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Over One Million Adult Women in California Report Serious Psychological Distress During the Past Year

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Positive mental health and emotional well-being are crucial elements of a person's overall health status, but mental health is often less well understood than physical health. Having poor mental health can affect one's ability to live fully and function effectively. With the exception of substance abuse conditions, women report a higher need for health care assistance for emotional or mental health problems than men.[1] According to 2009 national health survey data, women represent two-thirds of the users of mental health services, and have a rate of prescription medicine use to treat a mental health condition at almost twice the rate of men (14.7% vs. 7.6%).[2] In California, women also report higher rates of psychological distress compared to men.[3] Highlighted in this policy brief, a new study finds that slightly over one million adult women in California have symptoms associated with serious psychological distress.

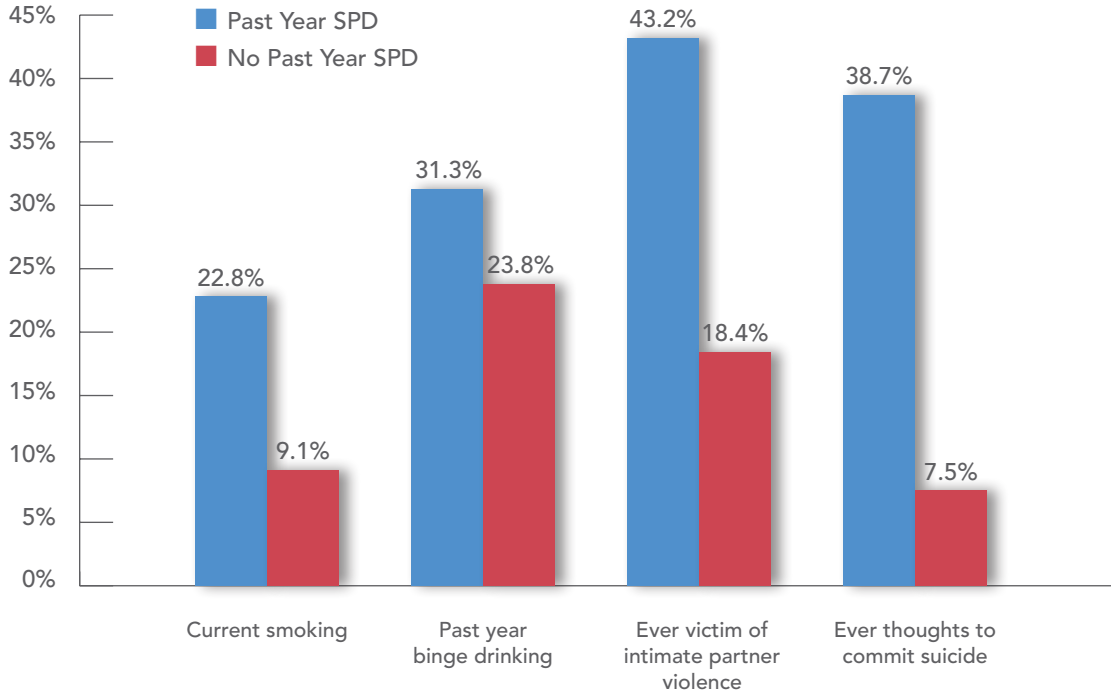
Slightly over one million adult women in California have symptoms associated with serious psychological distress

Utilizing data drawn from the 2009 California Health Interview Survey (CHIS 2009), this policy brief focuses on the mental health of women in California 18 years of age and older, underscoring the socio-demographic groups most at risk. We examine the extent of serious psychological distress (SPD), associated risks, the reported effects on women's daily life functioning, differences in prevalence by demographic factors, the level of women's need for mental health assistance, and the gap between those women needing help for mental health, alcohol, or drug issues and those obtaining such help.

Past Year Symptoms of Serious Psychological Distress

The Kessler 6-Item Serious Psychological Distress Scale (K6) is used to measure serious, nonspecific mental health distress among adults in CHIS. The scale covers six symptom areas associated with serious psychological distress (SPD), and provides

EXHIBIT 1 | Associated Risks Among Adult Women with Serious Psychological Distress, California, 2009



Note: Only women 18–65 years old were asked if they had ever been a victim of intimate partner violence since turning 18.

