



Women's
Mental Health
Australia



Beyond the Surface 2026: Investigating the *Mental Health* *Realities* for Australian Women

PROUDLY FUNDED AND PRODUCED BY WOMEN'S MENTAL HEALTH AUSTRALIA



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About Women's Mental Health Australia

Women's Mental Health Australia is the nation's leading organisation dedicated to improving mental health outcomes for women across the lifespan. We work to ensure gender is recognised as a critical factor in mental health by advancing research, advocating for evidence-informed policy and reform, delivering education and resources, and investing in innovative community initiatives. By partnering with government, health professionals, researchers, community organisations and people with lived experience, we are driving meaningful change; where every woman, at every stage of life, is seen, heard and supported.

This research was conducted by Women's Mental Health Australia with approval from the UNSW Human Research Ethics Committee (IRECS10209).

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Executive Summary

In 2026, 1 in 2 Australian women continue to experience mental health issues, with almost 1 in 4 experiencing severe psychological distress. Despite growing awareness and more women reaching out for support, the overall burden of women's mental ill-health remains persistently high.

Depression remains the most commonly reported mental health issue, affecting 1 in 3 women (31%), followed by anxiety or Generalised Anxiety Disorder and body image issues, both affecting approximately 1 in 5 women. Insomnia or other sleep-wake disorders affect around 1 in 6 women (16%), while Illness Anxiety Disorder or Health Anxiety affects around 1 in 9 women (11%).

Some women continue to carry a far greater mental health burden than others. Women experiencing poverty or homelessness recorded psychological distress within the severe range of the K10 scale, with almost 3 in 5 (59%) likely to be experiencing severe mental health issues. More than 2 in 5 LGBTQIA+ women (42%) and 2 in 5 women living with disability (42%) were also likely to be experiencing severe mental health issues. These findings reinforce that women's mental health cannot be separated from the broader social, economic and health inequalities shaping their lives.

One of the strongest findings continues to be the connection between women's physical and mental health. Women living with female-specific physical health conditions experience significantly greater psychological distress than women without physical health conditions, and greater distress than women with physical conditions affecting both sexes. The burden is particularly pronounced for women experiencing endometriosis, pregnancy loss, physical birth trauma, polyendocrine metabolic ovarian syndrome (PMOS), vaginal conditions and pelvic floor disorders. The findings paint a very clear picture that women's physical and mental healthcare needs to be considered alongside each other.

The research also demonstrates why sex and gender matter in mental healthcare. Hormonal changes across the menstrual cycle, pregnancy, postnatal period and menopause transition can

influence mental wellbeing for some women, yet female-specific mental health conditions remain under-recognised. Around 1 in 33 women (3%) experience Premenstrual Dysphoric Disorder (PMDD), increasing in prevalence to around 1 in 20 women aged 25–44 (5%). Perimenopausal anxiety and depression was discovered to affect 1 in 2 women currently experiencing perimenopause (49%). Women continue to report misunderstanding, dismissal and a lack of tailored support for these experiences.

Mental health outcomes are shaped by the pressures women carry every day. Around 1 in 3 (34%) women with mental health issues identify financial stress as a trigger, with the same proportion identifying low self-esteem or confidence (34%). Almost 1 in 3 (32%) identify sleep deprivation, while almost 3 in 10 (29%) point to the pressure they place on themselves. Aging, societal expectations, work-life balance, lack of support, physical illness and chronic pain also contribute, alongside gendered experiences including domestic and sexual violence, financial dependency, caring responsibilities, single parenting and discrimination.

There are encouraging signs in help-seeking. In 2026, 2 in 3 (66%) women experiencing mental health issues sought help, up from 57% in 2025. But reaching out does not guarantee effective support. Almost 1 in 3 (31%) women identify financial cost as a barrier, while others face long wait lists, difficulty finding appropriate services, lack of time, embarrassment and fear of judgement. Among women who sought help but did not find it useful, almost 1 in 4 (23%) said there were not enough tailored support services specifically for women – revealing the critical challenge facing the Australian health system.

The 2026 findings strengthen the case for a gender-responsive approach to mental health care. Women need integrated physical and psychological healthcare, greater recognition of female-specific mental health conditions, targeted support through key life stages, equitable access regardless of location or circumstance, and affordable care from professionals who understand the realities women face.

Acknowledgements

Acknowledgement of Lived Experience

We would like to acknowledge and express our gratitude to the individual women with lived or living experience of a mental health condition, their carers, families and loved ones, who generously shared their experiences and perspectives which informed and shaped this research. Their insights gathered in this report, remain essential to improving Australian women's mental health policy and practice.

Collaborator Acknowledgements

We would like to acknowledge the valuable contributions of the below collaborators who have been integral in bringing this report to life:

Dr Jodie Pestana, PhD

Dr Jodie Pestana is a neuroscientist and experienced women's mental health researcher. Completing her PhD in 2023, Jodie is currently a postdoctoral researcher in the School of Psychology at UNSW and a proud advocate for women's mental health; delivering award-winning talks and eagerly sharing science with the public. Driven by her passion for women's health, Jodie's research investigates how female-specific experiences,

such as hormonal fluctuations during pregnancy and the menstrual cycle, influence the brain's ability to regulate mental health and respond to treatments. She aims to produce research that creates the foundations for more evidence-based and tailored treatments for women with mental health conditions.

Women's Mental Health Australia is grateful for Jodie's expertise, analysis, and dedication in co-authoring and producing this year's report.

Professor Bronwyn Graham, PhD; M.Clin.Psychology

Bronwyn Graham is the Director of the Centre for Sex and Gender Equity in Health and Medicine at The George Institute for Global Health, and a Professor in the School of Psychology at UNSW Sydney.

Bronwyn is a globally recognised expert in women's mental health. At UNSW, Bronwyn leads an interdisciplinary research team that examines how female-unique factors, like the menstrual cycle and pregnancy, impact the development, trajectory, and treatment of mental illness in women. Bronwyn is a staunch advocate for sex- and gender-centred healthcare, and the Centre for Sex and Gender Equity in Health and Medicine is driving sex and gender integration in Australian health and Medicare research, policy, and healthcare delivery.

Women's Mental Health Australia is grateful for Bronwyn's time, expertise, collaboration and dedication in co-authoring this year's report.

Katrina Locandro

As the Chief Operating Officer for Women's Mental Health Australia, Katrina plays a pivotal role in leading the organisation towards its goals of advancing Australian women's mental health across the lifespan - through influencing national policy, investing in gender-specific research, and developing evidence-informed programs that address the gaps in Australia's mental health system.

Involved in this research since its inception in 2022; Women's Mental Health Australia is grateful for Katrina's ongoing commitment and dedication to this work.

The Centre for Sex and Gender Equity in Health and Medicine

The Centre for Sex and Gender Equity in Health and Medicine is an initiative of The George Institute for Global Health, the Australian Human Rights Institute at UNSW Sydney, and Deakin University, with support from collaborative partners the Victorian Department of Health, and the Association of Australian Medical Research Institutes.

Nielsen

The extended team.

Hyke Creative

Particular mention to Kamila.



A Note From Women's Mental Health Australia's COO & Co-author



Five years ago, we started this research because there were significant gaps in what we knew about Australian women's mental health. We wanted to listen to women, understand what was really

happening in their lives, and build the evidence needed to do something about it.

This research has become the cornerstone of our work at Women's Mental Health Australia. It gives us an increasingly powerful evidence base to advocate for better policy, influence health reform and challenge a system that still does not adequately recognise the ways sex, gender, biology and women's lived experiences can shape mental health.

For me, one of the most confronting things about this year's findings is how much remains unchanged.

We are talking about mental health more. Women are speaking up and reaching out. Our understanding of women's health has grown enormously. Yet the overall burden of psychological distress among Australian women remains stubbornly high. Too many women are still navigating fragmented systems, struggling to access affordable and appropriate support, or receiving care that considers their mental health in isolation from their physical health and the realities of their lives.

After five years of listening to women, the statistical evidence is telling us where the gaps are. It continues to show us the impact of female-specific health conditions, hormonal and reproductive transitions, financial insecurity, caring responsibilities, violence, discrimination and the many other pressures that can shape women's mental wellbeing. And importantly, it is showing us that a one-size-fits-all approach to mental health will not create equitable outcomes for women.

That is why this research matters so deeply to our organisation. We don't undertake it simply to describe the problem. We undertake it to change what happens next.

We will use these findings to keep pushing for gender-responsive policy, better integration between physical and mental healthcare, more appropriate and accessible support, and greater recognition of women's mental health across government and the broader health system.

Behind every data point in this report is a woman who trusted us with part of her experience. To every woman who contributed, thank you. We take the responsibility that comes with that seriously. Your experiences are not on the pages of this report alone. They inform the decisions, policies and systems that shape the health of the next generation of women.

Katrina Locandro

Chief Operating Officer and Co-author
Women's Mental Health Australia

Our Recommendations

Women's Mental Health Australia is calling on the Australian Government to move towards a mental health system that recognises and responds to the distinct ways sex, gender, biology, life stage and social circumstances shape women's mental health.

The prevalence and severity of psychological distress among Australian women has remained steady and unchanged since this research began in 2022 – with 1 in 2 Australian women experiencing a mental health issue, and 1 in 4 women experiencing

severe mental health issues. Although help-seeking has increased, these persistent outcomes indicate that greater awareness and increased service use alone are not enough. Structural reform is needed to ensure women can access affordable, appropriate and gender-responsive support before their mental health deteriorates further.

Women's Mental Health Australia puts forward the following priority policy reforms. Refer to Appendix C for the detailed Recommendations and Policy Asks.

1. COMMIT TO GENDER-RESPONSIVE MENTAL HEALTHCARE

1.1 Integrate targeted psychological support alongside women's physical healthcare to provide holistic, wrap-around care.

By investing in a national minimum standard requiring all Endometriosis and Pelvic Pain Clinics to assess psychological wellbeing, establish mental health referral pathways and report on access to psychological support as part of the program's existing monitoring and evaluation framework.

1.2 Invest in tailored mental health services for women across key life stages and transitions, including puberty, pregnancy, birth, motherhood, perimenopause and menopause.

By embedding preventative and responsive mental health support across women's healthcare.

1.3 Embed mental health considerations to become a standard component within the design, funding, implementation and evaluation of Australian Government policies and services focused on women's sexual, reproductive and physical health.

Treating psychological wellbeing as an integral component of health.

2. STRENGTHEN TRAINING, EDUCATION AND GENDER-RESPONSIVE CAPABILITY ACROSS THE HEALTH WORKFORCE

2.1 Embed sex- and gender-responsive mental health education within medical, nursing, midwifery and allied health curricula, accreditation standards and continuing professional development.

By building capability across the health workforce to recognise how sex, gender and life stage shape women's mental health and treatment.

2.2 Fund and implement a nationally consistent perinatal mental health screening, referral and follow-up pathway across public and private maternity care systems.

Including training for health professionals so every woman is routinely offered evidence-based mental health and psychosocial assessment during pregnancy and after birth.

2.3 Ensure national clinical guidelines and standards of care for women's health conditions and reproductive life stages integrate associated mental health needs – including assessment, management and referral pathways, supported by appropriate workforce training.

Starting with the new Australian Perimenopause and Menopause Guidelines.

3. IMPROVE THE AFFORDABILITY AND ACCESSIBILITY OF THE SUPPORT WOMEN FIND MOST EFFECTIVE

3.1. Invest in a nationally accessible, fully funded telehealth pathway through Medicare Mental Health, providing continuity of care with professionals trained in sex- and gender-responsive mental healthcare.

3.2 Provide access to up to 20 Medicare-subsidised mental health treatment sessions each year under Better Access for people who require ongoing care.

Where a treating practitioner determines that continued care is clinically required.

3.3 Broaden and better utilise the mental health workforce available to women.

By completing the implementation of the national regulation for counsellors and psychotherapists, exploring Medicare funding pathways for suitably qualified practitioners and improving access to existing Medicare-supported mental health social workers, occupational therapists.



Research Context



Research aims and objectives

The aim of this research was to explore the mental health of Australian women by identifying the most prevalent mental health issues, understanding key triggers for these mental health issues and evaluating help-seeking behaviours and barriers to seeking support. This research also intended to uncover the realities for women dealing with mental health issues at different life stages, from priority and minority population groups and with different physical health experiences.

Women's Mental Health Australia is committed to advancing gender-specific mental

health research to ensure that the design of mental health prevention programs, clinical interventions, and government policies reflect the realities of women's lives.

This research was conducted by Women's Mental Health Australia with approval from the UNSW Human Research Ethics Committee (IRECS10209).

Sample and definitions

A nationally representative sample of Australian women was obtained via an online panel in April 2026 and consisted of n=9,000 participants. A full demographic breakdown can be found at the end of this report (Appendix A).

For the purposes of our research, the term 'woman' or 'girls' refers to and captures the experiences of all those who identify as women; including cis-women, trans-women and gender diverse/fluid individuals. Women are asked to self report their mental health issues. No clinical diagnosis is required. Further definitions can be found in Appendix B.

Methodological refinements for 2026

Some methodological refinements have been introduced in the 2026 report to strengthen the quality, representativeness and ethical integrity of the research. These are outlined at the end of this report (Appendix A).



The State of Mental Wellbeing in Australian Women

Why do we use the K10 to measure mental wellbeing?

The Kessler Psychological Distress Scale (K10) is a trusted scientifically validated questionnaire that provides a reliable measure of psychological distress (Kessler et al., 2003). It asks people about symptoms commonly associated with anxiety and depression experienced over the past four weeks, providing a reliable picture of their current mental wellbeing. It helps identify people who may be experiencing symptoms of anxiety and depression and measures how severe those symptoms are.

Women's Mental Health Australia uses the K10 because it is a reliable way to understand women's mental health, providing meaningful insights into not just whether someone is struggling; but how severely. Because the K10 has been extensively tested and is used widely in Australia and internationally, it allows us to accurately compare results across different groups, and monitor changes over time. This is important when examining the unique pressures many women face, including gendered social, physical and economic stressors.

Using the same validated measure each year also allows us to track changes in women's mental health over time, identify trends across different age groups and communities, and build a strong evidence base to advocate for the support, services and policies women need most.



What do K10 total scores mean?



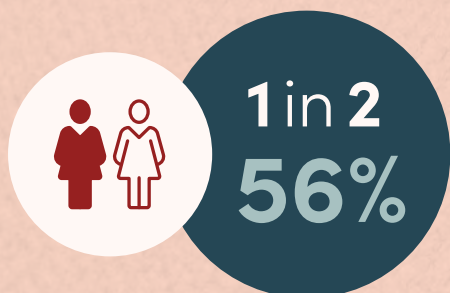
The total scores of the K10 are grouped into the following four levels of psychological distress (Kessler et al., 2003).

K10 score: Likelihood of having a mental disorder	
10 – 19	Likely to be well
20 – 24	Likely to have a mild disorder
25 – 29	Likely to have a moderate disorder
30 – 50	Likely to have a severe disorder

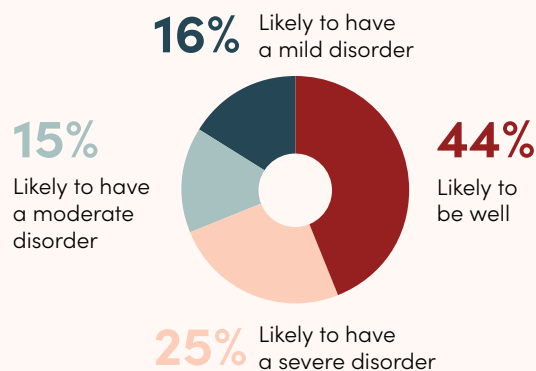
While the K10 does not provide a clinical diagnosis of mental health issues (like anxiety or depression), it is one of the strongest indicators of current psychological distress and future mental health risk. Women experiencing moderate or severe levels of distress are more likely to require mental health assessment, treatment and ongoing support. Monitoring psychological distress at a population level therefore provides an important early warning system, helping identify where investment, prevention and targeted intervention are most needed before mental health deteriorates further.



Levels of psychological distress in the general female population



1 in 2 (56%) Australian women are continuing to experience mental health issues in 2026, with a quarter of them struggling with severe mental health issues.



The prevalence and severity of mental health issues experienced by Australian women has been relatively stable since 2022.

This year, the average K10 total score across all women in this study was 22.8 (mild psychological distress).

Levels of psychological distress in the priority female populations

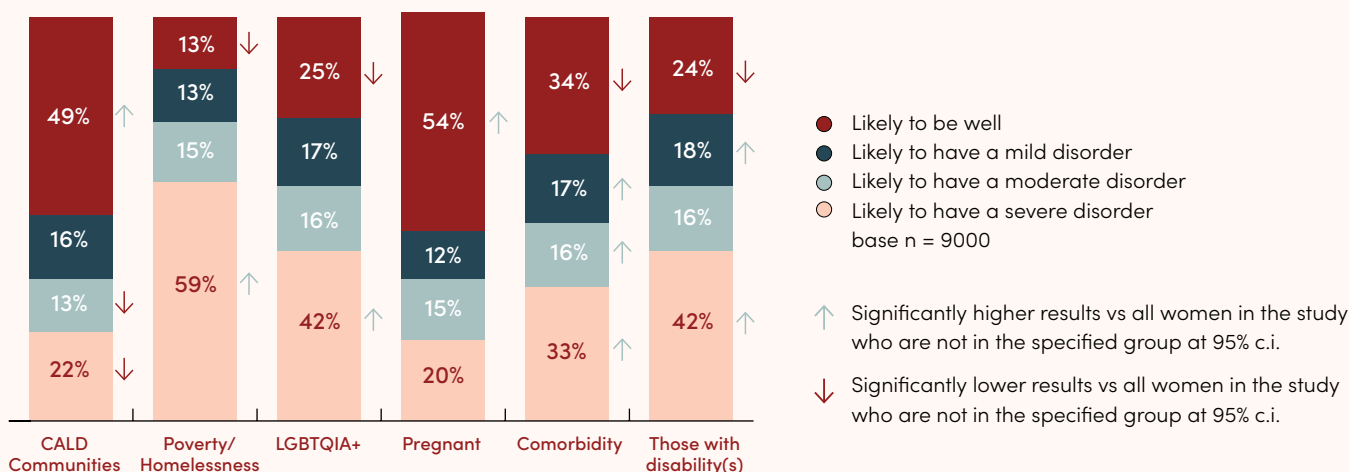
Women dealing with poverty and homelessness are experiencing severe levels of psychological distress (avg K10 score of 31.0), which was significantly higher than the overall sample.

In addition, women who identify as LGBTQIA+ (avg K10 score of 27.2) and women living with a disability (avg K10 = 27.2) are experiencing moderate levels of psychological distress, which were both significantly higher than the overall sample.

Women living with comorbid health issues (avg K10 = 24.8) are experiencing the upper end of mild levels of psychological distress, which was significantly higher than the overall sample.

