Mental Well-being

Department of Health Information and Research
Strategy and Sustainability Division
Secretariat for Health
Ministry for Social Policy
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Promotion of Mental Health has become an issue of concern not only in Malta but across the European Union. It is estimated that 50 million people across Europe are experiencing Mental Illness. This amounts to 11% of the European population. Every nine minutes someone dies within the European Union as a consequence of suicide. Depression continues to be the most common condition in Europe. Mental Illness accounts for 2%-3% loss in GDP which means 108 – 162 Million Euro per year.

It is the responsibility of us all to continue to give a voice to these clients who unfortunately are fragile and still experience social exclusion, discrimination and bias due to the stigma which regrettfully continues to add to the misery of these patients. Mental Health is and will continue to be at the fore of our political agenda. Our aim is to slowly but gradually increase the services within the community for patients with Mental Health problems.

In the meantime we need to be relentless with our determination to combat stigma and to promote social inclusion of our clients. Undoubtedly, awareness on Mental Health issues have increased and there is now much more talk and action on Mental Health. Our strategy to continue to change and reform this sector has now gained a certain impetus. Families and individuals with Mental Health Illness are slowly but gradually acknowledging the fact that this illness should not remain their hidden secret and they are now more willing to seek help. In this context it is imperative to acknowledge that patients, ex-patients, their families and service users can and shall be very important partners when evaluating existing services or in the planning of new services.

It is important to remember that the Lisbon Agenda is aimed to create wealth and create jobs based on a knowledge based society. But let us never forget that there is no health without mental health and that there is no wealth without mental health.

Indeed it is not Mental Illness that should shame us. It is the stigma, bias and discrimination against Mental Illness that should shame us all.

Hon. Mario Galea
Parliamentary Secretary for the Elderly and Community Care
Preface

This is the third thematic report derived from the European Health Interview Survey carried out in 2008 by the Department of Health Information and Research. This survey has been made possible through European funding from various schemes, including Transition Facility Funds and EUROSTAT grants and through funds made available by the Ministry of Social Policy. This questionnaire addressed a number of areas, including mental health and wellbeing of the respondents. This survey was conducted in a randomly selected sample of 5500 adults resident in Malta. A response rate of 72% was attained.

This report provides a comprehensive overview of the mental health status and the subjective well-being experienced by the Maltese population.

The absolute majority of the Maltese population stated they had positive feelings during the four weeks prior to the interview. Two validated indices have been used to further evaluate this – the vitality and mental health index. Unfortunately, few data exist on international measurements of the vitality index but the Maltese mean mental health index was 70, which compares very well to the rest of Europe with the highest recorded mean mental health index (also 70) being in Norway. Even though such a scale needs to be interpreted with caution as replies to such subjective questions may suffer from a cultural bias, this score certainly ranks Malta very well within Europe. In addition, just under 80% of the population judged their health to be good or very good.

Nevertheless, there is also a substantial proportion of our population which is facing difficulties. Around 35% of the population reports living with a chronic health condition lasting at least six months.

This report particularly focuses on two common mental health conditions – chronic depression and anxiety. 8% of the respondents report having suffered from chronic anxiety, followed closely by 7% having suffered from chronic depression.

Both the above scores and prevalence rates are also related to a number of socioeconomic factors, such as age, gender, and widowhood. Lower education and income and unemployment also increase the risk for such conditions.

The findings from this report are important in the formulation of mental health policy and planning of mental health services in Malta. Particular focus should be placed on sectors of the population that may require more care.

Dr. Neville Calleja
Director
Department of Health Information and Research

Dr. Natasha Azzopardi Muscat
Director General
Strategy and Sustainability Division
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The Department of Health Information and Research wishes to take this opportunity to thank all survey respondents as well as Informa, the market research company which was contracted to conduct the fieldwork, for their contribution towards the success of this exercise.

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Thanks also go to our sponsors for the support and gifts they have offered to aid in the success of this survey. These included:

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Locally, DHIR is indebted to NSO, particularly to Mr. Silvan Zammit and Mr. Etienne Caruana for carrying out the sampling and, the Directorate-General Strategy and Sustainability, led by Dr. Natasha Azzopardi Muscat, and the Ministry of Social Policy for its continued support for this project.

