

Australian Longitudinal Study on Women's Health



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on Women's Health

Submission to the Productivity Commission of Inquiry into Mental Health

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Table of Contents

Introduction	1
Research Findings on Mental Health in ALSWH Participants	2
Prevalence and trends	2
Mental health and violence and abuse.....	3
Mental health and socio-demographic characteristics and health behaviours	4
Mental health and physical health	5
Mental health and reproductive factors and pregnancy.....	5
Mental health and health service use.....	6
Recommendations for Policy	7
References	8

Introduction

We commend the Commonwealth Government on its commitment to support the Productivity Commission to undertake an inquiry into the role of mental health in supporting social and economic participation, and enhancing productivity and economic growth.

The Australian Longitudinal Study on Women's Health is a long-running survey that has tracked the health and health service use of women living across the country since 1996.

The study is a national research resource funded by the Australian Government Department of Health and managed by the University of Queensland and the University of Newcastle. ALSWH surveys women in four cohorts which encompass the adult lifespan; women born in 1989-95, 1973-78, 1946-51, and 1921-26. The Study's purpose is to provide scientifically valid information – based on current, accurate data – that is relevant to the development of health policy and practice in women's health.

In this submission, we present an overview of findings and policy recommendations from the ALSWH regarding mental health and health and productivity outcomes. This submission draws from the 2019 ALSWH report 'Policy Briefs from the Australian Longitudinal Study on Women's Health' prepared for the Australian Government Department of Health. The full report is available here: <https://www.alswh.org.au/publications-and-reports/major-reports>

This submission specifically contributes to the following assessment streams being undertaken by the Commission:

- The assessment of the consequences of mental ill-health, and the effectiveness of current and alternative programs.
- The changes that should be made in Australia's health sector to address specific concerns related to mental health, in particular recommendations for mental health promotion, prevention and early intervention, and comorbidities.

Research Findings on Mental Health in ALSWH Participants

Prevalence and trends

- All ALSWH cohorts have completed a general measure of mental health, in which higher scores reflect better health. Women aged 85-97 reported the best mental health (with an average score of 78)^{1,2}, followed by women aged 65-70 (average score of 77)³, then women aged 37-42 (average score of 72)⁴, and then women aged 22-27 (average score of 63).⁵
- As well as the differences between the cohorts, mental health improved within each cohort over time as the women aged, although a small group of women experienced chronically poor mental health in later life.^{4,6}
- Anxiety symptoms were more prevalent than depressive symptoms across the 1973-78, 1946-51 and 1921-26 cohorts.⁷
- Women in the 1989-95 cohort (aged 18-23 in 2013) had the worst mental health of the ALSWH cohorts. Specifically, they reported:
 - Higher levels of psychological distress and stress than women in the same age group in 1996, with the women who were younger and those with less than year 12 education indicating the highest distress and stress levels.
 - Around half (49%) reported high to very high levels of psychological distress.⁸
 - 59% reported feeling that life was not worth living at some point in their lives. While this was highest among women with less than year 12 education (78%), 48% of those with a university education also reported suicidal thoughts.⁸
 - 45% of women reported ever having self-harmed. Self-harm was more common among women with less than year 12 education, however one third of those with a university education reported self-harm.⁸
 - More than one in three women (35%) had been diagnosed with or treated for depression, and 28% had been diagnosed with or treated for anxiety. These diagnoses were most common among women with less than year 12

education, although the prevalence was still high among those with a university education.⁸

Mental health and violence and abuse

- Experiences of violence, abuse, and bullying in childhood and adulthood were associated with depression, anxiety, suicidal thoughts, and self-harm.
 - 41% of women born 1973-78 reported adversity during childhood. These women had higher GP, allied and specialists healthcare costs (Medicare and out of pocket costs) in adulthood than women who did not experience adversity.⁹
 - Bodily pain, poor general health, and depression were associated with childhood sexual abuse. Women who experienced childhood sexual abuse visited their GPs frequently but were less likely than other women to report satisfaction with their GP services.^{5,10}
 - Approximately three in four women (72%) in the 1989-95 cohort reported having been bullied. Bullying was associated with adverse health behaviours, poor physical health, psychological distress, suicidal thoughts and self-harm.¹¹
 - Women who experienced forced sex were more likely to have sleeping difficulties and take prescription sleep medication than women who had not experienced forced sex. Experiences of forced sex were also associated with illicit drug use, depression, anxiety, and self-harm.¹²
 - Women who experienced domestic violence had consistently poorer mental health than women who had never experienced domestic violence. For example, 75% of women in the 1989-95 cohort who had experienced domestic violence had felt that life was not worth living at some point in their lives, compared with 53% of women who had not experienced domestic violence.¹³
 - There was a lifetime deficit in mental health associated with domestic violence. This health deficit remained even after the abuse had ceased.¹⁴