Compared to the overall sample, the average K10 score was significantly lower for those in CALD communities (21.7) and there was no significant difference in average K10 scores for those who were currently pregnant (21.7), with both groups experiencing mild levels of psychological distress.

A high proportion of women experiencing poverty or homelessness (59%), women in LGBTQIA+ communities (42%), women living with disability (42%), and women with comorbidities (33%) were likely to have severe mental health issues.

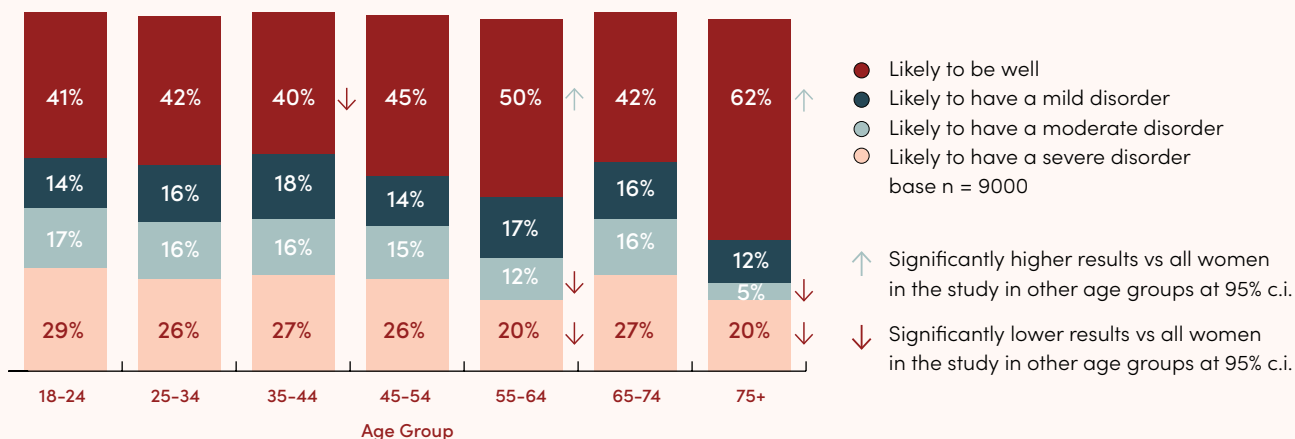


Levels of psychological distress by age group

Levels of psychological distress decreased with age. Women aged between 18 – 24 years old are experiencing the upper end of mild levels of psychological distress (Avg K10 score of 24.2) which was statistically higher than all other age groups.

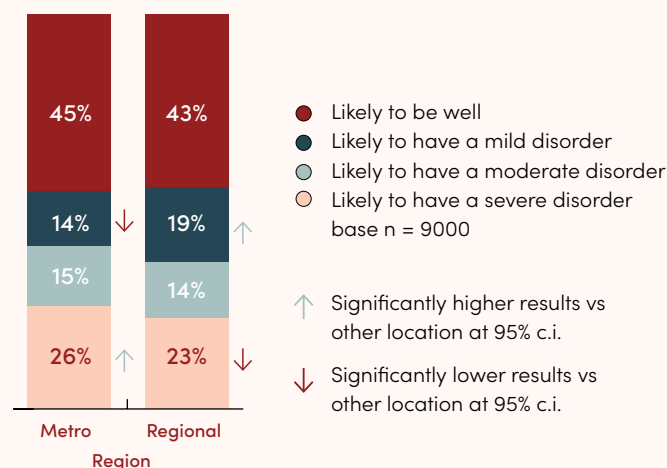
In addition, levels of psychological distress were significantly higher in women aged 25 – 34 years (avg K10 = 23.0), 35 – 45 years (avg K10 = 23.4) and 45 – 54 years (avg K10 = 23.3) compared to women aged 55 – 64 years (avg K10 = 21.6) and 65 – 74 years (avg K10 = 22.2).

Women aged 75 years + were likely to be well, and had significantly lower levels of psychological distress (avg K10 = 20.2) than all other age groups.



Levels of psychological distress by location

The levels of psychological distress amongst women across metro and regional areas of Australia remained steady from 2022 – 2026 and are in line with the overall figures nationally. Women living in metro areas and regional areas are experiencing mild levels of psychological distress, although average K10 scores were slightly but significantly higher for those living in metro areas (23.0) than regional areas (22.5).



Levels of psychological distress by other demographic information



Household income

Women whose primary source of income was a pension had moderate levels of psychological distress (Avg K10 score of 29.8), which was significantly higher than women in all other household income groups. These findings suggest that women on a pension may be a particularly vulnerable group for mental health issues. There were no other statistically significant differences in average K10 scores across household income groups.

The full rate of Age Pension is \$1,200.90 per fortnight for a single person and \$905.20 per fortnight (each) for a couple (Services Australia, 2026). However the poverty line for pensioners in 2026 sits at \$807.13 per week, or \$1614.26 per fortnight (Melbourne Institute of Applied Economic and Social Research, 2026); making these payments inadequate. This alone could be a significant cause of psychological distress for people relying on the pension for sole income.

Work status

Women on disability/sick leave had the upper end of moderate levels of psychological distress, which was the highest among all other work groups (Avg K10 score of 28.2). Other groups with moderate levels of psychological distress included those on prolonged unpaid leave (avg K10 = 26.0) and those not currently in the workforce (avg K10 = 25.4). Full-time students (avg K10 = 25.4) and part-time students (avg K10 = 25.0) also reported moderate levels of psychological distress, highlighting the potential impact academic-related stressors may have on mental health issues.

Women employed part-time (29 hours/week or less) or full-time (30 hours/week or more) reported mild levels of psychological distress with average K10 scores of 22.7 and 22.4, respectively. Mild levels of psychological distress were also reported by women who were retired (avg K10 = 21.8), women working home duties (avg K10 = 23.1), women on maternity/parental leave (avg K10 = 22.5), and women who were self-employed (avg K10 = 21.7).



Education level

Women with a graduate diploma had higher levels of psychological distress (avg K10 = 23.5) compared to women with a higher degree (avg K10 = 21.9). There were no other statistical differences in average K10 scores across education levels, with all groups experiencing mild levels of psychological distress.

The 2026 findings on overall wellbeing reinforce that psychological distress among Australian women is not improving. Despite growing awareness of mental health, the overall prevalence and severity of psychological distress has remained largely unchanged since Women's Mental Health Australia first began measuring these outcomes in 2022. This suggests that current approaches alone are insufficient to reduce the mental health burden experienced by women.

Importantly, these findings also demonstrate that mental wellbeing is not experienced equally across the female population. Women experiencing socioeconomic disadvantage, disability, multiple health conditions, or belonging to LGBTQIA+ communities consistently report significantly

higher levels of psychological distress than the broader population. These differences highlight the influence of broader social, economic and health determinants on women's mental wellbeing and reinforce the need for policies and services that recognise the diverse realities of women's lives.

Improving women's mental wellbeing requires more than expanding access to mental health services. It requires addressing the underlying factors that contribute to psychological distress, including financial insecurity, physical health, discrimination, caregiving responsibilities and unequal access to appropriate healthcare. These underlying triggers and drivers are discussed further in the report.

"I live in a multi-generational home with my youngest daughter & granddaughter. Both have ADHD & mental health issues. My daughter is working casually & studying, and my granddaughter recently commenced homeschooling. There are a lot of big emotions & tension, medications are regularly overlooked & breakdowns happen as a result."





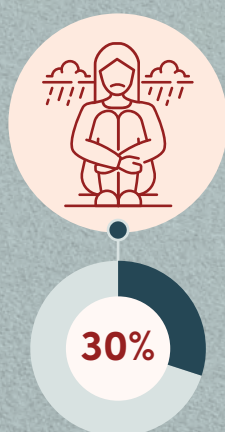
Prevalence of Women's Mental Health Issues in Australia

The top five mental health issues currently faced by Australian women

The top five mental health issues reported by Australian women in 2026 remain the same as those reported in 2025 – depression, anxiety, body image issues, sleep wake disorders, and health anxiety.

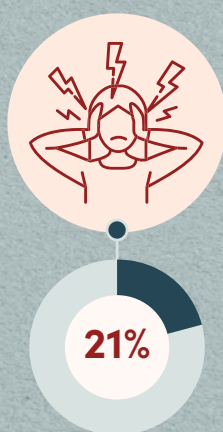
Since 2025, reported rates of anxiety, body image issues, insomnia, and health anxiety have declined, whereas depression rates have remained stable.

2026 Top 5 Mental Health Issues



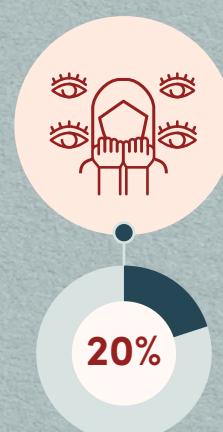
1 in 3

Australian women experience depression



1 in 5

Australian women experience anxiety or generalised anxiety disorder



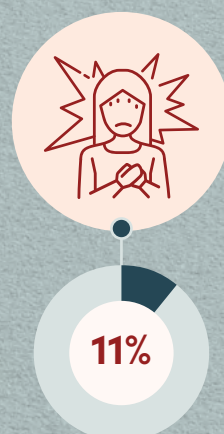
1 in 5

Australian women experience body image issues



1 in 6

Australian women experience insomnia or other sleep wake disorders



1 in 9

Australian women experience illness anxiety disorder or health anxiety

The table below outlines the prevalence rates of women who recorded experiencing each particular mental health issue, calculated as a proportion of the total sample of women in 2026 – outlining the true extent of each particular mental health issue and its burden on women in Australia.

Mental health has been referred to as MH in the table below

	2025 (% of those with MH issues)	2025 (% total sample)	2026 (% of those with MH issues)	2026 (% total sample)
ANXIETY & ANXIETY DISORDERS				
Anxiety & Generalised Anxiety Disorder (GAD)	44%	25%	32% ↓	21% ↓
Illness Anxiety Disorder or Health Anxiety	20%	11%	16% ↓	11% ↓
Post-Traumatic Stress Disorder (PTSD)	18%	10%	13% ↓	9% ↓
Social phobia	16%	9%	16%	10%
Panic Disorder	13%	7%	13%	9%
Obsessive-Compulsive Disorder (OCD)	11%	6%	11%	7%
Specific Phobias or Agoraphobia	4%	2%	4%	3%
AFFECTIVE OR MOOD DISORDERS				
Depression	52%	29%	45% ↓	30% ↓
Dysthymia (also referred to as persistent depressive disorder)	4%	2%	4%	2%
Bipolar Affective Disorder	3%	2%	3%	2%
BODY IMAGE ISSUES	39%	22%	29%	20%
INSOMNIA OR OTHER SLEEP-WAKE DISORDER	30%	17%	24%	16%
EATING DISORDERS				
Binge eating disorder	11%	6%	8% ↓	5% ↓
Anorexia nervosa	3%	2%	3%	2%
Bulimia nervosa	2%	1%	2%	1%
MENSTRUAL CYCLE RELATED DISORDERS				
Perimenopausal Anxiety/Depression	14%	8%	14%	9%
Premenstrual dysphoric disorder (PMDD)	4%	2%	4%	3%
NEURODEVELOPMENTAL DISORDERS				
Attention-Deficit/Hyperactivity Disorder (ADHD)	14%	8%	10% ↓	7% ↓
Autism Spectrum Disorder (ASD)	6%	3%	5%	3%
PERINATAL MENTAL HEALTH ISSUES				
Perinatal Anxiety (including Antenatal and Postnatal periods)	3%	2%	3%	2%
Perinatal Depression (including Antenatal and Postnatal periods)	3%	2%	3%	2%
Perinatal Psychosis (including Antenatal and Postnatal periods)	1%	1%	1%	1%
Perinatal Obsessive Compulsive Disorder (including Antenatal and Postnatal periods)			2%	1%
SUICIDE AND SELF-HARM	9%	5%	6% ↓	4% ↓
SUBSTANCE USE DISORDERS (drug and alcohol abuse)	8%	4%	6% ↓	4% ↓
GENDER DYSPHORIA	1%	1%	2% ↑	1% ↑
PERSONALITY DISORDERS				
Borderline Personality Disorder	5%	3%	3% ↓	2% ↓
PSYCHOTIC DISORDERS				
Psychosis and Psychotic disorders	1%	1%	2%	1%
Schizophrenia	1%	1%	1%	1%
DEMENTIA OR ALZHEIMER'S	2%	1%	3% ↑	2% ↑

↑ Significantly higher results vs 2025 at 95% c.i. ↓ Significantly lower results vs 2025 at 95% c.i.

Top mental health issues and notable findings by location

Australian women living in regional areas are reporting significantly higher rates of the top five mental health conditions compared to those living in metro areas. Women in regional areas are also reporting significantly higher rates of PTSD, panic disorder, ADHD, suicide and self harm, substance use disorders (drug and alcohol abuse), and perimenopausal anxiety and depression. These disorders were between 1.3x and 1.9x more common in women living in regional areas compared to those living in metro areas.

On the other hand, Australian women living in metro areas are reporting significantly higher rates of Alzheimer's than those living in regional areas.

	Metro (N=6092)	Regional (N=2908)	Times more common than other location area
Depression	27% ↓	36% ↑	1.3x
Anxiety & Generalised Anxiety Disorder (GAD)	18% ↓	29% ↑	1.6x
Body image issues	17% ↓	24% ↑	1.4x
Insomnia or other sleep-wake disorder	14% ↓	21% ↑	1.5x
Illness Anxiety Disorder or Health Anxiety	9% ↓	14% ↑	1.6x
Perimenopausal Anxiety/Depression	8% ↓	11% ↑	1.4x
Post-Traumatic Stress Disorder (PTSD)	7% ↓	13% ↑	1.9x
Panic Disorder	8% ↓	10% ↑	1.3x
Attention-Deficit/Hyperactivity Disorder (ADHD)	6% ↓	8% ↑	1.3x
Suicide and self-harm	3% ↓	5% ↑	1.7x
Substance use disorders (drug and alcohol abuse)	3% ↓	5% ↑	1.7x
Alzheimer's	1% ↑	0% ↓	1.0x

↑ Significantly higher results vs other location at 95% c.i. ↓ Significantly lower results vs other location at 95% c.i.



Top mental health issues and notable findings by priority populations

The prevalence rates of mental health conditions across priority populations can be found in the table below.

	Overall % (N=9000)	Comorbidity (N=5255)	Those with disability (N=882)	CALD Communities (N=1612)	Poverty / Homelessness (N=709)	LGBTQIA+ (N=802)	Pregnant (N=183)
Depression	30%	37% ↑	54% ↑	30%	50% ↑	39% ↑	28%
Anxiety & Generalised Anxiety Disorder (GAD)	21%	26% ↑	42% ↑	21%	36% ↑	34% ↑	18%
Body image issues	20%	24% ↑	31% ↑	20%	32% ↑	33% ↑	15%
Insomnia or other sleep-wake disorder	16%	22% ↑	38% ↑	17%	29% ↑	22% ↑	14%
Illness Anxiety Disorder or Health Anxiety	11%	14% ↑	28% ↑	11%	20% ↑	14%	8%
Social phobia	10%	12% ↑	22% ↑	10%	19% ↑	13%	5%
Perimenopausal Anxiety/Depression	9%	13% ↑	11%	9%	15% ↑	7%	8%
Post-Traumatic Stress Disorder (PTSD)	9%	13% ↑	26% ↑	8%	26% ↑	17% ↑	7%
Panic Disorder	9%	12% ↑	18% ↑	9%	18% ↑	13% ↑	7%
Obsessive-Compulsive Disorder (OCD)	7%	10% ↑	15% ↑	6%	12% ↑	13% ↑	6%
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	9% ↑	13% ↑	6%	14% ↑	17% ↑	3%
Binge eating disorder	5%	7% ↑	10% ↑	5%	11% ↑	10% ↑	5%
Suicide and self-harm	4%	5% ↑	10% ↑	4%	12% ↑	11% ↑	7%
Substance use disorders (drug and alcohol abuse)	4%	6% ↑	9% ↑	3%	13% ↑	10% ↑	2%
Autism Spectrum Disorder (ASD)	3%	4% ↑	9% ↑	2%	9% ↑	13% ↑	2%
Premenstrual dysphoric disorder (PMDD)	3%	4% ↑	4%	2%	4%	7% ↑	5%
Specific Phobias or Agoraphobia	3%	4% ↑	9% ↑	3%	7% ↑	6% ↑	7%
Dysthymia (also referred to as persistent depressive disorder)	2%	3% ↑	8% ↑	3%	6% ↑	5% ↑	5%
Borderline Personality Disorder	2%	3% ↑	6% ↑	2%	7% ↑	6% ↑	2%
Bipolar Affective Disorder	2%	3% ↑	6% ↑	2%	5% ↑	4%	2%
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	3% ↑	2%	2%	4% ↑	3%	17% ↑
Perinatal Depression (including Antenatal and Postnatal periods)	2%	2%	3%	2%	4%	4% ↑	14% ↑
Anorexia nervosa	2%	2%	3%	1%	3%	5% ↑	5%
Bulimia nervosa	1%	2%	2%	1%	2%	3% ↑	3%
Gender Dysphoria	1%	1%	2%	1%	2%	4% ↑	5% ↑
Psychosis and Psychotic disorders	1%	1%	3% ↑	1%	3% ↑	2%	1%
Perinatal Obsessive Compulsive Disorder (including Antenatal and Postnatal periods)	1%	1%	2%	1%	1%	1%	5% ↑
Dementia	1%	1% ↑	1%	1%	2%	2% ↑	5% ↑
Alzheimer's	1%	1%	1%	1%	2%	1%	1%
Schizophrenia	1%	1%	2%	1%	3% ↑	2%	2%
Perinatal Psychosis (including Antenatal and Postnatal periods)	1%	1%	1%	0%	1%	1%	3%

↑ Significantly higher results vs all women in the study who are not in the specified group at 95% c.i.

Women facing homelessness or poverty

Australian women facing homelessness or poverty generally reported significantly increased rates of mental health conditions compared to those who are not facing homelessness or poverty.

For example, 1 in 2 (50%) women currently facing homelessness or poverty reported depression, while 1 in 3 (36%) reported anxiety or generalised anxiety disorder. The prevalence rate of both conditions was around 1.7x higher than the overall sample.

PTSD was especially common among women facing homelessness and poverty, affecting around 1 in 4 (26%) in this group (2.9x higher than overall sample). Other anxiety and mood-related disorders were also significantly higher in women facing homelessness or poverty including specific phobias or agoraphobia (7%), panic disorder (18%), OCD (12%), social phobia (19%), illness anxiety disorder or health anxiety (20%), dysthymia (6%) and bipolar affective disorder (5%).

Women facing poverty and homelessness also reported experiencing higher rates of neurodevelopmental disorders including ADHD (14%) and autism spectrum disorder (9%). These conditions were more than twice more common in women facing poverty and homelessness compared to the overall sample.

Compared to the general population, women facing poverty and homelessness were 3x more likely to report experiencing schizophrenia (3%), psychosis and psychotic disorders (3%), and suicide or self-harm (12%), as well as 3.3x more likely to report substance use disorder (13%).