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This report has been compiled by Dr. Christine Baluci.
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Introduction

Mental health is a complex issue and encompasses emotional, psychological, intellectual, social and spiritual well being. It cannot be defined as simply the absence of mental illness. Mental illnesses or disorders are diagnosable conditions that affect cognitive and emotional functioning and include mood disorders (e.g. depression), anxiety disorders (e.g. agoraphobia), and psychotic disorders (e.g. schizophrenia). Mental health problems, on the other hand, denote short and longer term emotional and psychological difficulties, which cause distress and interfere with how people go about their everyday lives\(^1\).

Mental health problems are common. The World Health Organisation has predicted that, in high income countries, mental disorders will continue to account for about a third of the disease burden associated with non-communicable diseases\(^2\). Although different studies suggest different rates, one recent European study suggested that around 11% per cent of the population experience mental disorders every year\(^3\). About 6% of another study population was deemed as needing mental health care although 48% of these reported no formal health care use\(^3\). It is estimated that mental ill health costs developed countries 3-4% of GDP per annum\(^4\). These costs include direct costs of treatment and medication and welfare services (such as disability benefits, etc). Other costs include opportunity costs of income foregone due to incapacity and costs to those who are not directly affected (such as caregivers). Mental health problems also impose a heavy burden in terms of social exclusion, stigmatisation, and economic costs for people with mental health difficulties and their families. Mental health status is also considered an important determinant of health inequalities.\(^5\)

Measuring mental health in the community through household surveys is a complex task as mental disorders are usually determined through detailed clinical assessment. However, several questions within the HIS (Health Interview Survey) lend themselves to a general assessment of mental well-being of a population. Some questions have been recommended by the European Community Health Indicators Monitoring (ECHIM) project for use in the European Community Health Indicators (ECHI) system\(^6\). This report therefore attempts to give an indication of mental well-being based on relevant HIS 2008 data.

The 2008 Health Interview Survey (HIS) was conducted from June to August 2008 with a representative sample taken from the National Statistics Office (NSO) population register of Malta. The survey population was a weighted stratified sample based on the age, gender and locality of address. This survey was carried out through face-to-face interviews by specially trained interviewers with the more sensitive questions being administered as a self-completed questionnaire returned in a sealed

\(^1\) http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/background_paper_en.pdf

\(^6\) Kilpeläinen K, Aromaa A and the ECHIM Core Group (Editors). European Health Indicators: Development and Implementation (Final report of the ECHIM Project. Helsinki 2008
envelope to the interviewer following the face-to-face session. The study population consisted of 5500 Maltese persons aged 15 years and over. The response rate was 72%.

**Overview**

The following report attempts to describe the survey population’s:

- psychological well-being (including vitality and mental health indices)
- health status (including self-perceived health and limitations of activity);
- lifetime and 12-month prevalence of selected mental disorders (chronic anxiety, chronic depression, anorexia and bulimia nervosa, other mental health problems, and substance abuse);
- use of selected medical services and prescribed medicines (use of psychologist and/or psychotherapist in previous 12 months and use of prescribed medicines in previous 2 weeks);
- selected demographic, socio-economic and physical characteristics for some of the above outcomes.

A summary of the findings from the survey are presented in this report through text, diagrams and tables.
Psychological well-being

This section aims to give a picture of mental health in its broadest sense to include mental and emotional well-being. Nine statements on self-perceived physical and emotional states were presented to the respondents. Four statements covered positive feelings and five dealt with negative feelings. Positive feelings include feeling full of life, calm and peaceful, having lots of energy, and being happy. Statements related to negative feelings elicited states of being very nervous, feeling so down in the dumps that nothing can cheer you up, feeling downhearted and depressed, feeling worn out and feeling tired. These were scored on a five-point scale of “all of the time”; “most of the time”; “some of the time”; “a little of the time” and “none of the time”. The recall period of this question was of 4 weeks giving an indication of recent health. These questions explore emotional and vitality dimensions which are closely inter-related with mental well-being and to a wider extent, general health.

The measurement of emotions is, by its very nature, subjective. Differentiation between ‘some of the time’ and ‘a little of the time’ in this 5 point scale may be problematic. Respondents may feel that they related to the same frequency of occurrence within the previous four weeks. Another issue affecting responses may be that of wanting to give socially desirable answers to these questions.

