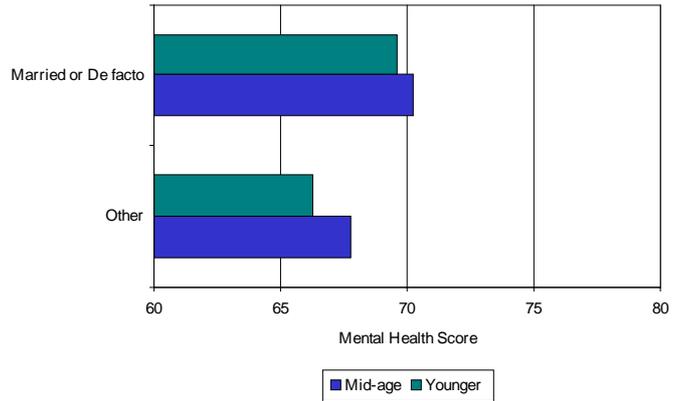
Figure 5 shows that the odds of being diagnosed with depression increase as the number of symptoms of physical illness, or the number of diagnosed physical conditions, increases. This patterns is found across the age span.

Figure 5. Diagnosed Depression and Physical Illness



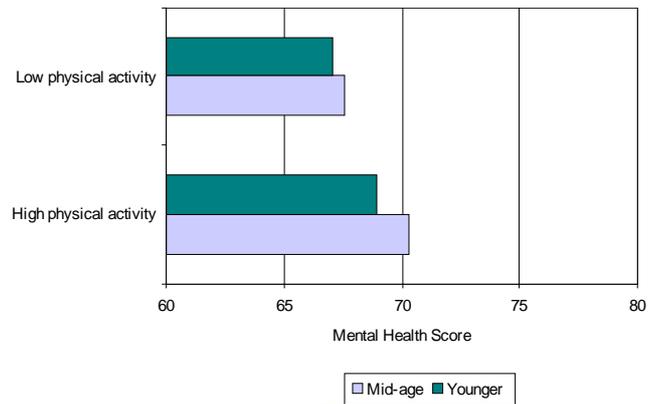
Social support is also associated with mental health; women who are married have better mental health scores than those who are not (see Figure 6).

Figure 6. Marriage and Mental Health

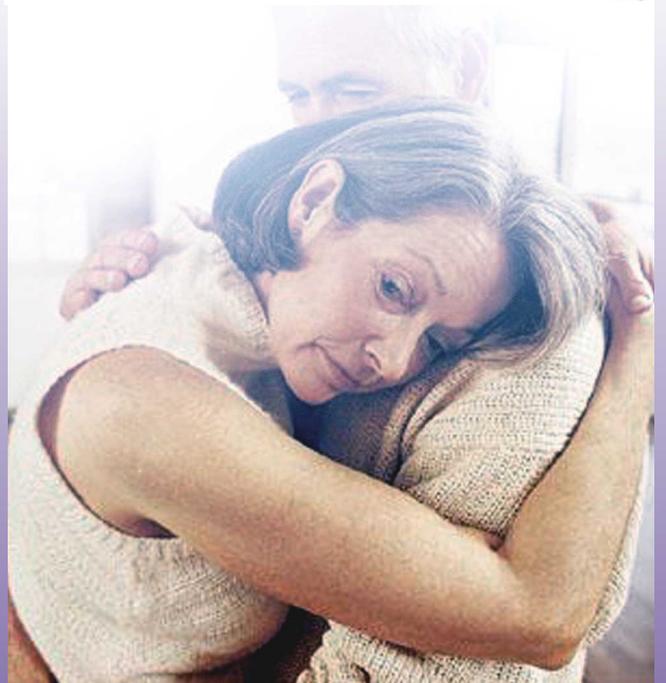


Even among the youngest women, a general pattern of poor physical health, unhealthy lifestyle, and poor mental health is apparent (see Figure 7).

Figure 7. Physical Activity and Mental Health



“I’m not the sort of person to talk about private things.”