Source: 2009 California Health Interview Survey

Women with past-year SPD are five times more likely to have ever thought of suicide (38.7%) compared to women without past-year SPD (7.5%)

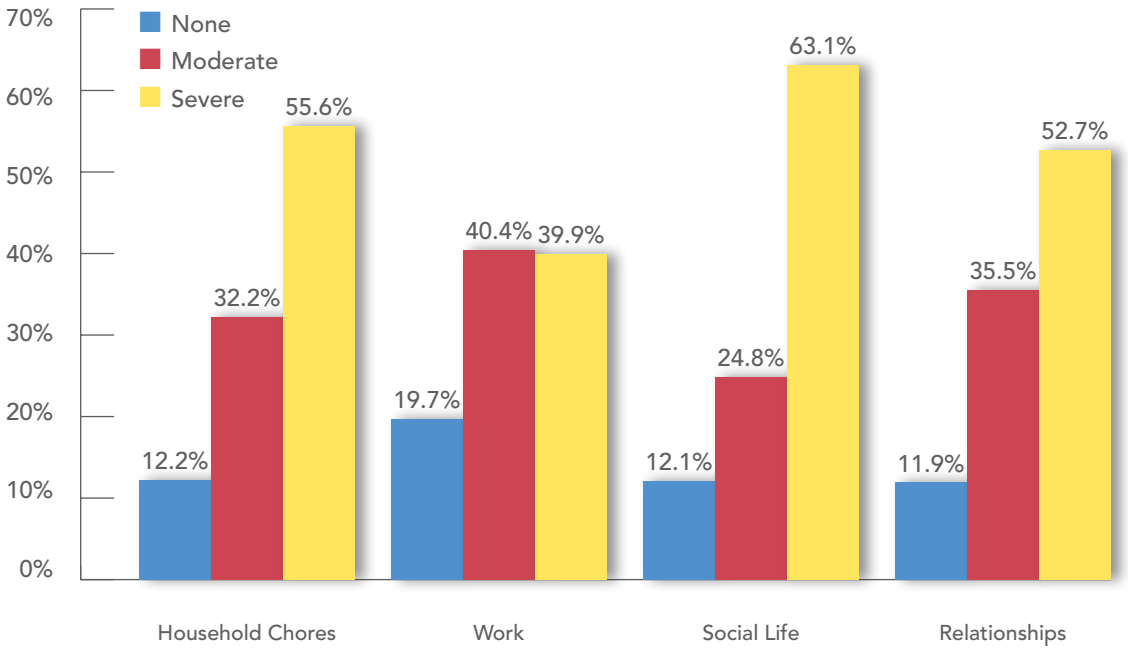
both past-month and past-year estimates of serious psychological distress.[4]

This policy brief focuses on serious psychological distress among adult women in California that occurred during the past year. According to 2009 CHIS findings, slightly more than 1 million California women 18 years or older (7.6% or 1,064,000 women) reported experiencing symptoms associated with SPD in the past year.

Associated Health Risks

Women who experience serious psychological distress may have been exposed to associated health risks in the past, such as violence.[5] They may attempt to cope with their distress by engaging in behaviors that can pose risks to their health.[6] Exhibit 1 displays results for the following associated health risks: current smoking, past-year binge drinking, experiences of intimate partner violence, and thoughts of suicide (i.e. suicide ideation) (EXHIBIT 1). Women with past-year SPD are two and half times more likely to smoke than those without such distress (22.8% vs. 9.1%). The rate of past-year binge drinking is higher among women with past-year SPD as well (31.3% vs. 23.8%). Women with past-year SPD are nearly two and a half times more likely to report being a victim of intimate partner violence (43.2%) than women without past-year SPD (18.4%). In addition, women with past-year SPD are five times more likely to respond that they have ever thought

EXHIBIT 2 | Past Year Functional Impairment Due to Emotional Distress Among Adult Women with Serious Psychological Distress, California, 2009



Note: As part of the Sheehan Disability Scale (SDS), only women 18–70 years old were asked whether distress impaired their work life.