During the 4 weeks preceding the interview, the majority of respondents experienced positive feelings. 64.2% felt full of life all the time or most of the time, 57.5% had a lot of energy, 73.4% reported they were happy and 64.6% felt calm and peaceful. The EU averages for these results are 64%, 55%, 65%, and 63% respectively. So it appears that Maltese respondents are at the same level or slightly better than the EU average.

60% of respondents felt tired some of the time while 11.5% felt tired all the time or most of the time in the previous 4 weeks. 17.6% reported being nervous all the time or most of the time. 42.5% have not felt nervous at all or only a little of the time. 5.6% felt depressed all the time or most of the time (Table 1). EU average rates for these feeling are 18% feeling tired all the time or most of the time, and 8% have felt depressed all or most of the time.

Vitality index

The extent of psychological well-being and positive mental health can be assessed by the individual’s perceived levels of energy and vitality. The vitality index is a summary measure for feeling energetic and full of life versus feeling tired and worn out as elicited by four of the questions discussed above – in the past 4 weeks, did you feel full of life?, did you have lots of energy?, did you feel worn out?, did you feel tired?. The score has a scale of 0 to 100, a high score indicating better vitality and mental health.

The mean vitality score for the survey population was 66. In 2002, the mean vitality score was 67. Males have a higher mean vitality index then females, at 69 and 63 respectively (Fig 1). In general, vitality decreases with age from a mean of 72 in the youngest age group to 55 in the oldest age group (Fig 2). There is a 10 point difference in vitality scores between the

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7 Special Euro barometer-Mental Well-being, EC May 2006
8 Nosikov, A & Gudex, C (2003), EUROHIS, Developing common instruments for health surveys, WHO
highest and lowest income groups with a score of 60 for persons earning <= 579 Euro and 70 for those earning >=1979 Euro (Fig 3). Vitality increases with increasing educational levels achieved although the difference is minimal within the post-secondary and tertiary levels of education (Fig 4). This trend may be confounded by age as those claiming a lower level of completed education tend to be within the older age groups. Average vitality index scores by BMI group, employment status and marital status can be found in figure 5, figure 6 and figure 7.

Mental health index

The mental health index aims to score the general mental health of the individual by including self-perceived negative feelings of depression and anxiety and general positive affect. This score implies non-specific mental distress with no attempt at diagnosing or measuring existing mental illness.

Respondents were asked questions about their feelings in the 4 weeks prior to the interview. These questions assessed both positive and negative emotions such as feeling nervous, downhearted, depressed, happy, peaceful and calm. Responses for these questions were used to compute a score on a 1 to 100 point scale, a higher mental health index indicating a better mental health state.

The mean mental health index of the survey population is 70 this shows no change from 2002. When compared to OECD (Organization for Economic Co-operation and Development) countries, Malta scores top along with Norway for the average mental health index in the population (Fig 8). OECD is an international body of major countries including many EU countries working together to foster economic growth and security and fight poverty. Malta is not a member of OECD however certain indictors in this report are comparable to their data. Unfortunately EUROSTAT presently does not have data on mental health that can be compared between EU member states.

Males have a higher mental health score (Fig 1). Mental health index decreases with age from a maximum of 73 points between the ages of 15 and 34 to a minimum of 67 in those over 75 years (Fig 2). Those earning <= 579 Euro per month have a mental health score of 63 while for those earning >=1979 Euro, the score is 73 (Fig 3). A marked increase in mental health score can be seen with increasing educational level from 66 in respondents having primary level education to 74.6 points in those with tertiary education (Fig 4). Average mental health index scores by, BMI group, employment status and marital status can be found in figure 5, figure 6 and figure 7.

9 Society at a glance, 2009, OECD
The majority of respondents experienced positive feelings during the 4 weeks prior to the interview.

- 64% felt full of life, calm and peaceful while more than 73% felt happy all or most of the time.
- About 18% felt very nervous while 6% felt depressed and more than 11% felt tired all or most of the time.
- The vitality and mental health indices are summary scores using the measures mentioned above and give an overall rating of mental well-being and vitality.
- These scores were significantly affected by gender, age, employment status, education and income.
- The mean vitality index for the population was 66.
- The mean mental health index was 70. Comparatively this score ranks Malta top alongside Norway when compared to OECD member countries.
Health determinants

Self-perceived health

Self-perceived health is a subjective assessment made by an individual about his/her own health. The related question, “How is your health in general?” encompasses several health dimensions, including physical, social and emotional well-being. It is influenced by the presence or absence of symptoms or complaints especially if these symptoms have been diagnosed as a possible disease.