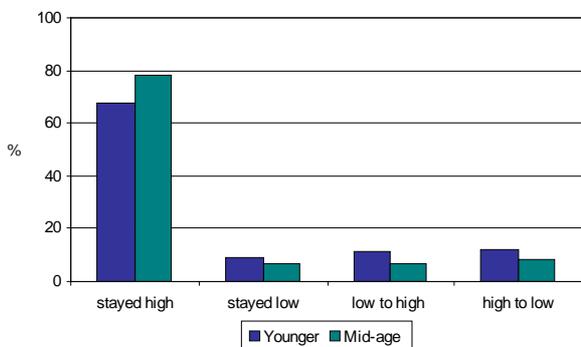


4 DOES MENTAL HEALTH CHANGE OVER TIME ?

Mental health problems are often chronic. Figure 8 shows changes over time in mental health scores for Younger and Mid-age women. While most women had good mental health at both surveys, 9% of the Younger women and 7% of Mid-age women had consistently low mental health scores. Around 10% in each age group moved from low to high, and the same number moved from high to low.

This indicates that there is a “core” of women who will have chronic problems, while others may move in and out of experiences of distress.

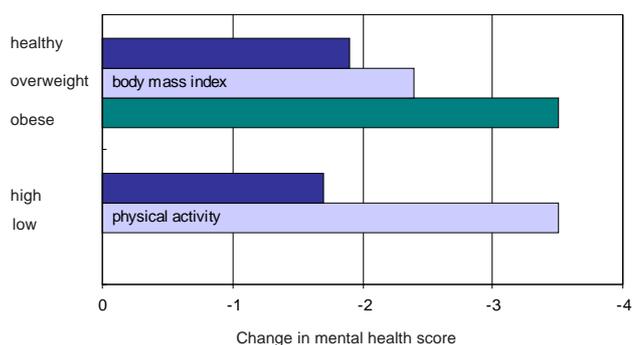
Figure 8. Changes in Mental Health Scores Over Time : Mid-age and Younger Women



Identifying predictors of future mental health problems is important in developing strategies for prevention. Longitudinal analysis has shown that predictors of future diagnosis of depression or anxiety include:

- many physical symptoms
- high use of GPs
- not being married
- experiencing financial problems
- smoking
- being overweight
- not being physically active
- use of illicit drugs

Figure 9. Changes in Mental Health Score by Health Behaviours - Mid-age Women



“... in other words instead of having a good recreational life, and a good... family support... and hobbies and distractions. I didn't have those. And I think if people have all of those other areas... you're validated in other areas. You don't just put your life in one confined box. And that's what I did. ”

Physical activity, non-smoking, and a healthy body weight are already recognised as important in the prevention of major chronic physical diseases. These data suggest that these health promotion targets are also likely to impact positively on mental health (see Figure 9).

Financial problems are consistently related to poor mental health. Low educational achievement and not being in the paid workforce are strongly associated with these variables. The evidence suggests that strategies that promote women's involvement in education and in the workforce are likely to benefit their mental health in the short and long term.

Being single is also strongly associated with risk of depression, supporting the need for social networks in maintaining good emotional health.

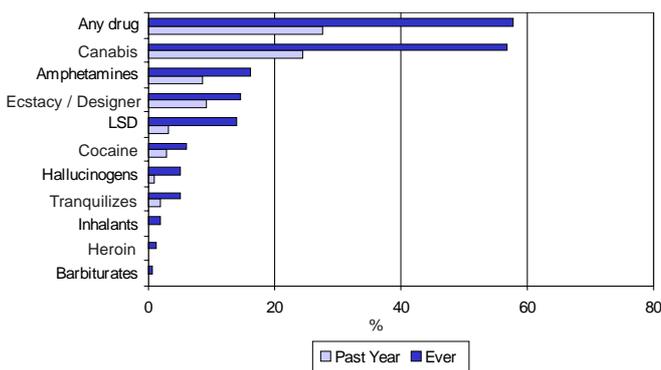
5 YOUNG WOMEN AND USE OF ILLICIT DRUGS

There is increasing concern, both in Australia and internationally, regarding the relationship between recreational drug use and mental health.