Source: 2009 California Health Interview Survey

Over half [of women with past-year SPD] indicate that household chores, their social life, and their relationships are severely impaired due to emotional distress

of suicide (38.7%) when compared to women without past-year SPD (7.5%) (EXHIBIT 1).

Functional Impairment Due to Distress among Women with SPD

Untreated mental illness or emotional problems may take an additional health toll by impairing one's ability to fully function at home, work, or socially, which in turn can impact one's quality of life. To measure functional impairment due to emotional distress, CHIS asked women with psychological distress about the extent to which distress interferes with daily life functions. The questions, which are part of the Sheehan Disability Scale (SDS), cover functioning at home, at work, in social life, and in personal relationships.[7] Respondents are asked if their emotions interfered with doing household chores, work performance, their social life, or relationships with family and friends "a lot" (severe), "somewhat" (moderate), or "not at all" (none).

Exhibit 2 displays the functional impairment results for women with past-year SPD. Over half indicate that household chores, their social life, and their relationships are severely impaired due to emotional distress (EXHIBIT 2). A major concern is social life impairment, with six in ten women who have past-year SPD reporting severe diminishment of function in this area of life (63.1%). According to respondents, emotional distress also severely interferes with

doing chores (55.6%) and with their relationships with family and friends (52.7%). Regarding a question posed only of women 18–70 years old, nearly four in ten with past-year SPD report that emotional distress interferes with their work either "moderately" (40.4%) or "severely" (39.9%) (EXHIBIT 2). Over half of women with past-year SPD report being disabled due to a physical, mental, or emotional condition (55.8%); such disability may impact their ability to work (data not shown).

Younger, Lower-Income, and Single Women Have Higher Rates of SPD

Although women of all ages, incomes, racial/ethnic backgrounds, and family structures may undergo periods of psychological distress, certain groups are disproportionately affected. Among adult women in California, younger age groups have higher past-year rates of serious psychological distress compared to older women. Specifically, women in the 18–44 and 45–64 years of age groups are twice as likely to have symptoms of past-year SPD compared to women 65 years or older (3.5%) (EXHIBIT 3).

CHIS results also highlight income disparities. As shown in Exhibit 3, women at 0–199% of the federal poverty level (FPL) have twice the rate (10.4%) of past-year serious psychological distress than women at 400% or above FPL (4.6%). Moderate-income women (200–399% FPL) also have a higher past-year SPD rate (8.6%) compared to the highest income category (400% or above FPL).

Rates of serious psychological distress differ by family type with single women having higher rates than married women. The rate of past-year SPD experienced by single women with children (13.7%) is twice as high as the rate among married women with children (6.1%). Single women without children have a significantly higher rate (9.3%) than married women without children (5.1%) (EXHIBIT 3).

Variation in SPD Rates by Racial/Ethnic Background. Serious psychological distress rates during the past year vary considerably among California's diverse racial/ethnic groups, spanning a range from 4.1% to 10.5%. Women from Asian and Native Hawaiian/Pacific Islander backgrounds have the lowest prevalence rate for past-year SPD (4.1%). Latinas (9.3%), African-American women (10.5%), and women of two or more races (10.2%) are twice as likely to have higher past-year serious psychological distress compared to Asian/Native Hawaiian/Pacific Islander women (4.1%). White women also have higher past-year SPD levels (7.0%) than Asian/Native Hawaiian/Pacific Islander women (4.1%) (EXHIBIT 3).[8]

SPD and Need for Mental Health, Alcohol or Other Drug Services

In an effort to measure perceived need for mental health services, CHIS respondents were asked if there was a time in the past 12 months when they thought they might need to see a professional because of *"… problems with your mental health, emotions, nerves or your use of alcohol or drugs."* About 2.3 million women in California (16.6%) responded that they needed professional help for mental health, alcohol, or drug problems in the past year (data not shown). Among those women with past-year SPD, 70.6% report