The overall the survey population assessed their health as being good or very good (78%). In 2002, the proportion of respondents reporting good health was 69% (17% very good, 52% good). The EU-25 average for 2006 was 65%. Males score better on self-perceived health (Table 2). The proportion of respondents reporting their health as being very good or good decreases with age. The proportion of 15-24 year olds reporting their health as being very good and good is 96% while in respondents over the age of 75 years, the percentage is 40%, out of which only 3% report very good health (Table 2).

Self-reported chronic morbidity

Self-reported chronic morbidity takes into account longstanding illnesses and health problems as reported by the respondents. The question defines chronic morbidity as illnesses or health problems which have lasted or are expected to last for 6 months or more. This indicator measures if respondents have a condition, irrespective of whether they have symptoms or limitations due to the condition. It also includes conditions which have not been diagnosed by a doctor.

The overall proportion of respondents who reported having a chronic condition is 35%, being slightly more in females than males (38% and 32% respectively). As expected, the proportion increases significantly along the age categories from 15% in the youngest age group to 68% in the oldest (Fig 9). In 2002, 25% of respondents reported having a long-standing illness or health problem. The EU-25 average for self-reported chronic morbidity as derived from the Indicators from the Statistics on Income and Living Conditions Surveys (EU-SILC) for 2006 is 34.8%.

✔ Self-perceived health is an assessment made by an individual about his/her own health.
✔ 78% judged their health to be good or very good.
✔ Self-reported chronic morbidity includes self-reported illness or health problems which have lasted or are expected to last for 6 months or more.
✔ 35% reported having a health problem.

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Prevalence of mental disorders

Respondents were asked about their lifetime experiences of chronic anxiety, depression, anorexia/bulimia nervosa and “other mental health problems” within a long list of other chronic disorders. This question intends to ask about chronic ill-health rather than temporary, minor health problems. The first question in this series asked respondents if they had ever in their lifetime had a health problem from a list of conditions (lifetime prevalence). Respondents who replied in the affirmative were then asked whether the reported health problem had been present in the previous twelve months (12-month prevalence) and whether the particular chronic condition was diagnosis by a physician. Though respondents were asked whether their condition was diagnosed by a physician, standard indicators focus on self-reported prevalence rates and therefore this data will be the focus of analysis.

This series of questions may be confounded by the fact that some of the listed health problems could be interpreted as being both medical conditions and symptoms of other medical conditions or emotional-states.

Of the survey population, 15% reported having had a lifetime mental disorder, i.e. a mental disorder at some point in their life. This number includes respondents who may have experienced more than one of the conditions listed e.g. depression and anxiety at a point in their lifetime. Compared to OECD member countries Malta has one of the lowest self-reported lifetime and 12 month prevalence rates of total mental health disorders (Fig 10).12

Chronic anxiety

Anxiety disorders generally involve feelings of tension, distress or nervousness and the term may include panic disorder, agoraphobia, social phobia, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

7.8% respondents reported suffering from chronic anxiety at some point in their lifetime. This percentage was 10.2% in 2002. Of these, 80.4% reported having symptoms in the previous 12 months and 73.9% had this condition diagnosed by a medical doctor. 42.7% reported having been prescribed medicines for tension or anxiety in the previous 2 weeks. Compared to 11 OECD member countries Malta is 5th for 12-month self-reported prevalence rate of chronic anxiety with Japan, the country with the lowest rate having a prevalence rate that is 1% lower (Fig 11).12

Women are significantly more likely than men within all age groups to report chronic anxiety (12.2% compared with 9.7%). Chronic anxiety increases with age, being most frequent in the over 75s (14.1%). It reaches a maximum of 16.9% in females older than 75 years, while in males, this condition increases with age to a maximum of 10% at the 55 to 64 year age group (Fig 12).

Chronic depression

Depression is characterized by mood disturbance and can be a serious medical illness. Unlike normal emotional experiences of sadness, loss, or passing mood states, major depression is a mental disorder characterized by persistent depression of mood, sleep and appetite disturbance, feelings of worthlessness, guilt and hopelessness, and can significantly interfere with an individual’s behaviour, activity, and physical health. Depression tends to be recurrent and the onset of individual episodes can be related to stressful events or situations.