Together these findings suggest that women facing homelessness or poverty are a particularly vulnerable group for mental health issues.



The general population is referred to as gen pop in the tables below.

	Gen Pop %	Women facing Poverty / Homelessness	Times more common than gen pop
Depression	30%	50% ↑	1.7x
Anxiety & Generalised Anxiety Disorder (GAD)	21%	36% ↑	1.7x
Body image issues	20%	32% ↑	1.6x
Insomnia or other sleep-wake disorder	16%	29% ↑	1.8x
Illness Anxiety Disorder or Health Anxiety	11%	20% ↑	1.8x
Social phobia	10%	19% ↑	1.9x
Perimenopausal Anxiety/Depression	9%	15% ↑	1.7x
Post-Traumatic Stress Disorder (PTSD)	9%	26% ↑	2.9x
Panic Disorder	9%	18% ↑	2.0x
Obsessive-Compulsive Disorder (OCD)	7%	12% ↑	1.7x
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	14% ↑	2.0x
Binge eating disorder	5%	11% ↑	2.2x
Suicide and self-harm	4%	12% ↑	3.0x
Substance use disorders (drug and alcohol abuse)	4%	13% ↑	3.3x
Autism Spectrum Disorder (ASD)	3%	9% ↑	3.0x
Specific Phobias or Agoraphobia	3%	7% ↑	2.3x
Dysthymia (also referred to as persistent depressive disorder)	2%	6% ↑	3.0x
Borderline Personality Disorder	2%	7% ↑	3.5x
Bipolar Affective Disorder	2%	5% ↑	2.5x
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	4% ↑	2.0x
Psychosis and Psychotic disorders	1%	3% ↑	3.0x
Schizophrenia	1%	3% ↑	3.0x

↑ Significantly higher results vs those who are not facing poverty or homelessness at 95% c.i.

Women who identify as LGBTQIA+

Australia women who identify as LGBTQIA+ generally reported significantly increased rates of mental health conditions compared to those who do not identify as LGBTQIA+.

For example, more than 1 in 3 women who identify as LGBTQIA+ reported depression (39%), and anxiety or generalised anxiety disorder (34%), both of which were statistically higher than those who do not identify as LGBTQIA+. Other anxiety and mood-related disorders were also significantly higher in this group including PTSD (17%), panic disorder (13%), OCD (13%), specific phobias (6%), and dysthymia (5%).

Neurodevelopmental disorders, including ADHD (17%) and autism spectrum disorder (13%), were especially common among this group. The prevalence rates of these conditions were around 2.4x and 4.3x higher than the overall sample, respectively.

Body image issues (33%) were also significantly higher, as were eating disorders including binge eating disorder (10%), anorexia nervosa (5%) and bulimia nervosa (3%).

Gender dysphoria was 4x more common in women who identify as LGBTQIA+ compared to the overall sample, affecting 4% of women in this group.

Moreover, the prevalence rates of suicide and self harm (11%) and substance use disorders (10%) were more than twice as common in this group compared to the overall sample.

Other mental health conditions that were significantly higher in women who identify as LGBTQIA+ include insomnia or other sleep wake disorders (22%), borderline personality disorder (6%), dementia (2%), and hormonal-related conditions including premenstrual dysphoric disorder (PMDD) (7%) and perinatal depression (4%).

“I tried different things but they felt temporary, like band-aids on something much deeper.”

	Gen Pop %	Women who identify as LGBTQIA+	Times more common than gen pop
Depression	30%	39% ↑	1.3x
Anxiety & Generalised Anxiety Disorder (GAD)	21%	34% ↑	1.6x
Body image issues	20%	33% ↑	1.7x
Insomnia or other sleep-wake disorder	16%	22% ↑	1.4x
Post-Traumatic Stress Disorder (PTSD)	9%	17% ↑	1.9x
Panic Disorder	9%	13% ↑	1.4x
Obsessive-Compulsive Disorder (OCD)	7%	13% ↑	1.9x
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	17% ↑	2.4x
Binge eating disorder	5%	10% ↑	2.0x
Suicide and self-harm	4%	11% ↑	2.8x
Substance use disorders (drug and alcohol abuse)	4%	10% ↑	2.5x
Autism Spectrum Disorder (ASD)	3%	13% ↑	4.3x
Premenstrual dysphoric disorder (PMDD)	3%	7% ↑	2.3x
Specific Phobias or Agoraphobia	3%	6% ↑	2.0x
Dysthymia (also referred to as persistent depressive disorder)	2%	5% ↑	2.5x
Borderline Personality Disorder	2%	6% ↑	3.0x
Perinatal Depression (including Antenatal and Postnatal periods)	2%	4% ↑	2.0x
Anorexia nervosa	2%	5% ↑	2.5x
Bulimia nervosa	1%	3% ↑	3.0x
Gender Dysphoria	1%	4% ↑	4.0x
Dementia	1%	2% ↑	2.0x

↑ Significantly higher results vs those who do not identify as LGBTQIA+ at 95% c.i.

Women living with a disability

Australia women who are living with a disability generally reported significantly increased rates of mental health conditions compared to those who are not living with a disability, including the top five mental health conditions.

Indeed, more than 1 in 2 (54%) women living with a disability reported depression, and 2 in 5 (42%) reported anxiety or generalised anxiety disorder. The prevalence rates of these conditions were around 1.8x and 2.0x higher than the overall sample. Moreover, of the women living with a disability, 38% reported insomnia or other sleep wake disorders (2.4x higher than the overall sample), 31% reported body image issues (1.6x higher than the overall sample), and 28% reported illness anxiety disorder or health anxiety (2.5x higher than the overall sample).

Other anxiety and mood-related disorders were also significantly higher in this group including social phobia (22%), panic disorder (18%), OCD (15%), specific phobias (9%), dysthymia (8%), and bipolar affective disorder (6%). These disorders were more than twice as common, and in some cases more than three times more common, in women living with a disability compared to the overall sample. Moreover, PTSD was especially common among women living with a disability, affecting around 1 in 4 (26%) in this group (2.9x higher than the overall sample).

Other mental health conditions that were significantly higher in women living with a disability included neurodevelopmental disorders such as ADHD (13%) and autism spectrum disorder (9%), binge eating disorder (10%), suicide or self-harm (10%), substance use disorders (9%), borderline personality disorder (6%), and psychosis and psychotic disorders (3%). The prevalence rates of these conditions were between 1.9x and 3x higher in women living with a disability than the overall sample.

	Gen Pop %	Those with disability	Times more common than gen pop
Depression	30%	54% ↑	1.8x
Anxiety & Generalised Anxiety Disorder (GAD)	21%	42% ↑	2.0x
Body image issues	20%	31% ↑	1.6x
Insomnia or other sleep-wake disorder	16%	38% ↑	2.4x
Illness Anxiety Disorder or Health Anxiety	11%	28% ↑	2.5x
Social phobia	10%	22% ↑	2.2x
Post-Traumatic Stress Disorder (PTSD)	9%	26% ↑	2.9x
Panic Disorder	9%	18% ↑	2.0x
Obsessive-Compulsive Disorder (OCD)	7%	15% ↑	2.1x
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	13% ↑	1.9x
Binge eating disorder	5%	10% ↑	2.0x
Suicide and self-harm	4%	10% ↑	2.5x
Substance use disorders (drug and alcohol abuse)	4%	9% ↑	2.3x
Autism Spectrum Disorder (ASD)	3%	9% ↑	3.0x
Specific Phobias or Agoraphobia	3%	9% ↑	3.0x
Dysthymia (also referred to as persistent depressive disorder)	2%	8% ↑	4.0x
Borderline Personality Disorder	2%	6% ↑	3.0x
Bipolar Affective Disorder	2%	6% ↑	3.0x
Psychosis and Psychotic disorders	1%	3% ↑	3.0x

↑ Significantly higher results vs those who are not living with a disability at 95% c.i.



Women with comorbidities

Women with comorbidities (defined by those with other physical health conditions) generally reported significantly increased rates of mental health conditions compared to those without comorbidities, including the top five common mental health conditions.

More than 1 in 3 (37%) reported depression, 1 in 4 (26%) reported anxiety or generalised anxiety disorder, 1 in 4 (24%) reported body image issues, more than 1 in 5 (22%) reported insomnia or other sleep wake disorders, and 1 in 7 (14%) reported illness anxiety disorder or health anxiety. The prevalence rates of these conditions were between 1.2x and 1.4x higher in women with comorbidities than the overall sample.

Other anxiety and mood-related disorders were also significantly higher in this group including social phobia (12%), PTSD (13%), panic disorder (12%), OCD (10%), specific phobia (4%), dysthymia (3%), and bipolar affective disorder (3%).

Women living with comorbidities also reported significantly higher rates of neurodevelopmental disorders including ADHD (9%) and autism spectrum disorder (4%), as well as hormonal related conditions including premenstrual dysphoric disorder (PMDD) (4%), perinatal anxiety (3%) and perimenopausal anxiety/depression (13%).

Substance use disorders (6%) and suicide or self-harm (5%) were also significantly more prevalent in those with comorbidities compared to those without, as was binge eating disorder (7%), borderline personality disorder (3%), and dementia (1%).



	Gen Pop%	Those living with a comorbid health conditions	Times more common than gen pop
Depression	30%	37% ↑	1.2x
Anxiety & Generalised Anxiety Disorder (GAD)	21%	26% ↑	1.2x
Body image issues	20%	24% ↑	1.2x
Insomnia or other sleep-wake disorder	16%	22% ↑	1.4x
Illness Anxiety Disorder or Health Anxiety	11%	14% ↑	1.3x
Social phobia	10%	12% ↑	1.2x
Perimenopausal Anxiety/Depression	9%	13% ↑	1.4x
Post-Traumatic Stress Disorder (PTSD)	9%	13% ↑	1.4x
Panic Disorder	9%	12% ↑	1.3x
Obsessive-Compulsive Disorder (OCD)	7%	10% ↑	1.4x
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	9% ↑	1.3x
Binge eating disorder	5%	7% ↑	1.4x
Suicide and self-harm	4%	5% ↑	1.3x
Substance use disorders (drug and alcohol abuse)	4%	6% ↑	1.5x
Autism Spectrum Disorder (ASD)	3%	4% ↑	1.3x
Premenstrual dysphoric disorder (PMDD)	3%	4% ↑	1.3x
Specific Phobias or Agoraphobia	3%	4% ↑	1.3x
Dysthymia (also referred to as persistent depressive disorder)	2%	3% ↑	1.5x
Borderline Personality Disorder	2%	3% ↑	1.5x
Bipolar Affective Disorder	2%	3% ↑	1.5x
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	3% ↑	1.5x

↑ Significantly higher results vs those without comorbidities at 95% c.i.

Women from CALD communities

The five most common mental health conditions for women from CALD communities were the same as the overall sample. The prevalence rates of all mental health conditions were similar among people from CALD communities and those who were not from CALD communities.

Women who are currently pregnant

Unsurprisingly, Australian women who are currently pregnant reported statistically higher rates of perinatal (i.e., antenatal and postnatal) mental health conditions compared to those who are not currently pregnant.

Of those that are currently pregnant, 1 in 6 (17%) reported that they were currently experiencing perinatal anxiety and 1 in 7 (14%) reported that they were currently experiencing perinatal depression. These prevalence rates are broadly consistent with existing studies showing that perinatal anxiety and depression are among the most common mental health conditions during pregnancy (Dennis et al., 2017). The findings also support previous research suggesting that perinatal anxiety may be more prevalent than perinatal depression (Caffieri et al., 2024), and highlight the importance of routine screening and assessment for both anxiety and depressive symptoms during pregnancy.

Moreover, 1 in 20 (5%) women who were currently pregnant reported experiencing perinatal OCD, and 1 in 33 (3%) reported experiencing perinatal psychosis. While less common, these mental health conditions remain clinically important due to their potential impact on maternal wellbeing, functioning, and early mother-infant outcomes (Fairbrother et al., 2025; VanderKruik et al., 2017). In particular, perinatal psychosis is a severe mental health condition that requires timely identification and urgent intervention (VanderKruik et al., 2017).

Gender dysphoria was also significantly more prevalent in women who were currently pregnant, affecting 5% of this group. This was 5x more common than the overall sample.



Top mental health issues and notable findings across the lifespan

In this report, we compare the prevalence rates of mental health conditions across the female lifespan. This is important because women's mental health is shaped by a combination of biological, hormonal, psychological, and social factors that change across different life stages.

A lifespan approach helps identify periods of increased vulnerability, tailor interventions to specific age groups, and ensure prevention and treatment strategies are developmentally appropriate.

The prevalence rates of mental health conditions across age groups can be found below.

	Overall % (N=9000)	18-24 (N=895)	25-34 (N=1917)	35-44 (N=1756)	45-54 (N=1428)	55-64 (N=1349)	65-74 (N=1202)	75+ (N=453)
Depression	30%	29%	28%	28%	32%	31%	35%	26%
Anxiety & Generalised Anxiety Disorder (GAD)	21%	28% ↑	24%	18% ↓	26% ↑	23%	17% ↓	8% ↓
Body image issues	20%	33% ↑	24% ↑	18%	19%	17%	15% ↓	8% ↓
Insomnia or other sleep-wake disorder	16%	11% ↓	12% ↓	12% ↓	20% ↑	23% ↑	18%	14%
Illness Anxiety Disorder or Health Anxiety	11%	11%	9%	9%	12%	13%	12%	7%
Social phobia	10%	11%	10%	10%	13%	11%	10%	5%
Perimenopausal Anxiety/Depression	9%	4% ↓	4% ↓	11%	25% ↑	9%	1% ↓	12%
Post-Traumatic Stress Disorder (PTSD)	9%	7%	9%	9%	15% ↑	10%	6% ↓	4%
Panic Disorder	9%	8%	7%	7%	10%	10%	9%	7%
Obsessive-Compulsive Disorder (OCD)	7%	10%	7%	9%	9%	5%	6%	2% ↓
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	12% ↑	10% ↑	7%	7%	5%	2% ↓	1% ↓
Binge eating disorder	5%	11% ↑	6%	6%	4%	4%	4%	1%
Suicide and self-harm	4%	9% ↑	4%	3%	4%	3%	2% ↓	3%
Substance use disorders (drug and alcohol abuse)	4%	5%	4%	4%	6% ↑	4%	2% ↓	1%
Autism Spectrum Disorder (ASD)	3%	7% ↑	3%	4%	4%	1% ↓	1% ↓	1%
Premenstrual dysphoric disorder (PMDD)	3%	4%	5% ↑	5% ↑	2%	1%	0% ↓	0% ↓
Specific Phobias or Agoraphobia	3%	3%	3%	2%	4%	3%	2%	1%
Dysthymia (also referred to as persistent depressive disorder)	2%	2%	3%	2%	3%	3%	2%	1%
Borderline Personality Disorder	2%	4%	3%	2%	2%	2%	2%	1%
Bipolar Affective Disorder	2%	3%	2%	3%	3%	2%	1%	1%
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	2%	5% ↑	3%	1%	1% ↓	0% ↓	0% ↓
Perinatal Depression (including Antenatal and Postnatal periods)	2%	2%	5% ↑	3%	2%	1%	0% ↓	0% ↓
Anorexia nervosa	2%	5% ↑	2%	2%	1%	1%	2%	1%
Bulimia nervosa	1%	3% ↑	1%	2%	1%	1%	1%	1%
Gender Dysphoria	1%	3% ↑	1%	1%	1%	1%	1%	1%
Psychosis and Psychotic disorders	1%	2%	1%	2%	1%	1%	1%	1%
Perinatal Obsessive Compulsive Disorder	1%	1%	2% ↑	1%	1%	1%	0% ↓	0% ↓
Dementia	1%	1%	1%	2%	1%	1%	1%	0%
Alzheimer's	1%	0%	0%	1%	1%	1%	2%	1%
Schizophrenia	1%	1%	1%	1%	1%	1%	1%	1%
Perinatal Psychosis (including Antenatal and Postnatal periods)	1%	1%	1% ↑	1%	0%	0%	0%	0% ↓

↑ Significantly higher results vs all women in the study in other age groups at 95% c.i.

↓ Significantly lower results vs all women in the study in other age groups at 95% c.i.

18 - 24 year olds



Body image issues were the most common mental health condition among women aged 18–24 years, affecting 1 in 3 (33%). This prevalence rate was statistically higher than all other age groups, and 1.7x more common than the overall

sample. Eating disorders were also statistically increased among women aged 18–24 years including binge eating disorder (11%) which was 2.2x more common than the overall sample, anorexia nervosa (5%) which was 2.5x more common than the overall sample, and bulimia nervosa (3%) which was 3x more common than the overall sample.

Moreover, more than 1 in 4 (28%) women aged 18–24 years reported anxiety disorder and generalised anxiety disorder, which was 1.3x more common than the overall sample.

Neurodevelopmental disorders, including ADHD (12%) and autism spectrum disorder (7%), were also statistically increased among this age group compared to all other age groups. The prevalence rates of these conditions were around 1.7x and 2.3x more common in this age group than the overall sample, respectively.

Finally, women aged 18–24 years reported gender dysphoria (3%) at 3x higher rates than the overall sample.

In contrast, women aged 18–24 years had statistically lower rates of insomnia or other sleep-wake disorders compared to all other age groups.

25 - 34 year olds



Depression was the most common mental health condition among women aged 25–34 years, affecting more than 1 in 4 (28%) of this age group. The prevalence of depression was comparable to all other age groups.

Women aged 25–34 years reported significantly higher rates of body image issues, affecting almost 1 in 4 (24%) of this age group. Body image issues were 1.7x more common in women aged 25–34 years compared to the overall sample. In addition, 1 in 10 (10%) of women in this age group reported ADHD (10%) and 1 in 20 (5%) reported premenstrual dysphoric disorder (PMDD), both of which were statistically higher than all other age groups, and 1.4x and 1.7x more common than the overall sample, respectively.

Compared to the overall sample, women aged 25–34 years old also reported higher rates of perinatal mental health issues including perinatal anxiety (5%), perinatal depression (5%), perinatal OCD (2%), and perinatal psychosis (1%). The higher prevalence rates of perinatal mental health issues were likely because a higher proportion of women in this age group were either pregnant or had recently given birth compared to younger and older age groups.

On the other hand, women aged 25–34 years reported significantly lower rates of insomnia or other sleep wake disorders (12%) and unsurprisingly, lower rates of perimenopausal anxiety/depression (4%).





35 - 44 year olds



Women aged 35–44 years old generally reported similar prevalence rates of mental health issues compared with other age groups.

Depression was the most common mental health condition among women aged 35–44 years affecting 1

in 4 (28%), followed by anxiety and generalised anxiety disorder which affected 1 in 6 (18%). These prevalence rates were comparable to all other age groups.

The only mental health condition with a significantly higher prevalence in this age group was premenstrual dysphoric disorder (PMDD). Compared with other ages, women aged 35–44 years reported higher rates of PMDD, affecting 5% of this age group. The prevalence of PMDD was 1.7x higher than that observed in the overall sample.