Figure 10 shows that 59% of the Younger women reported “ever” having used any illicit drug, and that cannabis is by far the most commonly reported drug.

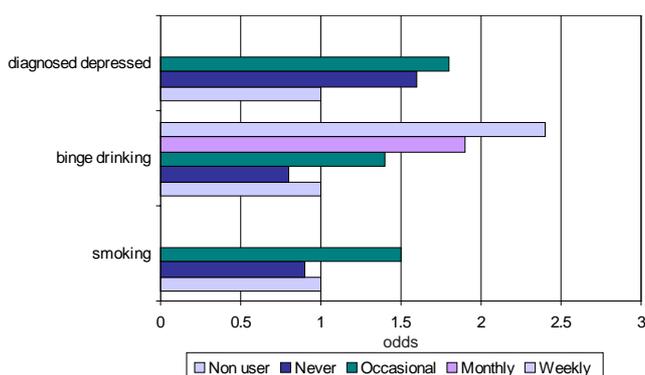
Almost all women who have used any drug have used cannabis, and almost all began using cannabis before they tried any other illicit drug. In fact, most multiple drug users had started using cannabis before they started tobacco. This suggests that it may be easier for young women to obtain cannabis than cigarettes (Figure 12).

Figure 10. Reported Use of Illicit Drugs in the Past Year and “Ever” : Younger Women



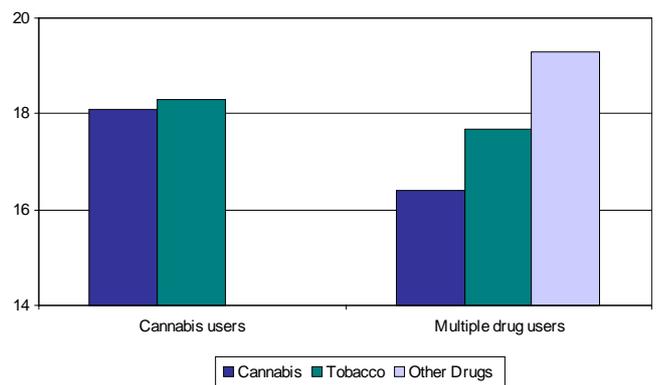
Young women who use illicit drugs have many of the same characteristics as women with diagnosed depression – they are likely to smoke and to binge on alcohol, and they are likely to be single. Depression is associated with illicit drug use, and the odds of being diagnosed as depressed increase with use of illicit drugs (see Figure 11).

Figure 11. Odds of Using Cannabis, by Depression and Legal Drug Use : Younger Women