Of the study population, 6.6% reported a lifetime experience of chronic depression.

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12 Society at a glance, 2009, OECD
Women experienced a higher rate of chronic depression than men (7.7% and 5.4% respectively). These figures remained relatively unchanged from 2002. 77.6% of those experiencing chronic depression at any point in their lifetime reported symptoms within the previous 12 months and 91.6% were diagnosed with chronic depression by a medical doctor. 74.5% of those reporting having a lifetime experience of chronic depression were prescribed anti-depressive medicine in the previous 2 weeks while 34% of these were prescribed medicines for tension or anxiety.

Reported lifetime depression is low in the younger age groups, rising to 7.2% in females over 35 years and increasing to a maximum of 13% in the 65-74 year age group. In males, the proportion of respondents with chronic depression is less than 4% until the age of 45 after which the rate increases to a maximum of 10.6% in the 55 - 64 year age group (Fig 13).

**Anorexia and bulimia nervosa**

Only 3 respondents reported having a lifetime experience of anorexia and/or bulimia nervosa. All were female. 2 were between 15 – 24 years of age, while 1 was between 65 – 74 years. One respondent only reported having symptoms during the past year and having the condition diagnosed by a doctor. The 2002 HIS survey reported that 0.8% (n=35) suffered from anorexia and/or bulimia in their lifetime (1.1% females and 0.6% males).

**Other mental health problems**

Only 47 respondents reported having a lifetime experience of other mental disorders, giving a total of 1.3% rate in the general population. There are no significant differences with gender and age. This question probably captures those mental disorders with an early onset and/or genetic predisposition. There is a peak of 9% in females over 75 years while the peak in males occurs between the ages of 65-74 years (Fig 14). These peaks might reflect old age dementia or Alzheimer’s disease however one must appreciate that there may be lower response rates amongst those with dementia or Alzheimer’s disease because of the debilitating nature of these diseases and lack of self-awareness. It is difficult to assess the rate of such conditions within the population through self-reported questionnaires.

**Population characteristics**

Mental health and mental illnesses are determined by multiple and interacting individual, social, psychological, and biological factors, including economic disadvantage, poor housing, and lack of social support (WHO, 2005). Conversely, the presence of a mental health problem may have an impact on a person's employment, housing, social support, etc.

Overall, women experienced higher rates of lifetime experience of the selected mental disorders than men. 9.7% women reported having chronic anxiety as compared to 5.6% males, while the percentages for chronic depression are 7.7% for females and 5.4% for males (Fig15).

The lifetime prevalence of chronic anxiety and chronic depression increases across the age groups, up till the ages of 55 to 64 years. Chronic anxiety peaks again in the over 75 year age group (14% within this age group). Other mental disorders are mostly constant along age groups but peaks at the over 75 year age group (6.3%, n=18, 12 of which were reported by proxy and not self). Among all age groups, chronic anxiety had the highest prevalence, except in the 55 to 64 age group which has the highest rate for chronic depression (Fig 16).
Marital status has been shown to be related to a person's physical and mental health. In this survey, widowed respondents (followed by those who are divorced or separated) are more likely than single or married respondent to have had chronic anxiety or depression (Fig 17). This trend is significant for males and females with chronic anxiety and for females with chronic depression where the same patterns are visible.

In this survey, respondents claiming a primary educational level are twice as likely to report having had chronic anxiety and nine times more likely of having had chronic depression during their lifetime than those of higher educational levels (Fig 18).

Adverse health effects of unemployment include increased incidence of depression and anxiety\(^\text{13}\). On the other hand, people who have mental illness may also be more likely to fall into economic disadvantage. Respondents who are gainfully employed are less likely to report chronic anxiety or depression than those who are unemployed, retired or fulfil domestic tasks (Fig 19). No correlations were found with the type of employment (employee, self-employed, full time or part time) and occupation. The lifetime prevalence of these mental disorders increases with decreasing household monthly income. Those with lowest income are 3 times more likely to report chronic anxiety and depression then those within the highest income groups (Fig 20).

Social relationships and networks can act as protective factors against the onset or recurrence of mental illness and enhance recovery from mental disorders (WHO, 2005). The HIS 2008 included a question on the number of people (friends, family or other) who are close to the individual and can be counted upon when having a serious personal problem. Respondents who had a number of people to rely on were less likely to have a lifetime experience of mental disorder then those who had none. The relationship is only statistically significant for chronic depression (Fig 21). No significant relationship was found between these mental disorders and the actual number of persons living in the household.