On the other hand, women aged 35–44 years reported significantly lower rates of anxiety and generalised anxiety disorder (18%) and insomnia or other sleep wake disorders (12%).

45 - 54 year olds



Depression was the most common mental health issue among women aged 45–54 years affecting almost 1 in 3 (32%). The prevalence of depression in this age group was comparable to that observed in other age groups.

This was followed by anxiety and generalised anxiety disorder which affected more than 1 in 4 (26%) women aged 45–54 years. The prevalence of anxiety in this age group was significantly higher than in all other age groups, and 1.2x more common than the overall sample.

The third most prevalent mental health condition among women aged 45–54 years was perimenopausal anxiety/depression which affected 1 in 4 (25%). This was statistically higher compared to all other age groups.

Women aged 45–54 also reported statistically higher rates of insomnia or sleep wake disorder (20%) which was 1.3x more common than the overall sample, PTSD (15%) which was 1.7x more common than the overall sample, and substance use disorders (6%) which was 1.5x more common than the overall sample.

55 - 64 year olds



Depression was the most common mental health issue among women aged 55-64 years affecting almost 1 in 3 (31%) people in this age group, a comparable prevalence rate to all other age groups.

The second most common mental health condition was insomnia or sleep wake disorder, affecting almost 1 in 4 (23%) women aged 55-64 years. The prevalence rate of insomnia or sleep wake disorder was significantly higher in this age group compared to all other age groups, and 1.4x more common than the overall sample.

On the other hand, compared to all other age groups, women aged 55-64 years reported significantly lower rates of autism spectrum disorder and perinatal anxiety. There were no other significant differences in prevalence rates of mental health issues in this age group compared to all other age groups.

65 - 74 year olds



Depression was the most common mental health condition among women aged 65-74 years affecting 1 in 3 (35%), followed by insomnia or sleep wake disorder which affected 1 in 6 (17%). These prevalence rates were comparable to that observed in all other age groups.

Women aged 65-74 years generally reported significantly lower rates of mental health conditions compared to all other age groups, including anxiety and generalised anxiety disorder (17%), body image issues (15%), PTSD (6%), ADHD (2%), suicide and self-harm (2%), substance use disorders (2%), and autism spectrum disorder (1%). Expectedly, this age group also reported significantly lower rates of premenstrual dysphoric disorder (PMDD) and perinatal mental health conditions.

There were no other significant differences in prevalence rates of mental health issues in this age group compared to all other age groups.

75+ year olds



Depression was the most common mental health condition among women aged 75 years+, affecting more than 1 in 4 (26%) of this age group. The prevalence of depression was comparable to that observed in all other age groups. The second most common mental health condition among this age group was insomnia or other sleep wake disorders, affecting 14% of this age group, which was also comparable to other age groups.

Women aged 75 years+ are generally reporting significantly lower rates of mental health conditions compared to all other age groups including anxiety and generalised anxiety disorder (8%), body image issues (8%), OCD (2%) and ADHD (1%).

Expectedly, this age group also reported significantly lower rates of premenstrual dysphoric disorder (PMDD) and perinatal mental health conditions. There were no other significant differences in prevalence rates of mental health issues in this age group compared to all other age groups.

"Due to the symptoms of my mental health condition, I feel that I am not able to accurately express or explain what is happening for me."



Women's Physical Health and its Influence on Mental Health

Women's physical and mental health cannot be understood in isolation. While it is well recognised that living with a physical health condition can affect emotional wellbeing, far less attention has been paid to whether female-specific health conditions place women at an even greater risk of psychological distress.

To better understand this relationship, levels of psychological distress were examined using the Kessler Psychological Distress Scale (K10) across three groups of women: those with no physical health conditions, those with physical health conditions that commonly affect both females and males, and those living with female-specific physical health conditions such as endometriosis, polyendocrine metabolic ovarian syndrome (PMOS), pelvic floor disorders (while this can also impact males, it is disproportionately experienced by females), and menopause.

This comparison is important because it allows us to determine whether poorer mental health is simply associated with living with a physical illness, or whether the unique biological, hormonal, reproductive and gendered experiences associated with female-specific conditions contribute an additional burden on women's mental health.

The findings revealed that having a female-specific physical health condition is associated with greater mental distress relative to those without physical health conditions, and relative to those with non-female specific health conditions – a pattern consistent with the findings from our 2025 research.

Women with female-specific physical health conditions (e.g., endometriosis, reproductive cancers)** are experiencing moderate levels of psychological distress (Avg K10 Score of 25.5), which is statistically higher than those with physical health conditions that impact both sexes (e.g., heart disease)* (Avg K10 Score of 24.3) and those without physical health conditions (Avg K10 score of 20.4). The average K10 scores from those with physical health conditions that impact both sexes (e.g., heart disease) was also statistically higher than those without physical health conditions.

This suggests that women with a physical health condition are still more likely to experience poor mental health, with the greatest impact seen in women with female-specific physical health conditions – highlighting the importance of recognising that physical and mental health are deeply interconnected. These findings reinforce the need for a more integrated model of care, where

psychological support is embedded within women's physical healthcare services. Treating the physical condition without recognising its mental health impact risks leaving a substantial part of women's healthcare needs unaddressed.

Average K10 Scores

Group	Average K10 score	Sample Size
Women with no physical health conditions	20.4	N = 4440
Women with physical health conditions that impact both sexes*	24.3↑	N = 3061
Women with female-specific physical health conditions**	25.5↑↑	N = 687

↑↑ Significantly higher results vs women with physical health conditions that impact both sexes and women with no physical health conditions at 95% c.i.
↑ Significantly higher results vs women with no physical health conditions in the study at 95% c.i.

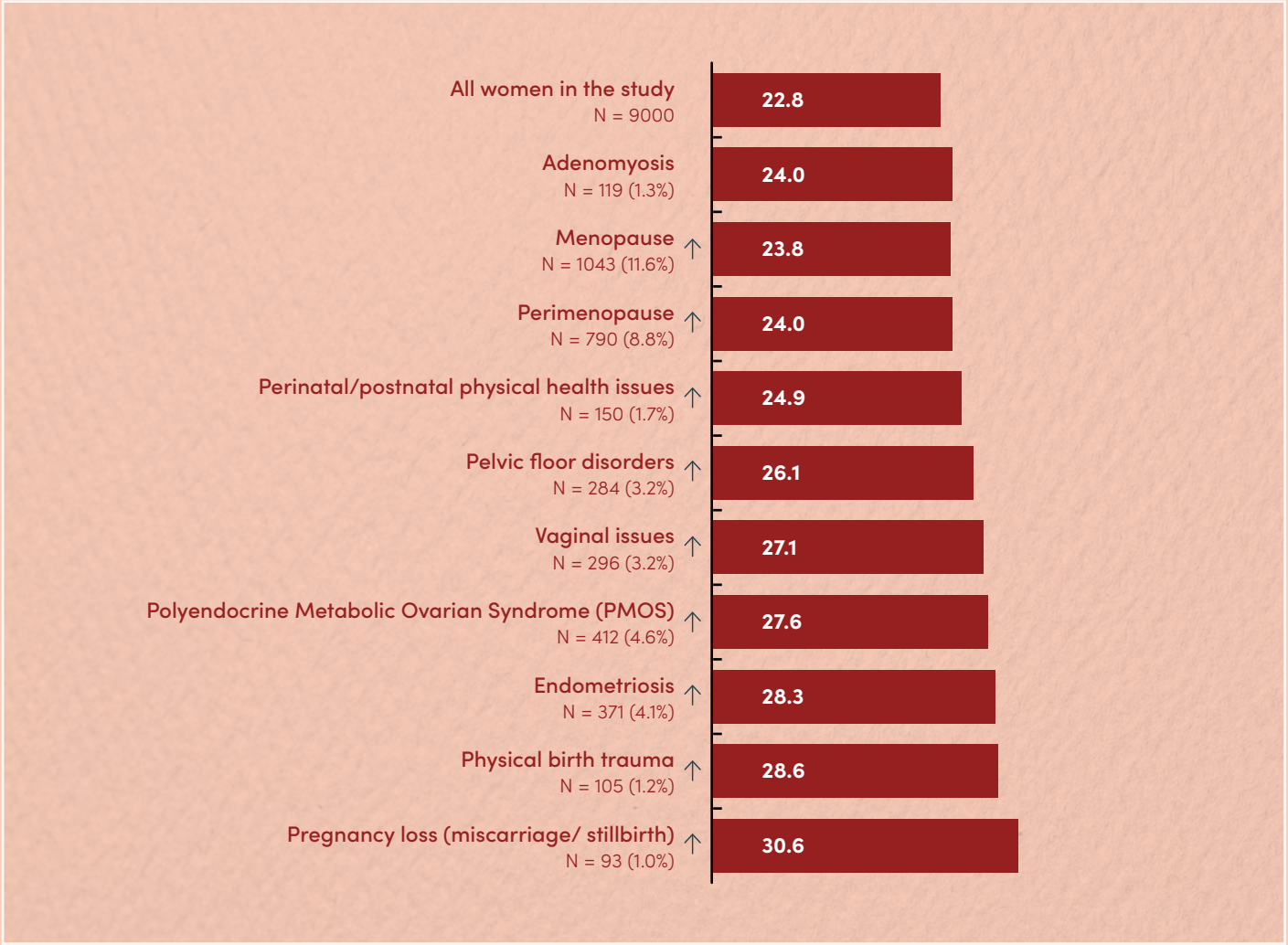
*Physical health conditions that impact both sexes included: Cardiovascular disease / heart problems, Arthritis, Back problems, Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Cancer, Any physical disability, Other serious illness/disability that significantly affects the quality of life.

**Female-specific physical health conditions included: Polycystic Ovarian Syndrome (PCOS), Endometriosis, Ovarian or cervical cancer, Pelvic floor disorders, Pregnancy loss (miscarriage/stillbirth), Vaginal issues (bacterial vaginosis, vaginitis, uterine fibroids, and vulvodynia), Physical birth trauma, Breast Cancer, Peripartum issues (perinatal/postnatal physical health issues), and adenomyosis.



Further analysis has uncovered some female-specific physical health issues are associated with significantly higher levels of psychological distress. The conditions are presented in order of average K10 score, with statistical comparisons between women with each condition and those without the respective condition.

Female-specific physical health issues associated with higher psychological distress.



↑ Significantly higher results vs all women in study without the condition of interest at 95% c.i. ■ Average K10 score

Note: those who endorsed experiencing breast cancer, ovarian or cervical cancer were too small of a sample size and therefore not included in this analysis.

Polyendocrine Metabolic Ovarian Syndrome (PMOS)

Polyendocrine metabolic ovarian syndrome (PMOS) previously known as polycystic ovarian syndrome (PCOS) is a common chronic health condition that affects about 1 in 7 women and gender diverse people during their reproductive years (Teede et al., 2026). PMOS is the second leading cause of non-fatal disease burden among females due to reproductive and maternal conditions, after genital prolapse (AIHW, 2025).

This year, the term polycystic ovary syndrome (PCOS) was changed to polyendocrine metabolic ovarian syndrome (PMOS) because the previous name incorrectly suggested that the condition is primarily defined by ovarian cysts, when in fact it is a complex endocrine and metabolic disorder affecting multiple body systems, not just the ovaries. PMOS is caused by changes in hormone regulation, including insulin and androgen (male-type hormone) levels, and can affect reproductive, metabolic, and overall health. Common symptoms of PMOS include irregular menstrual periods, difficulty becoming pregnant, excess facial or body hair, acne, scalp hair thinning, weight gain

or difficulty managing weight, and insulin resistance. People with PMOS also have an increased risk of developing conditions such as type 2 diabetes, high blood pressure, abnormal cholesterol levels, fatty liver disease, sleep apnoea, and mental health conditions including anxiety and depression. The goal of the name change to PMOS is to improve diagnosis, reduce fragmented care and stigma, and promote greater recognition in research and health policy (Teede et al., 2026).

Women who reported having PMOS are experiencing moderate levels of psychological distress (avg K10 score of 27.6) which was significantly higher than women who did not report having PMOS (av K10 score of 22.6).

Women with PMOS are experiencing most mental health issues at significantly higher rates than those without PMOS. These findings are consistent with previous academic studies showing that PMOS is associated with higher rates of mental health conditions such as anxiety and depression (Dybciak et al., 2023).

The general population is referred to as gen pop in the tables below.

	Gen Pop %	People with PMOS	Times more common than gen pop
Depression	30%	47% ↑	1.6x
Anxiety & Generalised Anxiety Disorder (GAD)	21%	39% ↑	1.9x
Body image issues	20%	40% ↑	2.0x
Insomnia or other sleep-wake disorder	16%	27% ↑	1.7x
Illness Anxiety Disorder or Health Anxiety	11%	19% ↑	1.7x
Social phobia	10%	20% ↑	2.0x
Post-Traumatic Stress Disorder (PTSD)	9%	22% ↑	2.4x
Panic Disorder	9%	17% ↑	1.9x
Obsessive-Compulsive Disorder (OCD)	7%	15% ↑	2.1x
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	18% ↑	2.6x
Binge eating disorder	5%	14% ↑	2.8x
Suicide and self-harm	4%	10% ↑	2.5x
Substance use disorders (drug and alcohol abuse)	4%	9% ↑	2.3x
Autism Spectrum Disorder (ASD)	3%	8% ↑	2.7x
Premenstrual dysphoric disorder (PMDD)	3%	9% ↑	3.0x
Specific Phobias or Agoraphobia	3%	7% ↑	2.3x
Borderline Personality Disorder	2%	6% ↑	3.0x
Perinatal Depression (including Antenatal and Postnatal periods)	2%	7% ↑	3.5x
Bulimia nervosa	1%	4% ↑	4.0x
Perinatal Obsessive Compulsive Disorder	1%	4% ↑	4.0x

↑ Significantly higher results vs those without PMOS at 95% c.i.

The most common mental health condition in women with PMOS was depression, affecting almost 1 in 2 (47%), which is a rate 1.6x higher than the overall sample.

Prevalence rates of anxiety and stress-related mental health issues were also statistically increased in women with PMOS compared to those without PMOS. This included anxiety and generalised anxiety disorder (reported by 39% of women with PMOS), illness anxiety disorder or health anxiety (19%), social phobia (20%), OCD (15%), specific phobias or agoraphobia (7%), and PTSD (22%). These conditions were between 1.7x and 2.4x more common in women with PMOS compared to the overall sample.

Women with PMOS also reported significantly higher rates of body image issues affecting 2 in 5 (40%). Eating disorders were also more prevalent among women with PMOS, including binge eating disorder (14%) which was 2.8x more common, and bulimia nervosa (4%) which was 4x more common in women with PMOS compared to the overall sample.

Interestingly, prevalence rates of hormonal-related mental health conditions were also increased in women with PMOS, including premenstrual dysphoric disorder (PMDD) (9%) which was 3x more common, perinatal depression (7%) which was 3.5x common, and perinatal OCD (4%) which was 4x more common compared to the overall sample. Together, these findings suggest a potential association between PMOS and mental health conditions that are influenced by hormonal fluctuations.

Women with PMOS also reported significantly higher rates of neurodevelopmental disorders including ADHD affecting 18% (2.6x higher than overall sample), and autism spectrum disorder affecting 8% (2.7x higher than overall sample).

Prevalence rates of suicide and self harm (10%) as well as substance use disorders (9%) were also elevated, which were 2.5x and 2.3x more common in women with PMOS compared to the overall sample, respectively.

"My social worker does not have [PMOS] and does not really understand the condition as she has not lived it. That makes it difficult for her and I to connect on my struggles with weight and poor body image."



Endometriosis

Endometriosis is a common reproductive health condition that affects about 1 in 7 women and gender diverse people, where tissue similar to the lining of the uterus grows outside it in other parts of the body (Endometriosis Australia, n.d.). Common symptoms of endometriosis include pelvic pain, pain in other areas of the body, fatigue, and heavy or irregular bleeding (Healthdirect, 2025).

Women who reported having endometriosis are experiencing moderate levels of psychological distress (Avg K10 score of 28.3) which was significantly higher than women who did not report having endometriosis (Avg K10 score of 22.6).

Women with endometriosis are experiencing many mental health issues at significantly higher rates compared to women without endometriosis. These findings are consistent with previous academic studies showing that endometriosis is associated with higher rates of mental health conditions such as anxiety and depression (Culley et al., 2013).

The most common mental health condition in women with endometriosis was depression, affecting almost 1 in 2 (48%), which was closely followed by anxiety and generalised anxiety disorder which affected 47%. The prevalence rates of these mental health issues were 1.6x and 2.2x more common in women with endometriosis compared to the overall study population, respectively.

Prevalence rates of other anxiety and stress-related mental health issues were also elevated in women with endometriosis including illness anxiety disorder or health anxiety (reported by 19% of women with endometriosis), panic disorder (18%), OCD (22%), specific phobias or agoraphobia (8%), and PTSD (21%). These mental health issues were

between 1.7x and 3.1x more common in women with endometriosis compared to the overall sample.

Women with endometriosis also reported statistically higher rates of hormonal-related mental health conditions compared to those without endometriosis. Premenstrual dysphoric disorder (PMDD) was reported by more than 1 in 8 women with endometriosis (13%) and was 4.3x more common than the overall sample. Other conditions reported at higher rates included perinatal anxiety (5%), which was 2.5x more common; perinatal depression (6%), which was 3x more common; and perimenopausal anxiety and depression (17%), which was 1.9x as common.

Prevalence rates of neurodevelopmental disorders were particularly increased in women with endometriosis including ADHD affecting 22% (3.1x higher than the overall sample), and autism spectrum disorder affecting 12% (4.0x higher than the overall sample).

Women with endometriosis also reported significantly higher rates of body image issues (43%) and binge eating disorder (13%) than those without endometriosis, both of which were more than twice as common in women with endometriosis than the overall study population.

Prevalence rates of suicide and self harm (13%) as well as substance use disorders (11%) were also elevated, which were 3.3x and 2.8x more common in women with endometriosis compared to the overall sample, respectively.

Borderline personality disorder was particularly high in women with endometriosis, affecting 1 in 12 (8%). This was 4.0x more common than in the overall sample.

"I didn't realize the severity of my mental health condition until recently."