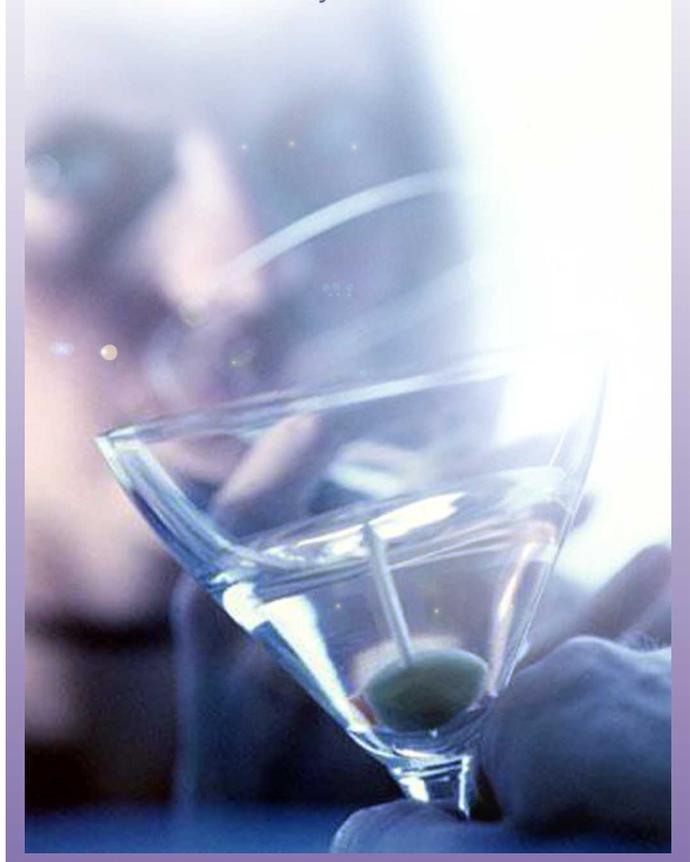


Illicit drug use is common among young Australian women, although it often appears to be self-limiting. There were more ex-users (31%) than current users (28%) among women in their early twenties. Cannabis seems to serve as a “gateway” to other drugs, probably because it is easy to obtain and because there is a perception that it is “herbal” and therefore healthy.

Figure 12. Age at First Use of Cannabis, Tobacco and Other Drugs : Younger Women



“... I am pretty healthy except ... I smoke too much and I also smoke marijuana regularly ... I know it is detrimental to my health but I find it very difficult to go without it. It also causes a lot of conflict with my mother ...”



6 EMOTIONAL DISTRESS FROM THE INSIDE – WHAT WOMEN SAY

Interviews with Mid-aged women experiencing poor mental health suggest that these women's understandings of their distress are very different from the perspectives of health service providers and other experts. How women make sense of the experience of emotional distress provides valuable information for the development of appropriate and acceptable services.

- Not all women who meet criteria for distress will identify their feelings as depression, and many will not regard medical intervention as appropriate.

"...I didn't want a label, to be put in a basket..."

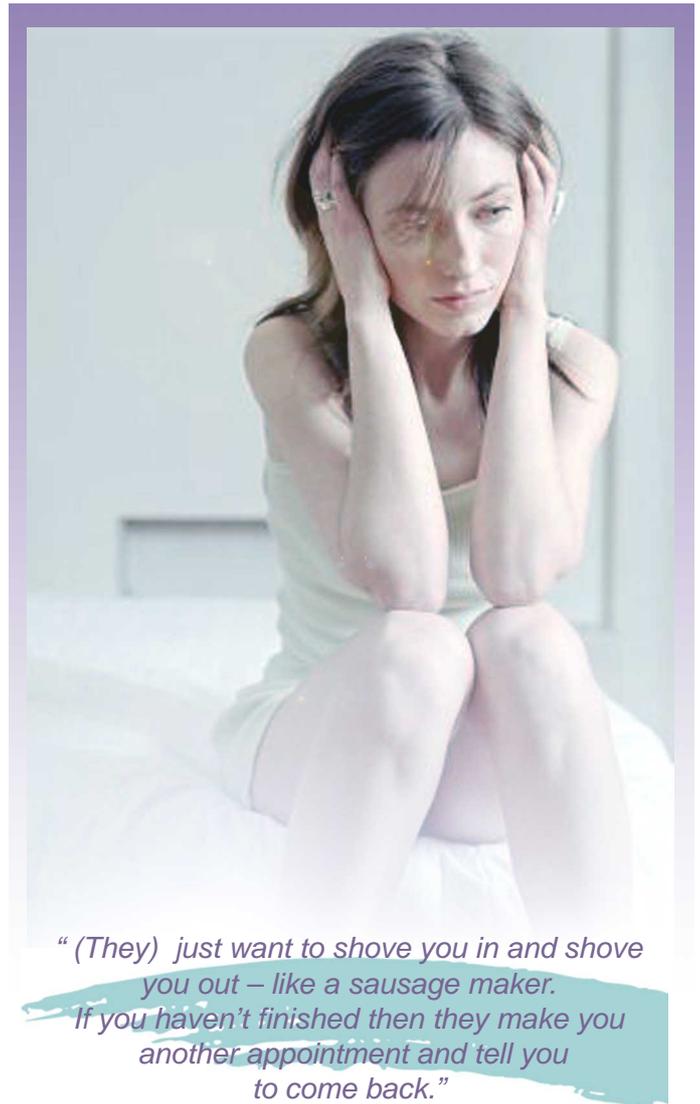
Most distressed women identify personal, family and work-related problems, not medical conditions, as the cause of their distress. By far the most common group of causes were difficulties with family, including partners, children, parents, and in-laws, mentioned by 81% of women surveyed.