9.2% respondents living in urban areas report having suffered from chronic anxiety at some point in their lives as opposed to 6.6% living in sub-urban or rural areas. There is no statistically significant difference for chronic depression. 11% of respondents claiming severe exposure to noise and air pollution reported a lifetime experience of chronic anxiety.

### Substance use disorders

Substance use disorders include the harmful use and/or dependence on alcohol and drugs (WHO, ICD-10). A question was also included in the HIS on the misuse of prescribed medicines, mainly tranquilisers or sedatives used without a doctor’s prescription.

Alcohol use was the most prevalent substance use. In the previous 12 months, approximately 10% of respondents (16% males, 6% females) consumed an alcoholic drink more than 4 times a week. 3.2% of those consuming alcohol (4.3% males, 1.6% females) reported drinking alcohol alone every day of the week before the interview.

Only 1.5% of respondents made use of tranquilisers and/or sedatives without a doctor’s prescription compared to 18% having such medications prescribed to them. About 5% tried cannabis (0.6% within the previous month, 1.2% within the past year but not within past month, and 3% previously but not within the previous year). This makes cannabis use the most common reported illicit

\(^\text{13}\) The World Health Report 2008 - Primary Health Care – Now More Than Ever
(http://www.who.int/whr/2008/whr08_en.pdf)
substance used by the survey respondents. There is a statistically significant difference in use by gender, males using this substance more than females. Approximately 11% were between 15 to 24 years of age at first time use of cannabis. Around 1% reported having consumed ecstasy and/or cocaine at some point during their lifetime with up to 3% using it for the first time between the ages of 15 and 24 years. The use of all these substances is commonest in the younger age groups.

Opiate use (heroin) is reported to be the most frequently used illicit substance in Europe. Annual estimates of the prevalence of opiate use in Europe compiled by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) consistently see Malta ranking top along with Italy and Austria. In 2008 it is estimated that for every 1000 persons in Malta aged 15 to 64 there are 5 people who have a heroin problem (Fig22)\textsuperscript{14}.

\textsuperscript{14} Annual report 2008: The state of the drugs problem in Europe, EMCDDA, 2008
The lifetime prevalence of any mental disorder was 15%.
The lifetime prevalence of chronic anxiety was 7.8%
The lifetime prevalence of chronic depression was 6.6%
Prevalence rates of chronic anxiety and depression are influenced by age, gender and other socio-economic factors.
Widowed respondents were more likely than single or married respondents to report chronic anxiety or depression.
Those with a primary education level are twice as likely to report having had chronic anxiety and nine times more likely of having had chronic depression during their lifetime than those with a tertiary level of education.
Those within the lowest income group are 3 times more likely to report chronic anxiety and depression than those within higher income groups.
18% used sedatives/tranquilizers which were prescribed by their doctor at some point in their lifetime.
About 5% of the survey population reported having tried cannabis at some point in their lifetime.
It is difficult to assess the prevalence of eating disorders due to the low number of reported cases within the population probably brought on by lack of insight about their condition.
Use of selected health care services and prescribed medicines

The question “in the past 12 months, have you used the services of one of the following on your behalf - (psychologist or psychotherapist)” is part of the health care use module and aimed at all respondents irrespective of whether they reported chronic disease. 2.5% of respondents (i.e. independent on whether there is a history of mental disorders) used the services of a psychologist and/or psychotherapist. There is no significant difference between male and female use and no visible trends with age.

The question on the prescribed use of medicines included the use of medicines for depression, tension or anxiety and sleeping pills in the 2 weeks prior to the survey. This question was posed to respondents irrespective of their experience of medical (and mental) conditions.

5% of respondents claim to be using medicines for depression prescribed by a doctor. Distinction between short-term and long-term use of this medication cannot be made. Overall females consume more anti-depressives than males.

Males only surpass females in consumption within the 25 to 34 age group. Rate of consumption increases with age for both males and females with a peak of 8.8% for males aged between 55 and 64 and 10.9% of females aged 65 to 74.

Prescribed medicines for tension or anxiety are used by 5% of respondents. Males make use of these medicines more than females in the 55 to 64 age groups possibly indicating anxiety on leaving the workforce (Table 3).