	Gen Pop %	Women with Endometriosis	Times more common than gen pop
Depression	30%	48% ↑	1.6x
Anxiety & Generalised Anxiety Disorder (GAD)	21%	47% ↑	2.2x
Body image issues	20%	43% ↑	2.2x
Insomnia or other sleep-wake disorder	16%	29% ↑	1.8x
Illness Anxiety Disorder or Health Anxiety	11%	19% ↑	1.7x
Perimenopausal Anxiety/Depression	9%	17% ↑	1.9x
Post-Traumatic Stress Disorder (PTSD)	9%	21% ↑	2.3x
Panic Disorder	9%	18% ↑	2.0x
Obsessive-Compulsive Disorder (OCD)	7%	22% ↑	3.1x
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	22% ↑	3.1x
Binge eating disorder	5%	13% ↑	2.6x
Suicide and self-harm	4%	13% ↑	3.3x
Substance use disorders (drug and alcohol abuse)	4%	11% ↑	2.8x
Autism Spectrum Disorder (ASD)	3%	12% ↑	4.0x
Premenstrual dysphoric disorder (PMDD)	3%	13% ↑	4.3x
Specific Phobias or Agoraphobia	3%	8% ↑	2.7x
Borderline Personality Disorder	2%	8% ↑	4.0x
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	5% ↑	2.5x
Perinatal Depression (including Antenatal and Postnatal periods)	2%	6% ↑	3.0x

↑ Significantly higher results vs those without Endometriosis at 95% c.i.

Adenomyosis

Adenomyosis is a reproductive health condition that affects about 1 in 10 women and gender diverse people, where tissue similar to the lining of the uterus grows into the muscle wall of the uterus (Healthdirect, 2024). Adenomyosis is different to endometriosis, but it is possible to have both conditions at the same time. Common symptoms of adenomyosis include pelvic pain, painful and heavy periods, and longer menstrual cycles (Jean Hailes for Women’s Health, n.d.).

Women who reported having adenomyosis are experiencing the upper end of mild levels of psychological distress (Avg K10 score of 24.0) which was comparable to those who did not report having adenomyosis.

However, women living with adenomyosis reported experiencing mental health issues at significantly higher rates than women without adenomyosis. The most commonly reported conditions were depression (experienced by 54% of women with adenomyosis), anxiety and generalised anxiety disorder (38%), body image concerns (37%), insomnia and other sleep problems (30%), and illness anxiety or health anxiety (25%). These mental health conditions were nearly twice as common, and in some cases more than twice as common, among women with adenomyosis compared with the overall study population.

Hormonal-related mental health conditions were also elevated in women with adenomyosis, including premenstrual dysphoric disorder (PMDD) which affected more than 1 in 10 (14%) and was 4.7x more common than in the overall sample, and



perimenopausal anxiety/depression which affected 1 in 4 (26%) and was 2.9x more common than in the overall study population.

Prevalence rates of neurodevelopmental disorders were also particularly increased in women with adenomyosis including ADHD affecting 22% (3.1x higher than the overall sample), and autism spectrum disorder affecting 13% (4.3x higher than the overall sample).

Other mental health issues with increased prevalence rates in women with adenomyosis included OCD affecting 1 in 5 (2.9x higher than the overall sample), PTSD affecting 1 in 5 (2.2x higher than overall sample), and suicide and self-harm affecting 12% (3.0x higher than the overall sample).

	Gen Pop %	Adenomyosis	Times more common than gen pop
Depression	30%	54% ↑	1.8x
Anxiety & Generalised Anxiety Disorder (GAD)	21%	38% ↑	1.8x
Body image issues	20%	37% ↑	1.9x
Insomnia or other sleep-wake disorder	16%	30% ↑	1.9x
Illness Anxiety Disorder or Health Anxiety	11%	25% ↑	2.3x
Perimenopausal Anxiety/Depression	9%	26% ↑	2.9x
Post-Traumatic Stress Disorder (PTSD)	9%	20% ↑	2.2x
Obsessive-Compulsive Disorder (OCD)	7%	20% ↑	2.9x
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	22% ↑	3.1x
Suicide and self-harm	4%	12% ↑	3.0x
Autism Spectrum Disorder (ASD)	3%	13% ↑	4.3x
Premenstrual dysphoric disorder (PMDD)	3%	14% ↑	4.7x

↑ Significantly higher results vs those without Adenomyosis at 95% c.i.

Pelvic floor disorders

Pelvic floor disorders, also known as pelvic floor dysfunction, occur when the muscles of the pelvic floor are not functioning correctly. Pregnancy, childbirth, being overweight, constipation, heavy lifting, and changes in hormonal levels can all cause issues with a woman’s pelvic floor muscle. This can lead to a variety of issues, including urinary and fecal incontinence, pelvic organ prolapse, and sexual dysfunction (Healthdirect, 2025).

Women who reported having pelvic floor disorders are experiencing moderate levels of psychological distress (Avg K10 score of 26.1) which was significantly higher than women who did not report having pelvic floor disorders (Avg K10 score of 22.7).

Women living with pelvic floor disorders reported experiencing mental health issues at significantly higher rates than women without pelvic floor disorders.

Depression was the most common mental health issue, affecting more than 1 in 2 (51%) women with pelvic floor disorders, a rate 1.7x more common than in the overall sample. The second most common mental health issue was insomnia or other sleep wake disorders which affected 2 in 5 (41%) and was 2.6x more common in women with pelvic floor disorders than in the overall sample.

Anxiety and stress-related disorders were also elevated in women with pelvic floor disorders. This included anxiety or generalised anxiety disorder (experienced by 40% of women with pelvic floor disorders), illness anxiety disorder or health anxiety (23%), social phobia (18%), PTSD (22%), OCD (14%), and specific phobias or agoraphobia (8%). These conditions were between 1.8x and 2.7x more common among women with pelvic floor disorders compared to the broader study population.

Other mental health issues with increased prevalence rates in women with pelvic floor disorders included body image issues (experienced by 30% of women with pelvic floor disorder), perimenopausal anxiety/depression (18%), suicide and self harm (9%), and autism spectrum disorder (7%). These conditions were between 1.5x and 2.3x more prevalent in women with pelvic floor disorders than in the overall study sample.

Dysthymia (also referred to as persistent depressive disorder) was particularly elevated in women with pelvic floor disorders, affecting 6% which was 3x more common than in the overall sample.

	Gen Pop %	Pelvic floor disorders	Times more common than gen pop
Depression	30%	51% ↑	1.7x
Anxiety & Generalised Anxiety Disorder (GAD)	21%	40% ↑	1.9x
Body image issues	20%	30% ↑	1.5x
Insomnia or other sleep-wake disorder	16%	41% ↑	2.6x
Illness Anxiety Disorder or Health Anxiety	11%	23% ↑	2.1x
Social phobia	10%	18% ↑	1.8x
Perimenopausal Anxiety/Depression	9%	18% ↑	2.0x
Post-Traumatic Stress Disorder (PTSD)	9%	22% ↑	2.4x
Obsessive-Compulsive Disorder (OCD)	7%	14% ↑	2.0x
Suicide and self-harm	4%	9% ↑	2.3x
Autism Spectrum Disorder (ASD)	3%	7% ↑	2.3x
Specific Phobias or Agoraphobia	3%	8% ↑	2.7x
Dysthymia (also referred to as persistent depressive disorder)	2%	6% ↑	3.0x

↑ Significantly higher results vs those without Pelvic floor disorders at 95% c.i.

Vaginal issues

Vaginal issues is a broad term used to describe a range of health problems affecting the vagina, including infections, abnormal bleeding, and discomfort. These issues can manifest as changes in vaginal discharge, itching, burning, pain during urination or intercourse, and even pelvic pain (Healthdirect, n.d.). Specific vaginal conditions like bacterial vaginosis, vaginitis, uterine fibroids, and vulvodynia can cause extreme discomfort and mental distress for women; ultimately impacting their mental health outcomes.

Women who reported having vaginal issues are experiencing moderate levels of psychological distress (Avg K10 score of 27.1) which was significantly higher than women who did not report having vaginal issues (Avg K10 score of 22.7).



The most common mental health issue among women with vaginal issues was depression, affecting more than 1 in 3 (38%). However, this was comparable to the prevalence rate observed in women without vaginal issues.

Women living with vaginal issues reported experiencing other mental health issues at significantly higher rates than women without vaginal issues.

Anxiety and stress-related mental health conditions were particularly elevated in women with vaginal issues, including anxiety or generalised anxiety disorder which affected 1 in 3 (33%) and was 1.6x more common than in the overall sample. In addition, women with vaginal issues reported higher rates of illness anxiety disorder or health anxiety (experienced by 23%), PTSD (19%), OCD (16%), and specific phobias or agoraphobia (8%). These conditions were more than twice more common in women with vaginal issues compared to the broader overall study sample.

Hormonal-related mental health conditions were also elevated in women with vaginal issues, including premenstrual dysphoric disorder (PMDD); experienced by 9% of women with vaginal issues) which was 3x more common than in the overall sample; perinatal anxiety (7%) which was 3.5x more common than in the overall sample; and perimenopausal anxiety/depression (19%) which was 1.9x more common than in the overall sample.

Other mental health issues with increased prevalence rates in women with vaginal issues included body image issues (experienced by 33% of women with vaginal issues), insomnia or other sleep wake disorders (26%), binge eating disorder (11%), substance use disorder (9%), ADHD (14%), and autism spectrum disorder (8%). These conditions were between 1.6x and 2.7x more prevalent in women with vaginal issues than in the overall study sample.

Dysthymia (also referred to as persistent depressive disorder) was particularly elevated in women with vaginal issues, affecting 7% which was 3.5x more common than in the overall sample.

"I have been suffering from chronic nerve pain for some years for which I don't know the reason why. It's impacting my mental health."



	Gen Pop %	Vaginal issues	Times more common than gen pop
Anxiety & Generalised Anxiety Disorder (GAD)	21%	33% ↑	1.6x
Body image issues	20%	33% ↑	1.7x
Insomnia or other sleep-wake disorder	16%	26% ↑	1.6x
Illness Anxiety Disorder or Health Anxiety	11%	23% ↑	2.1x
Perimenopausal Anxiety/Depression	9%	17% ↑	1.9x
Post-Traumatic Stress Disorder (PTSD)	9%	19% ↑	2.1x
Obsessive-Compulsive Disorder (OCD)	7%	16% ↑	2.3x
Attention-Deficit/Hyperactivity Disorder (ADHD)	7%	14% ↑	2.0x
Binge eating disorder	5%	11% ↑	2.2x
Substance use disorders (drug and alcohol abuse)	4%	9% ↑	2.3x
Autism Spectrum Disorder (ASD)	3%	8% ↑	2.7x
Premenstrual dysphoric disorder (PMDD)	3%	9% ↑	3.0x
Specific Phobias or Agoraphobia	3%	8% ↑	2.7x
Dysthymia (also referred to as persistent depressive disorder)	2%	7% ↑	3.5x
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	7% ↑	3.5x

↑ Significantly higher results vs those without vaginal issues at 95% c.i

Pregnancy loss (miscarriage/stillbirth)

Pregnancy loss encompasses both miscarriage and stillbirth – and is not just a reproductive or medical event – it is a major psychological and emotional rupture. Miscarriage is defined as a pregnancy loss before 20 weeks gestation. It is common, occurring in around 1 in 4 pregnancies. In a recent study, the Australian Institute of Health and Welfare found that 3 in 10 (30%) women who gave birth in 2022 had previously experienced at least one miscarriage, and 1 in 10 (10%) had experienced two or more miscarriages (AIHW, 2026). There are many different types of miscarriage, including early, late or recurrent miscarriage. Stillbirth on the other hand, is defined as the loss of a pregnancy after 20 weeks. In Australia, six babies are stillborn every day (Miscarriage Australia, 2025). The mental health implications for a woman suffering from a pregnancy loss cannot be understated – the grief, sadness and immense pain is deeply felt, alongside the many possible physical health burdens that women are then also left to deal with.

Women who reported experiencing pregnancy loss are experiencing severe levels of psychological distress (Avg K10 score of 30.6) which was significantly higher than women who did not report experiencing pregnancy loss (Avg K10 score of 22.8).

Women who experienced pregnancy loss reported a number of mental health issues at significantly higher rates than women who did not experience pregnancy loss. For example, women who experienced pregnancy loss reported higher rates of anxiety or generalized anxiety disorder (affected 39% of women who experienced pregnancy loss) which was 1.9x more common than in the overall

sample; body image issues (37%) which was 1.9x more common than in the overall sample, and PTSD (25%) which was 2.8x more common than in the overall sample. Higher prevalence rates of PTSD in women who experience pregnancy loss could be related to the distressing experiences that may accompany pregnancy loss. These findings suggest the importance of recognising pregnancy loss as a significant life event that requires ongoing mental health support and care for women.

Borderline personality disorder (reported by 11%) and bipolar affective disorder (14%) were also reported at higher rates among women who experienced pregnancy loss. These conditions were 5.5x and 7x more common compared with the overall sample, respectively.

Women who experienced pregnancy loss also reported statistically higher rates of perinatal mental health conditions compared to those who did not experience pregnancy loss. This included perinatal anxiety (experienced by 12% of women who experienced pregnancy loss) which was 6x more common than in the overall sample, and perinatal depression (16%) which was 8x more common than in the overall sample. These findings may partly reflect the fact that women who experienced pregnancy loss were more likely to have been in the perinatal period compared with the broader study population, and therefore were more likely to endorse perinatal mental health conditions.

	Gen Pop %	Pregnancy loss	Times more common than gen pop
Anxiety & Generalised Anxiety Disorder (GAD)	21%	39% ↑	1.9x
Body image issues	20%	37% ↑	1.9x
Post-Traumatic Stress Disorder (PTSD)	9%	25% ↑	2.8x
Borderline Personality Disorder	2%	11% ↑	5.5x
Bipolar Affective Disorder	2%	14% ↑	7.0x
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	12% ↑	6.0x
Perinatal Depression (including Antenatal and Postnatal periods)	2%	16% ↑	8.0x
Dementia	1%	9% ↑	9.0x

↑ Significantly higher results vs those who did not experience pregnancy loss at 95% c.i.

"I know I should reach out, but my body feels heavy and my mind's blank. First step? Can't even imagine it."

Physical birth trauma

Physical birth trauma is defined as any physical injury or damage experienced during or after childbirth. Physical birth trauma can include, but is not limited to, perineal tears, pelvic floor muscle damage, pelvic organ prolapse, pelvic fractures, or caesarean wounds. Additionally, it can encompass injuries resulting from instrumental deliveries (like forceps or vacuum), emergency caesarean sections, and postpartum hemorrhage (Birth Trauma Australia, n.d). A woman’s experience of interactions and/or events related to childbirth can cause overwhelming distressing emotions and reactions, leading to short and/or long-term negative impacts on a woman’s health and well-being.

Women who reported experiencing physical birth trauma are experiencing moderate levels of psychological distress (Avg K10 score of 28.6) which was significantly higher than women who did not report experiencing physical birth trauma (Avg K10 score of 22.8).

The most common mental health issue in women who reported physical birth trauma was body image issues, affecting more than 1 in 3 (36%). This was 1.8x more common than in the overall sample.

Perinatal mental health conditions were also significantly increased in women who reported physical birth trauma compared to those who did not report physical birth trauma. This included perinatal anxiety (experienced by 19% of women with physical birth trauma), perinatal depression (17%), perinatal OCD (10%) and perinatal psychosis (7%). These conditions were between 7x and 10x more common in women who reported physical birth trauma than the overall study population. These findings may partly reflect the fact that women who experienced physical birth trauma

were more likely to have been in the perinatal period compared with the broader study population, and therefore were more likely to endorse perinatal mental health conditions.

Prevalence rates of premenstrual dysphoric disorder (PMDD) were also significantly higher in women who reported physical birth trauma, affecting 1 in 10 (10%) which was more than three times more common than in the overall sample.



	Gen Pop %	Physical Birth Trauma	Times more common than gen pop
Body image issues	20%	36% ↑	1.8x
Premenstrual dysphoric disorder (PMDD)	3%	10% ↑	3.3x
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	19% ↑	9.5x
Perinatal Depression (including Antenatal and Postnatal periods)	2%	17% ↑	8.5x
Perinatal Obsessive Compulsive Disorder	1%	10% ↑	10.0x
Perinatal Psychosis (including Antenatal and Postnatal periods)	1%	7% ↑	7.0x

↑ Significantly higher results vs those who did not experience physical birth trauma at 95% c.i.

Perinatal (prenatal/postnatal) physical health issues

Physical perinatal issues refer to physical health concerns that can arise during pregnancy, delivery, and the first year after childbirth. These can include postpartum hemorrhage, infections, urinary tract infections, blood clots, gestational diabetes, physical pain after birth and birthing related complications etc. These issues can significantly affect a mother’s physical health, mental well-being, and her ability to bond with her baby.

Women who reported experiencing perinatal physical health issues are experiencing the upper end of mild levels of psychological distress (Avg K10 score of 24.9) which was significantly higher than women who did not report experiencing perinatal physical health issues (Avg K10 score of 22.8).

Perinatal mental health conditions were also significantly increased in women who reported perinatal physical health issues compared to those who did not report perinatal physical health issues. This included perinatal anxiety (experienced by 30% of women with perinatal physical health issues), perinatal depression (21%), perinatal OCD (14%) and perinatal psychosis (6%). These conditions were between 6x and 15x more common in women who reported perinatal physical health issues than the overall study population. These findings may partly reflect the fact that women who experienced perinatal physical health issues were more likely to have been in the perinatal period compared with the broader study population, and therefore were more likely to endorse perinatal mental health conditions.



	Gen Pop %	Perinatal issues	Times more common than gen pop
Perinatal Anxiety (including Antenatal and Postnatal periods)	2%	30% ↑	15.0x
Perinatal Depression (including Antenatal and Postnatal periods)	2%	21% ↑	10.5x
Perinatal Obsessive Compulsive Disorder	1%	14% ↑	14.0x
Perinatal Psychosis (including Antenatal and Postnatal periods)	1%	6% ↑	6.0x

↑ Significantly higher results vs those without perinatal physical health issues at 95% c.i.

Perimenopause

Perimenopause is the stage before a woman’s final period (menopause) when their body is transitioning to the end of its reproductive years. Perimenopause typically occurs between the ages of 45 and 55 years, although the timing and duration of perimenopause varies significantly among women. It is a natural part of a woman’s life characterised by irregular menstrual cycles and a reduced number of eggs in the ovaries. However, perimenopause is a period marked by both physiological change and complex psychosocial demands; making it a particularly challenging time for some women to navigate (Zhang et al., 2025; Badawy et al., 2024).

Women who reported experiencing perimenopause are experiencing the upper end of mild levels of psychological distress (Avg K10 score of 24.0) which was significantly higher than women who did not report experiencing perimenopause (Avg K10 score of 22.7).

Women experiencing perimenopause reported significantly higher rates of certain mental health issues compared to women not experiencing perimenopause. This included anxiety or generalised anxiety disorder (reported by 29% of women experiencing perimenopause), insomnia or other sleep-wake disorders (24%), PTSD (17%), social phobia (15%), autism spectrum disorder (7%), and substance use disorder (7%). These conditions occurred between 1.4x and 2.3x more frequently than in the overall sample.

In addition, women who were experiencing perimenopause also reported significantly higher rates of premenstrual dysphoric disorder (PMDD), affecting 8% which was 2.7x more common than in the overall sample.

Importantly, perimenopausal anxiety and depression affected nearly 1 in 2 (49%) women in the perimenopause stage; reinforcing the importance of providing mental health care support during the perimenopausal transition. For more information on perimenopausal anxiety and depression, please see a dedicated section near the end of this report.