EXHIBIT 3 | Selected Demographic Characteristics of Adult Women with Serious Psychological Distress, California, 2009

Selected Demographic Characterisitcs	Percent	Estimated Population
Age group		
18–44	8.6%	599,000
45–64	8.1%	387,000
65+	3.5%	77,000
Family Income		
0–199% FPL	10.4%	512,000
200–399% FPL	8.6%	301,000
400%+ FPL	4.6%	251,000
Family Structure		
Single, with children	13.7%	157,000
Single, no children	9.3%	474,000
Married, with children	6.1%	242,000
Married, no children	5.1%	191,000
Race/Ethnicity		
African American	10.5%	88,000
American Indian/Alaska Native	—	—
Asian/Native Hawaiian/Pacific Islander	4.1%	80,000
Latina	9.3%	409,000
Two or more races	10.2%	23,000
White	7.0%	451,000
TOTAL ALL WOMEN WITH SPD	**7.6%**	**1,064,000**

Note: — indicates that the results are too unstable to report due to small sample size.
Source: 2009 California Health Interview Survey

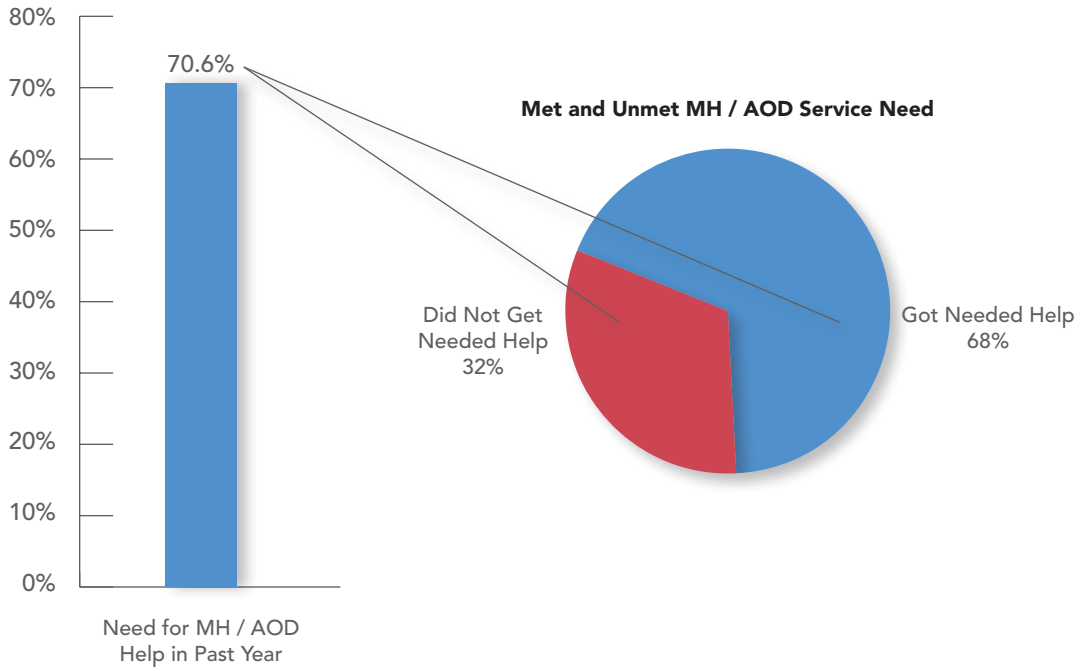
Nearly one-third (32.4%) indicate that they did not get the help they thought they needed for their emotional, alcohol, or drug problem

needing help in the past year for an alcohol, drug, or mental health problem (EXHIBIT 4).