Approximately 4% of the survey population uses sleeping pills with a doctor’s prescription. This proportion rises to 11% and 16% in females within the 65 to 74 and 75+ age groups while in males it is highest in the over 75s at nearly 10%.

- 2.5% of respondents used the services of a psychologist or psychotherapist irrespective of whether they had a reported history of mental health problems.
- 5% of respondents reported consuming medication for depression prescribed by a doctor.
- Also 5% of respondents reported consuming medication for anxiety prescribed by a doctor.
- Females overall consume more anti-depressive and anxiety medication than males.
- Approximately 4% reported using sleeping pills. This rate rises considerably with age especially amongst women.
Conclusion

This report attempts to describe the state of mental health and wellbeing of the Maltese population by examining outcomes to specific questions which have been included in the HIS 2008, an epidemiological tool for the collection of information on the health status and factors affecting health in a population. The proportion of population reporting having chronic depression in the previous 12 months, vitality and mental health indices and self reported health, chronic morbidity and limitations in daily activity have been recommended for use by the ECHI and are included in this report.

From this self-reported general health survey, only limited information can be gathered about the prevalence of major mental disorders especially conditions such as dementia due to the patients lack of insight. The latter will become increasingly prevalent in an ageing population. Other unexplored concerns include use of essential health care services and their costs such as management at community, outpatient and inpatient levels, other societal and personal costs.

Throughout the report, significant differences in several outcomes have been found for age and gender. Although differences in mental wellbeing have also been found within education, income and employment categories, these may have been confounded by age factors – the older age groups in the survey population are more likely to have a lower educational level, not presently working for profit (i.e. are pensioners) and have a lower reported monthly income. Cultural factors in perceiving and expressing mental health and emotional issues are also important when interpreting such results especially when comparing to other countries.
Figures and tables

Figure 1: Mean vitality index and mental health index scores by gender

Figure 2: Mean vitality index and mental health index scores by age
Figure 3: Mean vitality index and mental health index scores by income

Figure 4: Mean vitality index and mental health index score by education
Figure 5: Mean vitality index and mental health index scores by BMI group

Figure 6: Mean vitality index and mental health index scores by employment status
Figure 7: Mean vitality index and mental health index scores by marital status

Figure 8: Mean mental health index score for Malta when compared to OECD member countries.
Figure 9: Self-reported chronic morbidity by age

Figure 10: Lifetime and 12 month prevalence rates of mental disorders for Malta compared to OECD member countries
Figure 11: 12 month prevalence rate of chronic anxiety for Malta compared to OECD member countries

Figure 12: Lifetime prevalence rate of chronic anxiety by age and gender
Figure 13: Lifetime prevalence rate of chronic depression by age and gender

Figure 14: Lifetime prevalence rate of other mental disorders by age and gender
Figure 15: Lifetime experience of selected mental disorders by gender

Figure 16: Lifetime experience of selected mental disorders by age
Figure 17: Lifetime experience of chronic anxiety and depression by marital status

Figure 18: Lifetime experience of chronic anxiety and depression by education
Figure 19: Lifetime experience of chronic anxiety and depression by employment status

Figure 20: Lifetime experience of chronic anxiety and depression by income
Figure 21: Lifetime experience of chronic anxiety and depression by number of individuals living within household

Figure 22: Estimates of the annual prevalence of problem opiate (heroin) use, cases per 1,000 population aged 15 – 64 (Source: EMCDDA Annual report 2008)
Table 1: Response rates for measures relating to psychological well-being in the 4 weeks prior to interview