“There are so many different ways women experience menopause / peri-menopause it can be hard for healthcare professionals to help”

	Gen Pop %	Perimenopause	Times more common than gen pop
Anxiety & Generalised Anxiety Disorder (GAD)	21%	29% ↑	1.4x
Insomnia or other sleep-wake disorder	16%	24% ↑	1.5x
Social phobia	10%	15% ↑	1.5x
Perimenopausal Anxiety/Depression	9%	49% ↑	5.4x
Post-Traumatic Stress Disorder (PTSD)	9%	17% ↑	1.9x
Substance use disorders (drug and alcohol abuse)	4%	7% ↑	1.8x
Autism Spectrum Disorder (ASD)	3%	7% ↑	2.3x
Premenstrual dysphoric disorder (PMDD)	3%	8% ↑	2.7x
Specific Phobias or Agoraphobia	3%	5% ↑	1.7x

↑ Significantly higher results vs those who did not experience perimenopause at 95% c.i.

Menopause

Menopause is a normal and inevitable part of aging in women, which is when menstrual bleeding stops completely for at least 12 months. This is caused by the depletion of eggs in the ovaries (Zhang et al., 2025; Badawy et al., 2024; Jia et al., 2024). In Australia, the average age of menopause is 51. It's normal to reach menopause between the ages of 45 and 55 years, but some women reach menopause earlier or later than this. This is usually a gradual rather than sudden process, during which a woman goes through perimenopause before reaching menopause. After menopause, she is considered postmenopausal. Menopause is a period that coincides with biological changes, midlife stress, role changes, and health problems; making it a particularly challenging time for some women to navigate (Jia et al., 2024).

Women who reported experiencing menopause are experiencing the upper end of mild levels of psychological distress (Avg K10 score of 23.8) which was significantly higher than women who did not report experiencing menopause (Avg K10 score of 22.7).

Women experiencing menopause reported significantly higher rates of certain mental health issues compared to women not experiencing menopause. This included depression (reported by 36% of women experiencing menopause), body image issues (24%), insomnia or other sleep wake disorders (27%), illness anxiety disorder or health anxiety (15%), social phobia (15%), and PTSD (14%). These conditions were between 1.2x and 1.7x more common in women experiencing menopause than the overall sample. Moreover, perimenopausal anxiety and depression was also statistically increased in this group, affecting 17% which was 1.9x more common than the overall sample.



	Gen Pop %	Menopause	Times more common than gen pop
Depression	30%	36% ↑	1.2x
Body image issues	20%	24% ↑	1.2x
Insomnia or other sleep-wake disorder	16%	27% ↑	1.7x
Illness Anxiety Disorder or Health Anxiety	11%	15% ↑	1.4x
Social phobia	10%	15% ↑	1.5x
Perimenopausal Anxiety/Depression	9%	17% ↑	1.9x
Post-Traumatic Stress Disorder (PTSD)	9%	14% ↑	1.6x

↑ Significantly higher results vs those who did not experience menopause at 95% c.i.



Triggers and Contributing Factors for Mental Health Issues in Australian Women

To better understand the factors that may contribute to women's mental health issues, we explored a broad range of potential triggers across internal, interpersonal, societal and gendered domains. These included personal experiences such as low-self esteem or physical illness; life circumstances such as financial stress and work-life balance; wider societal triggers such as discrimination and social media pressures, and gendered societal triggers such as domestic violence, parenting responsibilities, and gendered discrimination.

Recognising that mental health is shaped by multiple, interconnected factors, women were asked to indicate whether each factor had contributed to the mental health issues they were currently facing. Understanding these triggers can help identify areas where greater support, prevention efforts, and policy change may improve women's mental health and wellbeing.

Overall Triggers

The key triggers reported to contribute to mental health issues in 2026 were largely consistent with those reported in 2025. Financial pressures, low self-esteem or confidence, sleep deprivation, and being too hard on oneself were among the leading reported triggers for overall mental health issues.

In regards to the top five mental health issues, these same factors also emerged as primary triggers for both depression and anxiety or generalised anxiety disorder.

In contrast, body image issues were reported to be mainly triggered by low-self esteem, unrealistic body standards, societal pressures, and social media.

Beyond financial pressures and low self-esteem, aging and chronic pain were the most commonly reported triggers for insomnia or other sleep-wake disorders, while physical illness/injuries and sleep deprivation were the most commonly reported triggers for illness anxiety disorder or health anxiety.

Hormonal factors such as menstruation and menopause also appeared as top reported triggers for body image issues and insomnia or other sleep-wake disorders.





Triggers for Mental Health Issues in 2026

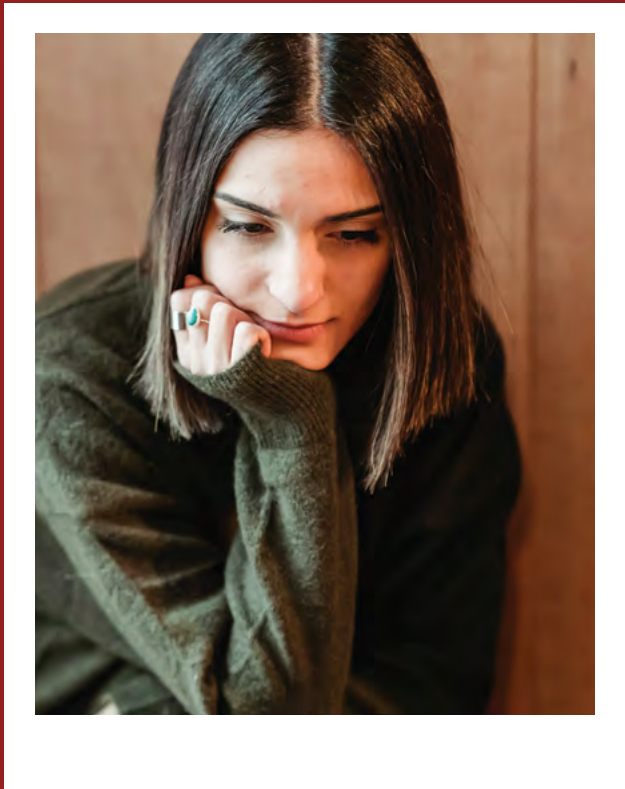
Financial stress/pressures	34%
Low self esteem or confidence	34%
Sleep deprivation or sleep disturbance	32%
Pressures created by own self/being too hard on own self	29%
Aging	24%
Too many expectations from society	22%
Unrealistic ideals of body image	18%
Trying to juggle career & work / work life balance	18%
Lack of support network	17%
Lack of social acceptance or belonging	17%
Unstable family situation/family breakdown/family conflict/relationship breakdowns	17%
Own physical illnesses/injuries	17%
Grief, death and/or loss	16%
Chronic pain	16%
Menstruation / Hormonal Fluctuations	16%
Media/Social media pressure to be perfect	13%
Menopause	13%
High pressure/competitive work environment	13%
Aging family members	13%
Childhood abuse and trauma	13%
Financial dependency	11%
Physical or mental illness/injuries of family members	11%
I am not sure what caused the mental health issues I am currently facing	11%
Living away from family/friends	11%
Bullying/emotional abuse	10%
The impact of my Physical Disability on daily life	10%
The impact of my Neurological Condition (eg. ADHD, Autism) on daily life	10%
My caring responsibilities for someone with a disability, medical condition, or who is frail aged	9%
Sexual dysfunction (eg. low sexual desire, impaired arousal and poor sexual self-image)	9%
Strict home environment while growing up	9%
Parenting young children	9%
Retirement/loss of purpose	8%
Domestic violence	7%
The demands of parenting child/children with special/increased needs or disabilities	7%
Addiction	7%
Career sacrifices	7%
Single parenting	7%
Living alone / Kids leaving home	6%
Academic pressure	6%
Others	5%
Sexual harassment / sexual violence	5%
Discrimination (other than gender and racial)	4%
Moving to a new school, university or city	4%
Gender discrimination	3%
Birth Trauma (Mental/Psychological)	3%
Infertility/Fertility Challenges	3%
Pregnancy loss (miscarriage/stillbirth)	3%
Pregnancy	3%
Birth Trauma (Physical)	2%
Racial discrimination	2%

Gendered social determinants of mental health

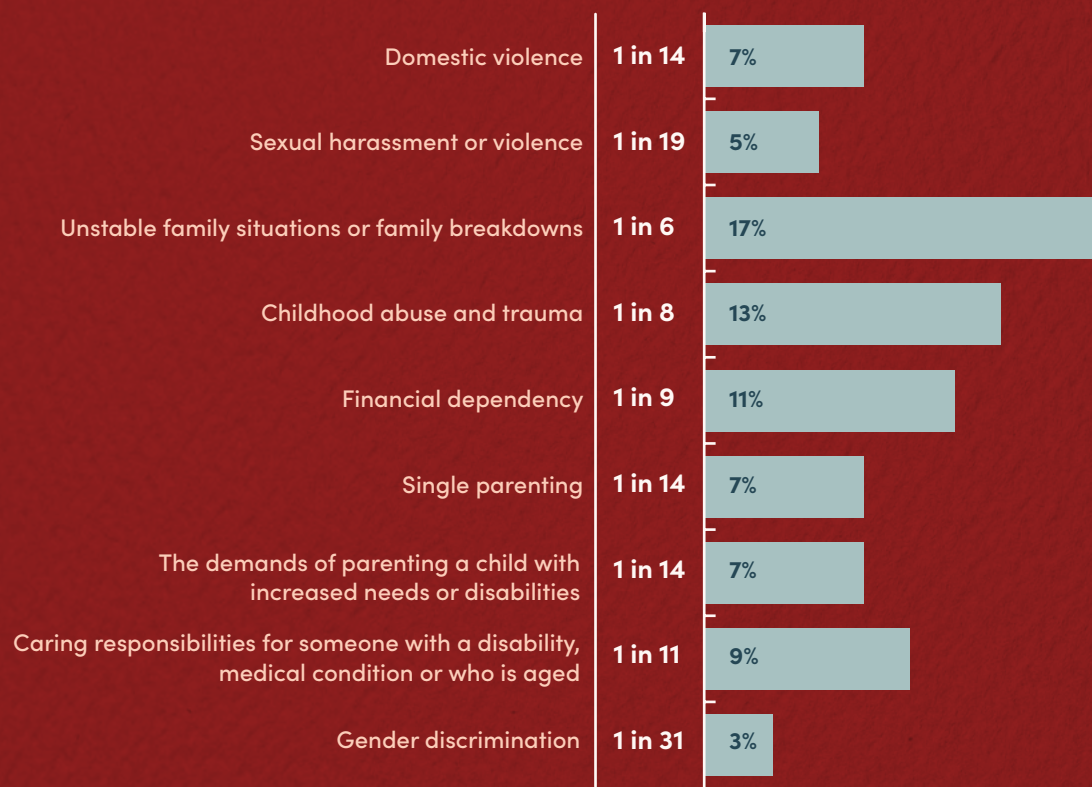
Mental health is shaped not only by individual experiences and biological factors, but also by the social environments in which people live. For women, some of these social determinants of mental health are gendered, meaning they arise from social norms, expectations and inequalities associated with gender. Gendered social determinants of mental health reflect the wider social and cultural environments that shape women's lives and create unequal risks for mental health challenges.

Women were asked to reflect on a range of gendered social factors that they believed had contributed to their mental health issues, with their responses highlighting the significant role that gendered social and structural experiences play in shaping women's mental wellbeing.

These findings highlight the importance of efforts to prevent gender-based violence, promote economic security and independence, support carers and parents, reduce discrimination, and create policies and services that better recognise and respond to women's lived experiences.



For women with mental health issues, the following triggers were reported to be contributing to the mental health issues they were currently facing:



Triggers by location

The top triggers contributing to mental health issues were similar for those living in metropolitan and regional areas of Australia, however each trigger was endorsed more frequently by those living in regional areas.

Triggers by priority population groups

WOMEN FACING HOMELESSNESS AND POVERTY

The leading reported triggers contributing to mental health issues were similar for women experiencing poverty or homelessness and the overall sample; however they were endorsed more frequently by women facing poverty/homelessness.

Financial pressures were a particularly key contributor, with over half identifying financial stress (52%) as a trigger, while one in five (20%) reported financial dependency as contributing to their mental health challenges.

Additional reported triggers for mental health issues include experiences of abuse, including childhood abuse and trauma (24%) and bullying/emotional abuse (20%).

Women facing homelessness and poverty	2026
Financial stress/pressures	52%
Low self esteem or confidence	43%
Sleep deprivation or sleep disturbance	36%
Pressures created by own self/being too hard on own self	34%
Aging	33%
Lack of support network	28%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	27%
Too many expectations from society	26%
Own physical illnesses / injuries	25%
Lack of social acceptance or belonging	24%
Childhood abuse and trauma	24%
Grief, death and/or loss	21%
The impact of my Physical Disability on daily life	20%
Bullying/emotional abuse	20%
Financial dependency	20%

WOMEN WHO IDENTIFY AS LGBTQIA+

Self-perception and personal pressures were particularly relevant contributors to mental health issues among women who identify as LGBTQIA+, with 44% identifying low self-esteem or confidence and 40% identifying pressure they place on themselves as triggers.

Other commonly reported triggers included unrealistic body image ideals (28%), menstruation or hormonal fluctuations (26%), and childhood abuse or trauma (24%).

Women who identify as LGBTQIA+	2026
Low self esteem or confidence	44%
Pressures created by own self/being too hard on own self	40%
Financial stress/pressures	40%
Sleep deprivation or sleep disturbance	36%
Too many expectations from society	32%
Unrealistic ideals of body image	28%
Lack of social acceptance or belonging	28%
Menstruation / Hormonal Fluctuations	26%
Trying to juggle career & work / work life balance	25%
The impact of my Neurological Condition (eg. ADHD, Autism) on daily life	25%
Childhood abuse and trauma	24%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	23%
Media/Social media pressure to be perfect (perfect appearance/career/house/life, etc.)	22%
Grief, death and/or loss	20%
Lack of support network	19%

WOMEN LIVING WITH A DISABILITY

Around half of women living with a disability reported that their own physical illness or injury (52%), and the impact of their physical disability on daily life (45%), were triggers for their mental health issues.

Other leading reported triggers for mental health issues among women living with a disability were similar to those reported by the overall sample, although they were endorsed more frequently.

Women living with a disability	2026
Own physical illnesses / injuries	52%
Sleep deprivation or sleep disturbance	51%
Financial stress/pressures	51%
Low self esteem or confidence	48%
The impact of my Physical Disability on daily life	45%
Pressures created by own self/being too hard on own self	42%
Aging	37%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	30%
Lack of support network	29%
Grief, death and/or loss	29%
Lack of social acceptance or belonging	28%
Physical or mental illness/injuries of family members	27%
Childhood abuse and trauma	26%
Too many expectations from society	25%
Unrealistic ideals of body image	22%

WOMEN FROM CALD COMMUNITIES

While similar factors emerged as primary triggers for mental health issues in women from CALD communities as the overall sample, there were some notable differences. Social connection played a particularly important role, with women reporting a lack of a support network (23%), unstable family situations (21%), living away from family/friends (20%), and a lack of social acceptance or belonging (20%) as triggers for their mental health challenges.

Women from CALD communities	2026
Financial stress/pressures	42%
Low self esteem or confidence	41%
Sleep deprivation or sleep disturbance	36%
Pressures created by own self/being too hard on own self	36%
Aging	30%
Too many expectations from society	26%
Lack of support network	23%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	21%
Unrealistic ideals of body image	20%
Living away from family/friends	20%
Trying to juggle career & work / work life balance	20%
Lack of social acceptance or belonging	20%
Own physical illnesses / injuries	19%
High pressure/competitive work environment	18%
Grief, death and/or loss	17%





"Due to my current physical health conditions, which has recently made me unable to work, I don't have the additional funds to seek help for my mental health issues."

WOMEN WITH COMORBIDITIES

Women with comorbidities reported similar triggers for their mental health issues as the overall sample. Almost 1 in 4 (23%) reported that their own physical illnesses/injuries were a trigger of their mental health issues.

Women with comorbidities	2026
Financial stress/pressures	39%
Low self esteem or confidence	37%
Sleep deprivation or sleep disturbance	36%
Pressures created by own self/being too hard on own self	32%
Aging	29%
Too many expectations from society	23%
Own physical illnesses / injuries	23%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	20%
Grief, death and/or loss	20%
Lack of support network	19%
Trying to juggle career & work / work life balance	19%
Lack of social acceptance or belonging	19%
Unrealistic ideals of body image	18%
Menstruation / Hormonal Fluctuations	18%
Menopause	17%

WOMEN WHO ARE CURRENTLY PREGNANT

1 in 3 (32%) women who were currently pregnant reported that their pregnancy was contributing to their mental health issues. Other triggers relevant to pregnancy and motherhood included parenting young children (17%), infertility/fertility challenges (7%), pregnancy loss (12%), single parenting (8%), as well as birth trauma from previous pregnancies in the form of mental/psychological trauma (16%) and physical trauma (5%).

Other notable triggers were trying to juggle their work life balance (20%) and media/social media pressure to be perfect (14%).

Women who are currently pregnant	2026
Sleep deprivation or sleep disturbance	32%
Pregnancy	32%
Financial stress/pressures	27%
Low self esteem or confidence	21%
Too many expectations from society	20%
Trying to juggle career & work / work life balance	20%
Lack of social acceptance or belonging	19%
Pressures created by own self/being too hard on own self	18%
Lack of support network	18%
Parenting young children	17%
Bullying/emotional abuse	16%
Unrealistic ideals of body image	16%
Birth Trauma (Mental/Psychological)	16%
The impact of my Neurological Condition (eg. ADHD, Autism) on daily life	15%
High pressure/competitive work environment	15%

Triggers across the lifespan

18 - 24 YEAR OLDS

Almost 1 in 2 (46%) women aged 18-24 years old reported low self-esteem or confidence as a trigger for their mental health issues. Other leading reported triggers in this age group included pressures created by oneself (39%), unrealistic ideals of body image (38%), expectations from society (35%) and a pressure to be perfect stemming from media and social media (30%). 1 in 4 women reported that academic pressures (25%) and juggling career and work life (25%) were triggers for their mental health issues, highlighting the unique challenges faced by women during early adulthood as they navigate study, employment, and career development. Almost 1 in 5 (18%) reported that childhood abuse and trauma were triggers for their mental health issues. Menstruation and hormonal fluctuations (20%) were also reported as triggers for 1 in 5 women in this age group.



18 - 24 year olds	2026
Low self esteem or confidence	46%
Pressures created by own self/being too hard on own self	39%
Unrealistic ideals of body image	38%
Too many expectations from society	35%
Financial stress/pressures	32%
Lack of social acceptance or belonging	31%
Media/Social media pressure to be perfect (perfect appearance/career/house/life, etc.)	30%
Sleep deprivation or sleep disturbance	29%
Academic pressure	25%
Trying to juggle career & work / work life balance	25%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	21%
Menstruation / Hormonal Fluctuations	20%
Lack of support network	18%
Childhood abuse and trauma	18%
The impact of my Neurological Condition (e.g. ADHD, Autism) on daily life	18%

"I'm afraid of being labelled as "unstable" by my colleagues, which could harm my career and reputation."