Obtaining Mental Health Services and Unmet Need. Over two-thirds of women with past-year SPD report seeing a professional for either mental health or alcohol or drug services they needed during the past year (67.8%). However, nearly one-third (32.4%) indicate that they did not get the help they thought they needed for their emotional, alcohol, or drug problem, a sign that there may be potential barriers to obtaining needed mental health or alcohol or other drug services (EXHIBIT 4).[9]

Younger and Lower-Income Women Report Higher Rates of Unmet Mental Health Services Need. Exhibit 5 highlights demographic characteristics and disparities among women with past-year SPD regarding their unmet emotional health services need. Younger women, ages 18–44 years, are more likely to report that they did not receive the psychological, alcohol, or drug help

EXHIBIT 4 | Past Year Met and Unmet Mental Health or Alcohol or Drug Service Need Among Adult Women with Serious Psychological Distress, California, 2009



Notes:

"MH / AOD" indicates mental health or alcohol or drug services.

Among women with past-year SPD, 70.6% reported needing mental health, alcohol or other drug services in the past year.

The pie chart breaks down those who did or did not get services among the 70.6% women with SPD who reported needing to see a professional for such services.

Source: 2009 California Health Interview Survey

African-American women have twice the rate of white women for unmet mental health need (47.8% vs. 21.1%)

they said they needed (36.4%) compared to those ages 65 years and older (21.9%; p=.09) (EXHIBIT 5). Income disparities in accessing needed services were also found. Low-income women (0–199% FPL) with past-year SPD are twice as likely (40.4%) to report unmet need compared to women at 400% or above FPL (20.2%). Among racial/ethnic groups with past-year SPD, African-American women have twice the rate of white women for unmet mental health need (47.8% vs. 21.1%; p=.06) (EXHIBIT 5).

Mental Health Prescriptions. While CHIS respondents were not asked to name the specific mental health medication they were prescribed, results show four in ten women with past-year SPD reported taking a daily prescription medication for their mental health needs in the past year (40.7%) (data not shown).

Potential Barriers to Care. Among women with past-year serious psychological distress, those without a usual source of general health care had a high rate of unmet mental health need (69.6%) (EXHIBIT 5). The type of one's usual source of care also mattered.

EXHIBIT 5 | Selected Demographic Characteristics of Adult Women with Serious Psychological Distress, by Met and Unmet Service Need, California, 2009

Women with Serious Psychological Distress	Unmet MH Service Need	Met MH Service Need
Age group		
18–44	36.4%	63.6%
45–64	26.8%	73.2%
65+	21.9%	78.1%
Family Income		
0–199% FPL	40.4%	59.6%
200–399% FPL	32.3%	67.7%
400%+ FPL	20.2%	79.8%
Race/Ethnicity		
African American	47.8%	52.2%
American Indian/Alaska Native	—	—
Asian/Native Hawaiian/Pacific Islander	30.4%	69.6%
Latina	45.1%	54.9%
Two or more races	—	—
White	21.1%	78.9%
Usual Source of Care		
No usual source	69.6%	30.4%
Clinic / Health Center	42.7%	57.3%
MD office / Kaiser / HMO	18.3%	81.7%
Health Insurance		
Currently uninsured or uninsured past 12 months	51.5%	48.5%
Insured all past 12 months	25.5%	74.5%
TOTAL ALL WOMEN WITH SPD	**32.4%**	**67.6%**

Notes:

"Unmet MH Service Need" = Among women with past-year SPD, percent with perceived need for mental health, alcohol or other drug services in the past year who did *not* get needed services.

"Met MH Service Need" = Among women with past-year SPD, percent with perceived need for mental health, alcohol, or other drug services in the past year who obtained the needed services.

Source: 2009 California Health Interview Survey

Women with past-year SPD who were cared for in health clinics or centers had a higher rate of unmet need (42.7%) than those cared for in doctors' offices or HMO settings (18.3%).

Lack of insurance coverage is another potential barrier to obtaining needed care. Among women with past-year SPD, those currently uninsured or uninsured at some point in the past 12 months had a higher rate of unmet mental health services need (51.5%) than those with insurance coverage every month of the past 12 months (25.5%) (EXHIBIT 5).