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel full of life?</td>
<td>20.6</td>
<td>43.6</td>
<td>24.7</td>
<td>9.2</td>
<td>1.7</td>
<td>0.3</td>
</tr>
<tr>
<td>Have you been very nervous?</td>
<td>5.0</td>
<td>12.6</td>
<td>39.6</td>
<td>27.3</td>
<td>15.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Have you felt so down that nothing could cheer you up?</td>
<td>1.5</td>
<td>4.7</td>
<td>21.9</td>
<td>32.5</td>
<td>39</td>
<td>0.4</td>
</tr>
<tr>
<td>Have you felt calm &amp; peaceful?</td>
<td>23.4</td>
<td>41.2</td>
<td>25.2</td>
<td>8.0</td>
<td>1.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Did you have lots of energy?</td>
<td>18.8</td>
<td>38.7</td>
<td>29.0</td>
<td>11.0</td>
<td>2.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Have you felt depressed?</td>
<td>1.4</td>
<td>4.2</td>
<td>26.9</td>
<td>32.7</td>
<td>34.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Did you feel worn out?</td>
<td>1.1</td>
<td>3.9</td>
<td>27.9</td>
<td>25.2</td>
<td>41.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Have you been happy?</td>
<td>25.7</td>
<td>47.7</td>
<td>21</td>
<td>4.4</td>
<td>0.9</td>
<td>0.2</td>
</tr>
<tr>
<td>Did you feel tired?</td>
<td>2.8</td>
<td>8.7</td>
<td>60</td>
<td>21.9</td>
<td>6.4</td>
<td>0.2</td>
</tr>
</tbody>
</table>
Table 2: Self-perceived health by gender and age

<table>
<thead>
<tr>
<th>GENDER</th>
<th>AGE CATEGORIES</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>Total</td>
<td>25.5%</td>
<td>27.9%</td>
<td>23.5%</td>
<td>53.4%</td>
<td>38.1%</td>
<td>31.8%</td>
<td>18.7%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>53.4%</td>
<td>38.1%</td>
<td>31.8%</td>
<td>18.7%</td>
<td>13.1%</td>
<td>7.3%</td>
<td>3.1%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>25.5%</td>
<td>27.9%</td>
<td>23.5%</td>
<td>53.4%</td>
<td>38.1%</td>
<td>31.8%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Good</td>
<td>Total</td>
<td>52.9%</td>
<td>53.8%</td>
<td>52.1%</td>
<td>43.0%</td>
<td>57.6%</td>
<td>58.0%</td>
<td>57.4%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>52.9%</td>
<td>53.8%</td>
<td>52.1%</td>
<td>43.0%</td>
<td>57.6%</td>
<td>58.0%</td>
<td>57.4%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>52.9%</td>
<td>53.8%</td>
<td>52.1%</td>
<td>43.0%</td>
<td>57.6%</td>
<td>58.0%</td>
<td>57.4%</td>
</tr>
<tr>
<td>Fair</td>
<td>Total</td>
<td>18.8%</td>
<td>15.8%</td>
<td>21.4%</td>
<td>3.1%</td>
<td>3.6%</td>
<td>10.1%</td>
<td>21.0%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>18.8%</td>
<td>15.8%</td>
<td>21.4%</td>
<td>3.1%</td>
<td>3.6%</td>
<td>10.1%</td>
<td>21.0%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18.8%</td>
<td>15.8%</td>
<td>21.4%</td>
<td>3.1%</td>
<td>3.6%</td>
<td>10.1%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Bad</td>
<td>Total</td>
<td>2.1%</td>
<td>1.8%</td>
<td>2.3%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.2%</td>
<td>2.3%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>2.1%</td>
<td>1.8%</td>
<td>2.3%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.2%</td>
<td>2.3%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2.1%</td>
<td>1.8%</td>
<td>2.3%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.2%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Very bad</td>
<td>Total</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.6%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.6%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

Table 3: Consumption of prescribed medication for depression and anxiety by age and gender

<table>
<thead>
<tr>
<th>Age categories</th>
<th>15 - 24</th>
<th>25 - 34</th>
<th>35 - 44</th>
<th>45 - 54</th>
<th>55 - 64</th>
<th>65 - 74</th>
<th>75+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed medicines for depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.4%</td>
<td>2.8%</td>
<td>1.7%</td>
<td>5.8%</td>
<td>8.8%</td>
<td>5.6%</td>
<td>6.8%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Female</td>
<td>1.4%</td>
<td>1.3%</td>
<td>4.4%</td>
<td>7.5%</td>
<td>8.6%</td>
<td>10.9%</td>
<td>9.4%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Prescribed medicines for anxiety/tension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.4%</td>
<td>0.8%</td>
<td>1.3%</td>
<td>4.5%</td>
<td>7.1%</td>
<td>2.8%</td>
<td>8.5%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Female</td>
<td>1.4%</td>
<td>3.3%</td>
<td>4.4%</td>
<td>5.6%</td>
<td>4.9%</td>
<td>9.4%</td>
<td>11.1%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>