Mental health and socio-demographic characteristics and health behaviours

- Lower education, income stress, being unemployed, and not having a partner were associated with poor mental health in women born in 1946-51 and 1973-78.^{7,15, 16}
- Continuing education up to the age of 40 was protective against depressive symptoms.¹⁷
- Poor social support increased risk of poor mental health, and poor mental health increased risk of poor social support.^{7,18}
- Among women born in 1946-51, caring for others was associated with poor mental health.⁷
- Smoking, lower levels of physical activity, excessive alcohol consumption, and not being a healthy weight were associated with poor mental health across the 1973-78, 1946-51 and 1921-26 cohorts.^{7,15}
- Among women born in 1973-78, psychological distress was a predictor of subsequently taking up smoking. Smoking was also a predictor of subsequent psychological distress.¹⁶
- For the 1946-51 cohort, meeting and/or exceeding the national physical activity guidelines was associated with reporting less stress.^{19,20}
- For the 1921-26 cohort, factors associated with high sitting time and low physical activity levels included having more symptoms of anxiety and depression.²¹
- Higher levels of physical activity were associated with better current and future health-related quality of life, particularly physical functioning and vitality. Even if walking was their only activity, women in their 70s to 80s had better health-related quality of life²² and mental health.²³⁻²⁶
- Depression was associated with poor quality diet.²⁵⁻²⁸
- Consumption of a 'Mediterranean-style' or anti-inflammatory type of diet reduced women's risk of depression or depressive symptoms.^{29,30}

- Fruit intake at the recommended level of two pieces/day and eating 5 serves of vegetables per day had a protective effect on depressive symptoms in mid-aged women.³¹
- Dietary zinc intake was associated with lower risk of developing depression.³²

Mental health and physical health

- Frequent sleep difficulties were predictive of depression.³³
- A history of comorbid depression and anxiety was associated with the new onset of heart disease.³⁴
- Among middle aged women, depression was found to predict stroke.³⁵
- Stress and depression were found to play a role in the onset of arthritis among women born in 1946-51.¹⁵
- Depressive symptoms and a history of depression were associated with urinary incontinence among women born in 1973-78.³⁶

Mental health and reproductive factors and pregnancy

- Infertility was associated with depressive symptoms.³⁷
- Psychological distress was found to precede and co-occur with diagnoses of polycystic ovary syndrome and endometriosis.³⁸
- Women who had a hysterectomy and bilateral oophorectomy before their mid-to-late 40s were more likely to have increasing depressive symptoms over time.³⁹
- Women with vasomotor symptoms (hot flushes, night sweats) were more likely to subsequently report depressed mood compared with those without these symptoms⁴⁰. Additionally women with depressed mood were more likely to experience subsequent vasomotor symptoms. In both situations this association was also related to sleep difficulties.⁴¹

- Women aged 47-52 years who had a hysterectomy or oophorectomy or used hormone therapy had higher depressive symptom scores than women of the same age group with natural menopause.³⁹
- Pregnancy loss was associated with poor mental health during subsequent pregnancies.⁴²
- There were disparities in access to routine perinatal depression screening and psychosocial assessment programs. For example, women who gave birth in the private maternity sector were less likely to be assessed across various domains of psychosocial health during pregnancy.⁴³
- Women who were asked by a health professional about their emotional health during the perinatal period were more likely to seek help and be referred for additional support than women who were not asked.^{44,45}
- Women who reported a history of depression and anxiety were more likely to report experiencing postnatal depression.⁴⁶

Mental health and health service use

- Poor mental health was associated with more GP consultations.¹⁵
- Uptake of Medical Benefits Schedule items for 'Better Access to Psychiatrists, Psychologists and General Practitioners' for mental health services (the Better Access scheme) increased over time. For women in the 1973-78 cohort, use of these items increased from 5% in 2007 to 11% in 2015. Even for women born in 1989-95, use of these items increased during their teens from 7% in 2009 to 13% in 2012.¹⁵
- Women with poor mental health living in regional and remote areas were less likely to use Better Access items than women living in metropolitan areas.⁴⁷
- Women with depression were less likely to have sought medical advice for fertility issues.⁴⁸

Recommendations for Policy

- Screening for mental health problems should be routine practice in all clinical settings because of the strong links with unhealthy behaviours, sexual and reproductive issues, and many chronic conditions.
- The high prevalence of mental health problems among young women underscores the importance of the Better Access MBS items. The availability of these items and other mental health support services should be improved for disadvantaged women, especially those living outside major cities.
- Updates of the current National Tobacco Strategy (2012-2018) should continue to recognise the social and health inequalities associated with tobacco use, especially the need to reduce smoking dependence among people with mental health problems.
- Prevention of domestic violence is a priority for improving women's health. However, even if domestic violence ceases, many Australian women will continue to experience health problems associated with past domestic violence. We need to determine how we can implement and augment existing programs using a strengths-based approach.
- Data items on depression/anxiety screening in the antenatal period, psychosocial referral in the antenatal period, presence or history of a mental health condition (as well as items on alcohol use and domestic violence) should be included in the Perinatal National Minimum Dataset.
- Prevention, detection and treatment of poor mental health prior to child bearing and during pregnancy are recommended to reduce the incidence of postnatal depression.
- Public health policies geared towards increasing adherence to physical activity (or increasing PA levels generally) should prioritise women of lower socioeconomic status, Asian-born women, women with children, women at risk of developing chronic conditions, and women with poorer mental health.

The ALSWH policy briefs on mental health and its associations with violence, abuse, sociodemographic characteristics, health behaviours, physical health, reproductive factors, pregnancy and health service use were prepared by:

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A detailed description of the background, aims, themes, methods, and representativeness of the sample and progress of the study is given on the project website. Copies of surveys are also available on the website, along with contact details for the research team, abstracts of all papers published, papers accepted for publication, and conference presentations.