- Most emotionally distressed women ascribe their feelings to current family, work, financial or relationship problems, or to ill health. Medical or hormonal explanations are uncommon or secondary, and even those women with traumatic childhoods do not believe these to be the cause of their present distress.

Almost all women interviewed perceived themselves as having strengths for coping with adversity. Perseverance, stubbornness and independence were considered important.

The second most common strength was a sense of being connected to family, despite the fact that family was also perceived as the most common cause of distress. Most women saw themselves as active agents in dealing with their distress.

- Those who had improved in mental health ascribed this to their own efforts or to family support, but most feared that improvements were only temporary and expected their depression to return.



"(They) just want to shove you in and shove you out – like a sausage maker. If you haven't finished then they make you another appointment and tell you to come back."

Only 8% saw professional assistance as responsible for their recovery from their last episode of psychological distress and only 12% attributed their improvement to medication. This is despite 66% having sought professional help for that particular period of depression.

Women with poor mental health:

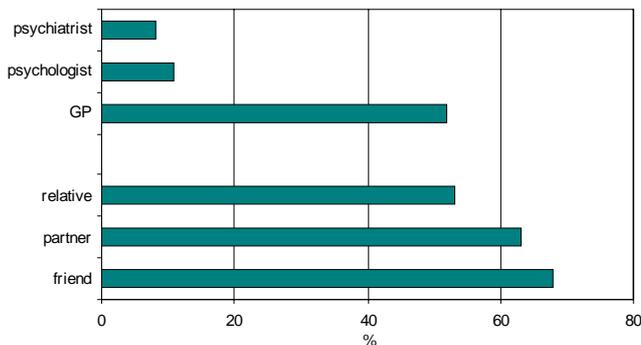
- generally do not label their problem as "depression"
- generally do not consider it a medical problem
- generally attribute it to family, health or work problems and not to biological or psychological factors
- generally attribute improvements to inner resources and to family support
- generally expect their problems to recur
- generally do not see professional assistance as likely to help

7 SEEKING HELP FOR MENTAL HEALTH PROBLEMS

Women's choices for seeking help for mental health problems are at odds with current medical practice.

Women with poor mental health were much more likely to seek help informally from friends and family than from formal health services (see Figure 13).

Figure 13. Seeking Help for Emotional Problems



Informal help

Women with poor mental health generally perceive:

- help from friends and relations as more helpful than from partners
- women as more helpful than men

“... he tries very hard to help but he can't. I've become awfully aware of the differences between men and women. They don't think they are being heartless but they really have no idea...”



Formal help

The GP is the first formal health service contact for most women with mental health problems. Women perceive GPs as:

- not experienced enough in treating mental health problems
- not interested in emotional symptoms
- too quick to prescribe medication without discussing the problem

Psychiatrists are generally viewed as “unhelpful” and “peculiar”.

“I have seen three different psychiatrists and... they all needed more help than I did.”

Psychologists, by contrast, are seen as very helpful but difficult to access, especially for rural women. Lack of Medicare coverage is a major barrier.

“It was easy to talk to the two psychologists, like a friend over a cup of tea.”

Medication

Prescription medication was a concern for many women. They regarded medication as unnatural, and as covering up the problem rather than helping them deal with it.

“...It dulls the pain but doesn't solve the problem. In some ways it was worse, you knew in the back of your mind it was counterproductive and you had to solve it.”