25 - 34 YEAR OLDS

The leading reported triggers for mental health issues for women aged 25-34 years were broadly consistent with those aged 18-24 years old. The leading reported triggers included low self esteem or confidence (36%), financial pressures (36%), and expectations from society (32%). 1 in 5 (20%) reported that parenting young children was a trigger for their mental health issues. Menstruation or hormonal fluctuations was reported as a trigger by 21% of women in this age group.

25 - 34 year olds	2026
Low self esteem or confidence	36%
Financial stress/pressures	36%
Pressures created by own self/being too hard on own self	34%
Too many expectations from society	32%
Sleep deprivation or sleep disturbance	31%
Trying to juggle career & work / work life balance	27%
Unrealistic ideals of body image	26%
Media/Social media pressure to be perfect (perfect appearance/career/house/life, etc.)	21%
Menstruation / Hormonal Fluctuations	21%
Parenting young children	20%
High pressure/competitive work environment	19%
Lack of social acceptance or belonging	18%
Lack of support network	17%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	17%
Childhood abuse and trauma	15%

35 - 44 YEAR OLDS

The leading reported triggers contributing to mental health issues were similar for women aged 35-44 years old and the overall sample. Some notable top reported triggers for this age group were parenting young children (17%), and the demands of parenting children with increased needs or disabilities (13%). Almost 1 in 4 (23%) reported that trying to juggle their work life balance was a trigger for their mental health issues. Similar to the younger age groups, menstruation or hormonal fluctuations (20%) emerged as a top trigger for mental health issues.

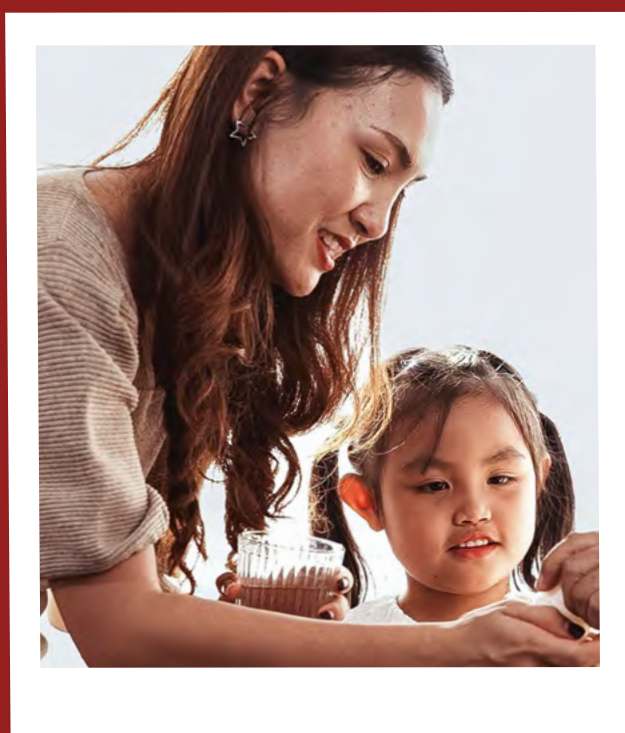
35 - 44 year olds	2026
Financial stress/pressures	32%
Sleep deprivation or sleep disturbance	30%
Low self esteem or confidence	30%
Pressures created by own self/being too hard on own self	28%
Too many expectations from society	24%
Trying to juggle career & work / work life balance	23%
Menstruation / Hormonal Fluctuations	20%
Lack of support network	19%
Unrealistic ideals of body image	18%
Parenting young children	17%
High pressure/competitive work environment	16%
Lack of social acceptance or belonging	15%
Aging	15%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	15%
The demands of parenting child/children with special/increased needs or disabilities	13%



45 - 54 YEAR OLDS

The leading reported triggers contributing to mental health issues were similar for women aged 45-54 years old and the overall sample. Hormonal factors such as menopause (32%) and menstruation or hormonal fluctuations (26%) also appeared as top reported triggers for women aged 45-54 years old. Aging (28%) and aging family members (17%) were also top triggers for this age group.

45 - 54 year olds	2026
Financial stress/pressures	48%
Low self esteem or confidence	41%
Sleep deprivation or sleep disturbance	39%
Menopause	32%
Pressures created by own self/being too hard on own self	31%
Aging	28%
Menstruation / Hormonal Fluctuations	26%
Trying to juggle career & work / work life balance	24%
Lack of support network	24%
Own physical illnesses / injuries	22%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	22%
Grief, death and/or loss	21%
Too many expectations from society	21%
Lack of social acceptance or belonging	19%
Aging family members	17%



55 – 64 YEAR OLDS

The leading reported triggers contributing to mental health issues for women aged 55–64 years were broadly consistent with the overall sample. Almost 1 in 3 (30%) reported that menopause was a trigger for their mental health issues. Their own physical illnesses and injuries (25%) and the impact of their physical disability on their daily life (16%) also appeared as top triggers.

55 - 64 year olds	2026
Sleep deprivation or sleep disturbance	39%
Financial stress/pressures	38%
Aging	37%
Low self esteem or confidence	36%
Pressures created by own self/being too hard on own self	31%
Menopause	30%
Own physical illnesses / injuries	25%
Grief, death and/or loss	22%
Aging family members	20%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	19%
Lack of support network	17%
Too many expectations from society	16%
The impact of my Physical Disability on daily life	16%
Lack of social acceptance or belonging	15%
Unrealistic ideals of body image	15%

65 – 74 YEAR OLDS

Almost half of women (47%) aged 65–74 years old reported that aging was a primary trigger for their mental health issues. Retirement or loss of purpose (22%) also appeared as a top trigger for this age group, as did their own physical illnesses and injuries (21%). Aging family members (13%), physical or mental illness/injuries of family members (14%), and grief or loss (19%) also emerged as top triggers for this age group.

65 - 74 year olds	2026
Aging	47%
Sleep deprivation or sleep disturbance	30%
Low self esteem or confidence	24%
Financial stress/pressures	24%
Retirement/loss of purpose	22%
Own physical illnesses / injuries	21%
Pressures created by own self/being too hard on own self	20%
Grief, death and/or loss	19%
Physical or mental illness/injuries of family members	14%
Aging family members	13%
I am not sure what caused the mental health issues I am currently facing	13%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	13%
The impact of my Physical Disability on daily life	12%
Lack of support network	11%
Too many expectations from society	11%

75+ YEAR OLDS

Aging (44%) and aging family members (21%) were the leading reported triggers for mental health issues in women aged 75 years+. Retirement or loss of purpose (14%) and financial dependency (8%) also appeared as a top trigger for this age group.



75+ year olds	2026
Aging	44%
Aging family members	21%
Sleep deprivation or sleep disturbance	20%
Own physical illnesses / injuries	18%
Financial stress/pressures	16%
Retirement/loss of purpose	14%
Low self esteem or confidence	14%
Pressures created by own self/being too hard on own self	14%
The impact of my Physical Disability on daily life	13%
Lack of support network	11%
Grief, death and/or loss	11%
Unstable family situation /family breakdown/ family conflict/relationship breakdowns	9%
Financial dependency	8%
Physical or mental illness/injuries of family members	8%
Lack of social acceptance or belonging	8%



Help Seeking Behaviours of Women with Mental Health Issues

Help Seeking Behaviours of Women
with Mental Health Issues

Overall, there has been an increase in help-seeking behaviours among women experiencing mental health issues, with 66% (2 in 3) of those women reaching out for support – a promising increase from 57% in 2025.

“I do not know where to start. I feel scared and unsure if anyone can help me. I worry about what others will think.”

Help seeking by location

Help seeking behaviours among women with mental health issues were comparable across metro and regional areas, as well as across various states of Australia.

	Metro	Regional
YES	66%	63%
NO	34%	37%

Help seeking by priority population

Compared to the overall sample, most priority populations were more likely to seek help for mental health concerns, including women experiencing poverty or homelessness, women identifying as LGBTQIA+, those who were currently pregnant, and those living with a disability. In contrast, women from CALD communities and women living with comorbidity were less likely to seek help compared to the overall sample at 57% and 64% respectively.

	CALD Communities	Poverty/ Homelessness	LGBTQIA+	Pregnant	Comorbidity	Those with disability(s)
YES	57% ↓	72% ↑	76% ↑	86% ↑	64% ↓	70% ↑
NO	43% ↑	28% ↓	24% ↓	14% ↓	36% ↑	30% ↓

↑ Significantly higher results vs overall at 95% c.i.

↓ Significantly lower results vs overall at 95% c.i.

Help seeking across the lifespan

Women aged 25–34 years old were more likely to seek help compared to the overall sample, whereas there were no other differences across age groups in help-seeking behaviours.

Age Group	18-24	25-34	35-44	45-54	55-64	65-74	75+
YES	65%	70% ↑	64%	64%	68%	61%	67%
NO	35%	30% ↓	36%	36%	32%	39%	33%

↑ Significantly higher results vs other age groups at 95% c.i.

↓ Significantly lower results vs other age groups at 95% c.i.

In 2026, the ways in which women are seeking support for their mental health have remained relatively consistent with previous years across mental health conditions, with a continued preference for GP's, mental health professionals and accessible options. However, there has been a notable decrease in the rate in which women are turning to these support services since 2025, and an increase in reliance on community systems.

GP visits remain the most common form of support, with 1 in 2 women (49%) with mental health issues turning to their GP for help, a significant decrease from 74% in 2025. This is followed by taking medication (41%) and speaking with a psychiatrist or mental health professional (38%), which decreased from 54% and 52% respectively in 2025. Of those that reached out to a mental health professional for support, 1 in 2 (50%) women turned to a psychologist for help, while 1 in 5 (20%) turned to a psychiatrist.

Social connection continues to play a key role, with 37% turning to friends or close ones for support, while 32% used exercise as a coping strategy; although these rates have significantly decreased since 2025. Other forms of social connection have seen an increase since 2025, including attending online (13%) and in-person (12%) support groups.

Use of online support services continues to grow, with 25% of women reporting to search for online mental health resources, and 15% turning to online counselling websites, a significant increase from 11% in 2025.

Support through community systems has also seen a growth with 14% attending a community agency, while 7% talked to a

school counsellor, talked to a teacher, or referred to tools/ information received at school or university.

The ways in which women are seeking support for their mental health were mostly similar across priority populations, however, there were some notable differences for those that were currently pregnant. Pregnant women were more likely to turn to online support services such as searching for online mental health resources (37%), using online counselling websites (33%) and attending online support groups (32%). This reflects the preference for mothers to absorb on demand, accessible and flexible options during pregnancy and early parenting - reinforcing the need to ensure evidence-

based, accurate information in online sources.

Help-seeking behaviours remained relatively consistent across age groups. Some notable differences were that 18-24 year olds were more likely to talk to their parents about their mental health (35%), while medications were more likely to be used by older age groups.

Together, this data suggests that women are embracing a broad and balanced range of support methods. While professional help remains to be the most common form of support, we are continuing to see a growth in women using digital resources and community initiatives to manage their mental health.

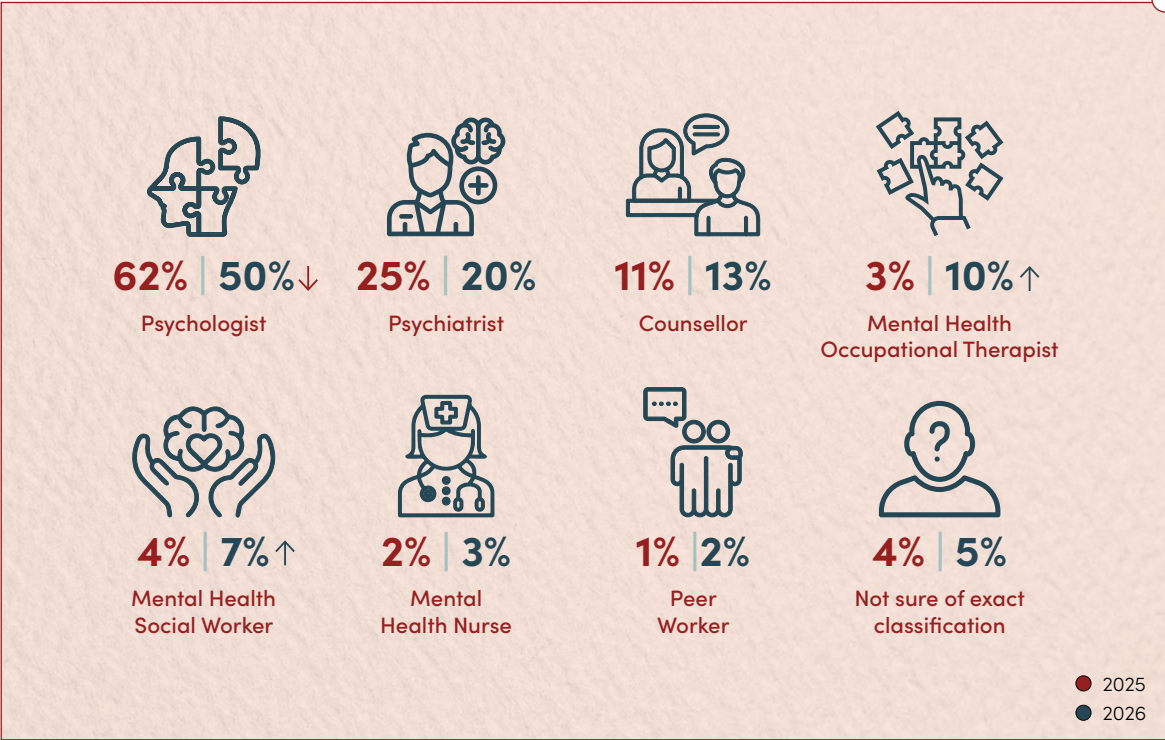


How women choose to seek help

	2025	2026
Went to a GP	74%	49% ↓
Took medication	54%	41% ↓
Went to a psychiatrist/mental health professional	52%	38% ↓
Talked to a friend/close one	49%	37% ↓
Exercised	40%	32% ↓
Did some internet search about online resources	28%	25%
Talked to parents	18%	16%
Went to an online counselling website	11%	15% ↑
Went to a community agency	9%	14% ↑
Attended online support groups	6%	13% ↑
Contacted a telephone hotline	11%	13%
Attended in person support groups	9%	12% ↑
Referred to tools/information received through work	6%	7%
Talked to a school counsellor	4%	7% ↑
Referred to tools/information received at school/university	4%	7% ↑
Talked to a teacher	3%	7% ↑
Others	7%	4% ↓

↑ Significantly higher results vs 2025 at 95% c.i. ↓ Significantly lower results vs 2025 at 95% c.i.

Help seeking by type of mental health professional



How helpful were the sources?

Women reported varied levels of helpfulness across the different sources of mental health support they accessed.

Mental health professionals were perceived as the most helpful sources of support. The majority of women who accessed these services reported that they were very helpful, including 61% of those who visited a mental health occupational therapist, 59% who saw a psychologist, 57% who saw a psychiatrist, and 53% who saw a counsellor. The other common forms of clinical support were also rated as effective, with 1 in 2 describing their GP visits (50%) and medication use (54%) as very helpful.

Sources of mental health support which foster social connection were particularly favourable, with 58% of women finding online support groups very helpful, and 56% of women finding in person support groups very helpful. Community agencies also received strong feedback, with 55% rating them as very helpful.

Some sources, however, were rated less positively, with 3 – 14% of women describing that their source of support was not at all helpful. For example, while 41% of women reported that contacting a telephone hotline was very helpful, 14% reported that this was not helpful at all. In addition, only 37% of women reported

that searching for online mental health resources, talking with a school counsellor or talking with a teacher was very helpful.

These results show that while women are drawing on a broad mix of support options, traditional clinical pathways such as visiting mental health professionals continue to deliver the most consistent sense of impact and relief. Peer support, exercise, and community services that foster social connection also remain valuable, reinforcing the importance of a holistic and accessible range of support.

	Not At All Helpful	Somewhat Helpful	Very Helpful
Mental Health Occupational Therapist	3%	36%	61%
Psychologist	9%	32%	59%
Attended online support groups	6%	36%	58%
Psychiatrist	10%	33%	57%
Attended in person support groups	7%	37%	56%
Went to a community agency	8%	37%	55%
Took medication	7%	39%	54%
Counsellor	9%	38%	53%
Talked to a friend/close one	5%	44%	51%
Went to a GP	7%	43%	50%
Exercised	5%	46%	50%
Went to an online counselling website	10%	41%	49%
Went to a psychiatrist/mental health professional	10%	42%	47%
Peer Worker*	6%	47%	46%
Talked to parents	8%	46%	46%
Mental Health Social Worker	8%	47%	45%
Contacted a telephone hotline	14%	44%	41%
Referred to tools/information received through work	11%	49%	40%
Referred to tools/information received at school/university	12%	48%	40%
Others	13%	48%	39%
Mental Health Nurse*	4%	58%	39%
Did some internet search about online resources for self directed learning about mental health issues & how to cope with them	9%	54%	37%
Talked to a school counsellor	11%	52%	37%
Talked to a teacher	8%	55%	37%

Note: Low base counts (<50) are marked with an '*'. Interpret these figures with discretion.

Why was it not helpful?