Discussion

Compared to physical health, women's mental health problems have received less public health attention in the past. Since the late 1990s, however, that trend has been changing.[10]

Our findings highlight links between social determinants of health (e.g., age, income, family structure, race/ethnicity), associated risks (e.g., smoking, binge drinking, violent victimization, suicide ideation), and serious psychological distress among women in California. Of the approximately one million women in California affected by past-year serious psychological distress, findings indicate that associated health risks are a serious concern. Women with past-year SPD are more likely to smoke, to engage in past-year binge drinking, to have been the victim of intimate partner violence, and to have had suicide thoughts compared to women without SPD. Whether some of the associated risks drive the serious distress levels, or whether the psychological distress level impacts associated risks is unclear. Women with SPD are also likely to report levels of severe impairment of daily life functioning.

Women with past-year SPD are more likely to smoke, to engage in past-year binge drinking, to have been the victim of intimate partner violence, and to have had suicide thoughts

Results indicate that women under age 45, single women with and without children, and women in the lowest income category have higher levels of serious psychological distress than women in other age, income, and family structure categories. Latina, white, and African-American women report SPD symptoms at higher rates than Asian and Native Hawaiian/Pacific Islander women combined.

Over 70% of women with past-year SPD indicate they need help for mental health or alcohol or other drug problems. On a positive note, the majority do obtain professional services; specifically, over two-thirds who say they need help get help for either mental health or alcohol or drug problems. However, a substantial group — almost one-third — does *not* receive needed help.

As our results show, lack of a usual source of care and unstable insurance coverage are significant barriers impacting unmet need. Other possible barriers might be the absence of a uniform mental health screening and referral system, the stigma surrounding obtaining such services, or limited awareness that mental health parity ensures access to such services among the insured.[11]

In an effort to expand mental health benefits, in 1999 California passed a mental health parity law (AB 88) mandating that mental health treatment be equally covered by private health insurance providers in the state.[12] In 2004, California passed the Mental Health Services Act (MHSA), designed to provide funding to expand county-operated mental health services. Despite these expanded mental health policies, the 2008 national "Great Recession" exacerbated California's fragile state economy, a situation affecting many women on multiple fronts.[13] California is currently faced with significant county and state budget cuts

that could threaten the existence of and access to a variety of mental health programs and services. Although the economy continues to show signs of recovery, the effects of the recession are still being felt.

Given these obstacles, more education around the existence of the mental health parity law, a public health campaign aimed at de-stigmatizing mental health problems, and expanding and improving evidence-based mental health screening and referral protocols in health care settings may prove beneficial. With full implementation of the Patient Protection and Affordable Care Act (ACA) in 2014, the lack of health insurance or a usual source of care should diminish as barriers.

Our findings should assist policymakers, researchers, health care practitioners, and advocates in their efforts to understand and address some of the behavioral and social determinants affecting women's mental health.[14] Additionally, the results should help in their endeavors to strengthen mental health and alcohol and drug evidence-based screening and services statewide so that throughout their lifetimes, women most in need will be identified early, treated without stigma or discrimination, counseled on associated risks, and referred appropriately to an array of needed emotional health services.

More education on mental health parity, a public health campaign aimed at de-stigmatizing mental health problems, and expanding and improving evidence-based mental health screening and referral protocol may prove beneficial

Data Information

Data for this policy brief is drawn from the 2009 California Health Interview Survey (CHIS 2009), a random-digit-dial telephone survey of the California population living in households, and the largest statewide survey conducted in the U.S. CHIS interviewed 28,051 women ages 18 and older in 2009. Sampling tolerances at the 95% confidence level were used to calculate statistically significant differences between groups. All differences between groups reported in the policy brief are statistically different at the $p<.05$ unless otherwise noted. The determination of adequate sample size to report data was based on analysis of the coefficient of variation (CV), using a criterion of 30. For more CHIS information, please visit www.chis.ucla.edu.

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Funder Information

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In Tribute

The authors will always be grateful for the guidance and wisdom provided by the late E. Richard Brown, PhD. Rick's vision led to the development of the California Health Interview Survey (CHIS), an invaluable part of his ongoing legacy to public health.

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Endnotes

1 U.S. Dept. of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, *Women's Health USA 2011*, *Health Care Utilization*, Rockville, MD: 2011 accessed at: http://www.mchb.hrsa.gov/whusall/hsu/pages/308mhcu.html.