Stigma and Confidentiality

For some women, seeking help for emotional problems was made difficult by a sense of shame and responsibility for their problem.

“... ashamed that I could not work it out myself...”

Rural women with mental health problems described notably more barriers to accessing help than urban women.

It was also difficult for those who worked in the mental health, medical or welfare fields to seek help from professionals.

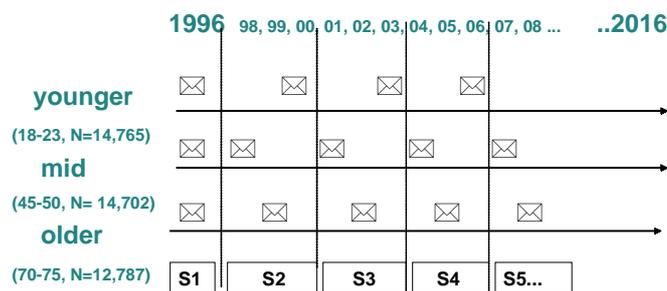
“Because I work at the hospital, I felt embarrassed with colleagues and in a small town people look at you as weak if you need counselling.”

8 Background: What is the Australian Longitudinal Study on Women's Health?

The Australian Longitudinal Study on Women's Health (ALSWH) – widely known as Women's Health Australia - is a longitudinal population-based survey which examines the health of over 40,000 Australian women. It provides information to assist the Commonwealth Department of Health and Ageing – and other Commonwealth and State Departments - to develop policies which are appropriate to Australian women of all ages.

Women in three age groups (aged 18-23 years, 45-50 years and 70-75 years in 1996) were selected from the Medicare database. Sampling was random within each age group, with women from rural and remote areas sampled at twice the rate of women in urban areas. The study is designed to run for 20 years, with each age cohort surveyed every three years, (see Figure 14).

Figure 14. Timeline for ALSWH Surveys.



The groups were selected in order to follow women through life stages which are critical to their health and well-being. When the study began, the Younger age group was in transition from adolescence to adulthood. They can be tracked as they move into the work force, enter adult relationships, and become mothers. At Survey 1, most were living with their families of origin (51%) or in shared housing (24%). Almost half (48%) were students; 79% were single; and 92% had no children. By Survey 2, 48% were married or in de facto relationships, although only 17% were mothers. Two-thirds (67%) had post-secondary educational qualifications and 59% were in full-time paid employment.

The Mid-age group was selected to examine the social and personal changes of that life stage as well as menopause. At Survey 1, 75% were married; 37% had full-time employment and 31% part-time.

While 91% were mothers, only 58% had children under 16 living with them. Middle age is a time of relative stability, so the picture was similar at Survey 3, with 78% married, 37% in full-time work and 23% in part-time work, although the number with children living at home had fallen to 37%

The Older group were in their early 70s when selected, to recruit older women who are still healthy and active. The focus is on predictors of continuing well-being and independence in older adult life. At Survey 1, the majority of older women (58%) were married, but widows increased from 36% to 41% of the sample by Survey 2. Over 80% are pensioners, though 35% have superannuation or other income.

The study goes beyond a narrow perspective that equates women's health with reproductive and sexual health, and takes a comprehensive view of all aspects of health throughout life. It assesses:

- Physical and emotional health (including health-related quality of life, diseases and conditions, symptoms)
- Use of health services (GP, specialist and other visits, access, satisfaction)
- Health behaviours and risk factors (diet, exercise, smoking, alcohol, other drugs)
- Time use (including paid and unpaid work, family roles, and leisure),
- Socio-demographic factors (education, employment, family composition)
- Life stages and key events (such as childbirth, divorce, widowhood).

Participants are also invited to consent to linkage of survey responses with unit records from the Medicare database, which provides information about type of service, characteristics of the provider, and out-of-pocket costs for Medicare-eligible services.

The information in this report was compiled by
Christina Lee and the ALSWH team

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