2 Substance Abuse and Mental Health Services Administration, *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings*, Center for Behavioral Health Statistics & Quality, NSDUH Series H-39, HHS Publication No. SMA 10-4609, Rockville, MD, 2010.

3 A policy brief using CHIS 2005 data found women more likely to say they needed mental health help compared to men (23% vs. 14%); see Grant D, Kravitz-Wirtz N, Aguilar-Gaxiola S, et al. *Mental Health Status and Use of Mental Health Services by California Adults*. UCLA Center for Health Policy Research, 2010. A related CHIS report uses a complex measure of mental health need; see Grant, D, et al. *Adult Mental Health in California: Findings from the 2007 California Health Interview Survey*. UCLA Center for Health Policy Research, 2011.

4 Originally developed for use in the US National Health Interview Survey (NHIS), the Kessler 6 scale was designed as a short screener to distinguish cases of serious mental illness (SMI) from non-cases. Respondents are initially asked about past-30-day symptoms. To measure past-year SPD, they are asked about the worst month in the past 12 months. The Kessler 6 asks: "During the past 30 days [or the worst emotional month in the past 12 months], about how often did you feel …1) nervous; 2) hopeless; 3) restless or fidgety; 4) so depressed that nothing could cheer you up; 5) that everything was an effort; 6) worthless?" The responses are: "all of the time (4), most of the time (3), some of the time (2), a little of the time (1), or none of the time (0)." Scores are summed with a range of 0–24; the scale's cutoff point of 13 or greater is the optimal level for assessing the prevalence of serious psychological distress in the national adult population. Kessler RC, Barker PR, et al. Screening for serious mental illness in the general population. *Archives of General Psychiatry*, 60(2): 184–189 (2003).

5 Zahnd E, Aydin M, Grant D and Holtby S. *The Link Between Intimate Partner Violence, Substance Abuse and Mental Health in California*. UCLA Center for Health Policy Research, 2011.

6 Krueger PM and Change VW. Being poor and coping with stress: health behaviors and the risk of death. *American Journal of Public Health* 98(5): 889–896, May 2008.

7 Leon AC, et al. Assessing Psychiatric Impairment in Primary Care with the Sheehan Disability Scale. *International Journal of Psychiatry in Medicine* 27(2): 93–105 (1997).

8 The past-year SPD rate for American Indian/Alaska Native women is unstable due to small sample size.

9 "Unmet need" is defined as a woman with past-year SPD reporting that she needed to see a professional about an alcohol, other drug, or mental health problem during the past year, but did not receive services.

10 Institute of Medicine of the National Academies, Women's Health Research Progress, Pitfalls, and Promise, Sept. 2010 accessed at: http://www.iom.edu/Reports/2010/Womens-Health-Research-Progress-Pitfalls-and-Promise.aspx.

11 For other potential barriers, see Kessler R. Epidemiology of women and depression. *Journal of Affective Disorders* 74(1):5–13, March 2003; Leong Frederick TL and Kalibatseva Z. Cross-cultural barriers to mental health services in the United States, Cerebrum, March 2011 at: http://www.dana.org/news/cerebrum/detail.aspx?id=31364.

12 Lake T, Sasser A, Young C and Quinn B. *A Snapshot of the Implementation of California's Mental Health Parity Law*. Cambridge, MA: Mathematica Policy Research, Inc., 2002. The law did not result in increased use of mental health care services; An R and Sturm R. Self-reported unmet need for mental health care after California's Parity Legislation. *Psychiatric Services* 61(9): 861, Sept. 2010.

13 Wyn R and Zahnd E. *Almost One-Quarter of California Nonelderly Women Uninsured in 2009*, Oakland, CA: Public Health Institute, 2011.

14 California Strategic Plan on Reducing Mental Health Stigma and Discrimination. 2009. Accessed at: http://www.dmh.ca.gov/PEIStatewidePCDMH_MH_Stigma_Plan_09_v5.pdf

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