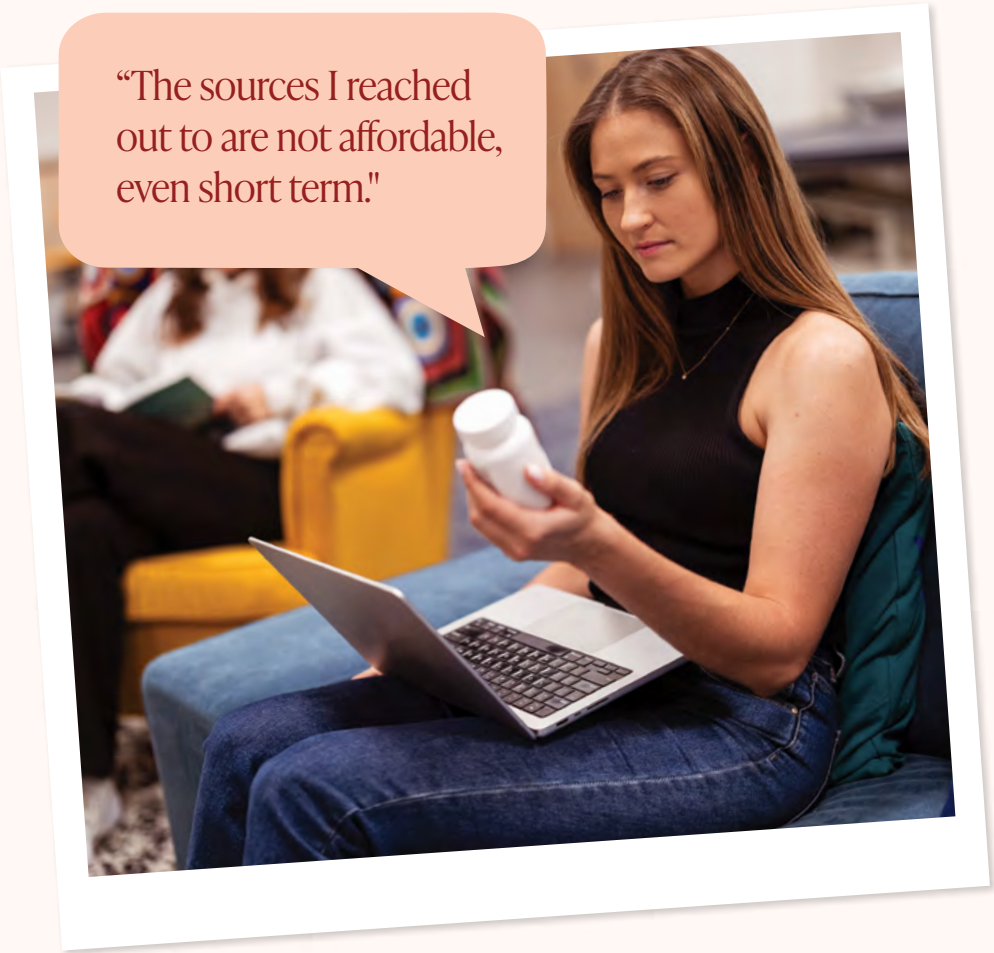
Of those who sought help but did not find it helpful, difficulties establishing a meaningful connection was among the most commonly reported barriers, with 31% finding it hard to express themselves or open up. Moreover, 24% of women reported that the person they spoke to could not relate to their situation, 22% felt they did not empathise with them and trivialised their condition, and 19% were unable to form a connection with their counsellor. Concerningly, more than 1 in 10 (12%) women reported that they felt like they were being discriminated against.

Barriers within the health system were also frequently reported. Almost 1 in 4 women (24%) cited long wait times or delays in securing an appointment, while 19% felt that the support they received was not worth the cost.

Challenges related to finding appropriate treatment were also common. Nearly 1 in 4 (23%) reported that there were insufficient tailored support services for women with their particular issues, while 21% felt that their health care provider was unable to help them. In addition, 18% reported receiving treatments or medications they were not comfortable with, and 18% experienced negative side effects from medication, highlighting the importance of providing women with treatments that align with their individual needs and preferences.

	2025	2026
I found it hard to express myself / Could not open up	35%	31%
The person I spoke to could not relate to my situation/background	25%	24%
Long waiting lists (to see a mental health professional)/It took too long to get an appointment	27%	24%
There are not enough tailor made support services available specifically for women for this issue	21%	23%
The person I spoke to could not empathize with me/trivialized my condition	23%	22%
The person I went to was not able to/did not know how to help me	22%	21%
I am not able to find people who share similar experiences as me	16%	19%
I am not able to form a connection with the counsellor	20%	19%
I did not feel it was worth the amount I paid for it	19%	19%
I was suggested a treatment/medication I was not comfortable with	16%	18%
I experienced negative side effects from the prescribed medication	18%	18%
I did not go to the right source/took the right action to manage my mental health	12%	13%
I feel like I'm being discriminated against (reframed in 2026)	3%	12% ↑
Others	21%	15% ↓

↑ Significantly higher results vs 2025 at 95% c.i. ↓ Significantly lower results vs 2025 at 95% c.i.



"I am aware of mental health plans but I don't have the funds for any gap payment that Medicare doesn't cover."



Barriers for women seeking help

In 2026, a wide range of barriers continue to prevent women from seeking support for their mental health. The most commonly reported barriers remained largely unchanged from 2025.

Financial constraints continued to rank among the top barriers, with almost 1 in 3 women (31%) stating that they were unable to afford help or considered it too costly.

In addition, 1 in 3 (32%) women cited that they could manage their mental health on their own and over 1 in 4 (29%) of women did not perceive their mental health issues as serious enough to warrant seeking support, reinforcing the ongoing challenge of recognising and

validating one's own needs.

Competing priorities and life pressures also continue to play a role, with 1 in 4 (26%) women saying they had more important things to focus on and 1 in 5 (20%) women saying that they lacked the time to address their mental health.

Emotional barriers were also commonly cited, with 19% of women reporting that they felt too embarrassed or ashamed to seek help, 16% felt a fear of being judged, and 13% felt scared of not being taken seriously.

Access to appropriate mental health services was also noted as a common barrier with 14% reporting they did not find it easy

to access services, 13% reporting that the wait times were too long, 9% reporting that they were unable to find the services needed, and 7% reporting that the right services were not available.

More serious barriers, such as fear of losing their job or facing domestic violence, were noted by 6%, and 4% of women reported being trapped or controlled by an abusive partner.

These findings highlight that while progress has been made in reducing stigma and expanding access, many women continue to face a combination of personal, financial and systemic obstacles to seeking help.





Sex and Gender-specific Mental Health Issues

Sex and Gender-specific
Mental Health Issues

Certain mental health conditions are defined by the role of sex and gender, influencing mental wellbeing in ways that are not experienced equally across the population.

For women, changes in hormone levels during key life stages can increase the vulnerability to mental health challenges in some women. Symptoms of mental health conditions can worsen during periods of hormonal change including puberty, pregnancy, the postnatal period, perimenopause, and also fluctuates over the menstrual cycle (Steiner et al., 2003).

Unfortunately, many women experience symptoms that are misunderstood, misdiagnosed or dismissed as a normal part of being female, delaying access to appropriate care and support. Understanding the prevalence, impact and preferred help-seeking behaviours associated with female-specific mental health conditions; and the important role that hormones can play in mental health for some people, is essential to delivering truly gender-responsive mental healthcare across the lifespan, particularly during key reproductive stages of life.

In this section, we focus on two female-specific mental health conditions: Premenstrual Dysphoric Disorder (PMDD), which is associated with cyclical hormonal changes across the menstrual cycle, and perimenopausal anxiety and depression, which occurs during the hormonal transition towards menopause. Although perinatal mental health conditions were also captured in this research, findings from that component will be presented in a dedicated special report later this year.

Premenstrual Dysphoric Disorder (PMDD)

Premenstrual dysphoric disorder (PMDD) is a severe health condition characterised by a number of psychological and physical symptoms that typically arise one to two weeks before the menstrual period begins (also known as the “luteal” phase of the menstrual cycle), and stop within a few days of bleeding. Symptoms are typically absent during other phases of the menstrual cycle, although the timing of symptom onset and offset in relation to specific menstrual cycle phases can show substantial variability between people, and within people (e.g., some people experience symptoms that extend across menstruation; others experience symptom onset during ovulation; Eisenlohr-Moul et al., 2020). Common PMDD symptoms include irritability, depressed mood, anxiety, difficulties concentrating, fatigue, changes in appetite, sleep changes, as well as breast tenderness, bloating or headaches (Epperson et al., 2012). The monthly emergence of these symptoms has a significant impairment on daily life and functioning, affecting relationships, work, and school performance.

Many women may also experience premenstrual mood symptoms that do not meet the criteria for a clinical diagnosis of PMDD but can still have a significant impact on their mental wellbeing and daily functioning, which is referred to as premenstrual syndrome (PMS).

Although not one of the leading mental health issues reported by Australian women, PMDD was experienced by 1 in 33 (3%) of all women in the study, with the prevalence rising to 1 in 20 (5%) among women aged 25–44 years. The prevalence rates in this research were consistent with previous academic studies showing a PMDD prevalence of between 3.2% – 7.7% across countries (Reilly et al., 2024).

The causes of PMDD are not yet fully understood, but is thought to involve an increased sensitivity to normal hormonal changes that occur across the menstrual cycle, particularly changes in oestrogen and progesterone levels (Hantsoo et al., 2023). Symptoms typically emerge when these hormones begin to decline in the second half of the menstrual cycle, and usually improve after menstruation begins when hormones begin to rise again, although there are likely different subtypes of PMDD which show different patterns of symptom change.

Women identified hormonal fluctuations as a leading trigger for their PMDD. Other key triggers that were reported included sleep issues, low self-esteem, and trying to juggle work life-balance.

Triggers for PMDD	(%)
Menstruation / Hormonal Fluctuations	43%
Sleep deprivation or sleep disturbance	24%
Low self esteem or confidence	18%
Trying to juggle career & work / work life balance	16%
Pressures created by own self / being too hard on own self	15%
Financial stress/pressures	13%
Too many expectations from society	12%
Unrealistic ideals of body image	10%
Impact of Neurological Condition (e.g., ADHD, Autism) on daily life	10%

This year, 3 in 5 (62%) women stated they were seeking help for their PMDD. The majority of women sought help from a psychologist (59%) or their GP (38%). Promisingly, these were mostly rated as very helpful. However, 15% of women who saw a psychologist rated this as not helpful at all.

Other forms of medical support were also commonly sought, with 1 in 4 (27%) women with PMDD reporting that they had seen a psychiatrist or mental health professional, and the same proportion reporting the use of medication to manage symptoms. Both of these sources of help were mostly rated as very helpful.

Social support from friends/close ones was reported by more than 1 in 4 (29%) women with PMDD and mostly rated as very helpful. While searching the internet and using online resources were a common source of help for women with PMDD, this option was broadly referenced as somewhat helpful only.

Of those who sought help but did not find it helpful, the main reasons cited were because the support services were not appropriate or adequately tailored to the specific needs of those experiencing PMDD. Many women reported that there was not enough tailor-made support services specifically designed for women with PMDD (31%), that the person they spoke to could not empathise with them or trivialised their condition (26%), and the person they spoke to was unable or did not know how to help them (21%). These findings suggest that existing sources of support are often not well suited to meeting the needs of women experiencing PMDD; indicating a pressing need to improve training for health professionals when it comes to mental health and its relationship with female-specific experiences such as the menstrual cycle.



This was also highlighted in quotes provided by the participants:

- “I felt like I was pushed aside and just told to take an antidepressant for my hormonal moods.”
- “Nobody seems to know what PMDD is.”
- “The methods and sources I’ve used to manage my mental health haven’t been helpful because they often feel too general and don’t match my personal experiences. Many self-help tips and advice from common sources are one-size-fits-all, so they don’t address the specific stress and emotions I’m dealing with.”

Other commonly reported reasons as to why support was perceived unhelpful included long waiting times for services (23%) and difficulties in expressing themselves or opening up about their experiences (25%).

Moreover 1 in 5 (19%) reported that they were given a treatment or medication that they were not comfortable with, which was also highlighted by one participant, “The advice they gave felt out of touch with my cultural background and values.”

Leading Avenues for Help-Seeking	(%)
Psychologist	59%
Went to a GP	38%
Talked to a friend/close one	29%
Went to a psychiatrist/mental health professional	27%
Took medication	27%
Did some internet search about online resources	26%

Help-Seeking Behaviour	Not at all Helpful (%)	Somewhat Helpful (%)	Very Helpful (%)
Psychologist	15%	31%	54%
Went to a GP	4%	33%	63%
Talked to a friend/close one	11%	37%	52%
Went to a psychiatrist/mental health professional	6%	42%	52%
Took medication	3%	39%	58%
Did some internet search about online resources	7%	53%	40%

“GP's do not take menstrual conditions seriously and I am sure I will be dismissed like I had been with my endometriosis for 6 years, so it wasn't worth asking for help”

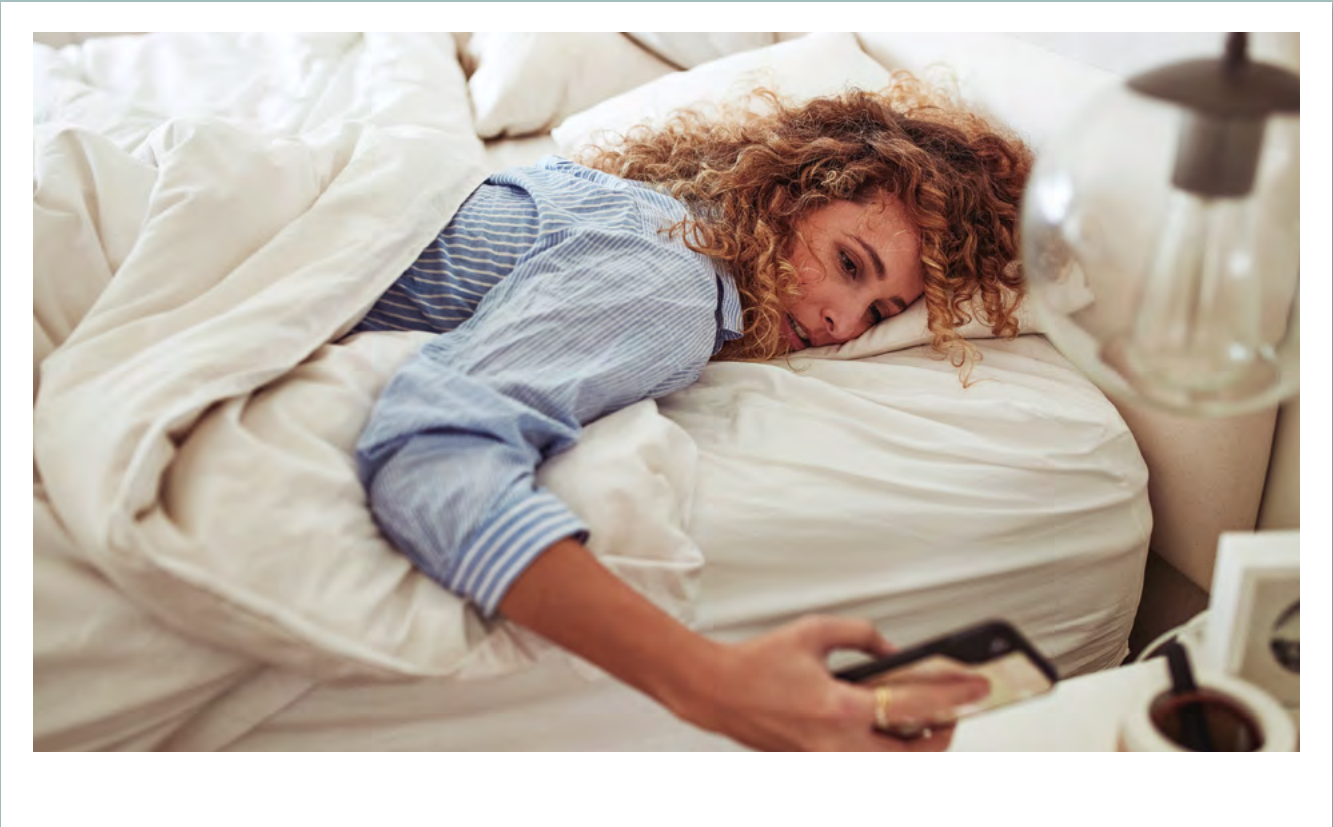
Of those that did not seek help for their PMDD, the main reasons were centred around an inability to afford (29%) or make time to seek help (19%), and wanting to self manage their mental health needs (22%).

- *“I've always dealt with hormonal fluctuations for 30+ years. I only found out [PMDD] was an actual disorder 2 years ago. I just thought it was normal.”*

Emotional barriers were also commonly cited, with 16% of women reporting that they felt scared of not

being taken seriously, and 16% felt too embarrassed or ashamed to seek help.

Taken together, our findings highlight the need for greater awareness and understanding of PMDD across the community and health systems. Moreover, these findings highlight the need for more targeted and evidence-based services, improved training for health professionals, and accessible support for women with PMDD that consider the unique experiences of the condition.



Perimenopausal Anxiety and Depression

Perimenopausal anxiety and depression are female-specific mental health conditions, strongly linked to hormonal fluctuations during a woman's transition to menopause, that deserves more attention at a national level. Perimenopause is a natural part of a woman's life encompassing the stage before a woman's final period (menopause) when the body is transitioning to the end of its reproductive years. Hormonal fluctuations, irregular periods and physical and emotional symptoms can have a great impact on a woman's mental health during this period of her life (Zhang et al., 2025; Badawy et al., 2024). In addition, women may experience other major life changes, such as retiring from work, children leaving home, divorce, or the death of loved ones. These transitions can bring feelings of loss, loneliness, or a change in identity which can also impact mental wellbeing (Schmidt et al., 2004).

Perimenopausal anxiety and depression was experienced by 1 in 11 (9%) of all women in this study. When examining the prevalence of perimenopausal anxiety and depression amongst those currently experiencing perimenopause, the prevalence was 1 in 2 (49%), making this issue a high priority amongst women during this life stage. Likewise, women who were currently experiencing menopause also reported higher rates of 17%, or 1 in 6.

As anticipated, this condition is significantly more prevalent among women aged 45–54 years (25%); however it must be noted that a small number of women in younger age groups (under 40 years old) and older age groups (over the age of 60 years old) also reported having this condition. These findings may reflect differences in health literacy and awareness of the menopausal transition across age groups. For older women, higher rates of endorsement may reflect retrospective reporting of their past perimenopausal experience, whereas the few reports among younger women may represent genuine cases of early or “premature” perimenopause. Alternatively, increased public attention and media coverage of perimenopause, coupled with poor mental health literacy, may influence how women interpret and report symptoms associated with the perimenopause life stage.

The most commonly reported triggers for perimenopausal anxiety and depression were menopause and hormonal fluctuations, emphasising the biological component of this condition. Other significant triggers included financial stress, sleep issues and aging.

Triggers	(%)
Menopause	30%
Menstruation / Hormonal Fluctuations	30%
Financial stress/pressures	27%
Sleep deprivation or sleep disturbance	26%
Aging	25%
Low self esteem or confidence	21%
Trying to juggle career & work / work life balance	15%
Pressures created by own self / being too hard on own self	14%
Aging family members	12%
Lack of support network	11%



This year, 1 in 2 (50%) women stated they were seeking help for this mental health issue. The majority of women sought help from their GP (49%), a psychologist (47%) or tried medications (43%). These options were broadly rated as very helpful. Other forms of medical support were also commonly sought including seeing a psychiatrist or mental health professional (25%) and seeing a counsellor (21%); however seeing a counsellor was broadly rated as somewhat helpful only. Exercise and social support from friends/close ones were commonly reported as very helpful sources of help for women with perimenopausal anxiety and depression. While 16% turned to the internet and online resources for support with this condition, this option was mostly referenced as somewhat helpful, with 10% reporting this as not helpful at all.

Help-seeking behaviour	(%)
Went to a GP	49%
Psychologist	47%
Took medication	43%
Exercised	34%
Went to a psychiatrist/mental health professional	25%
Talked to a friend/close one	24%
Counsellor	21%
Did some internet search about online resources	16%

Help-Seeking Behaviour	Not at all Helpful (%)	Somewhat Helpful (%)	Very Helpful (%)
Went to a GP	8%	42%	50%
Psychologist	2%	19%	79%
Took medication	2%	50%	48%
Exercised	0%	36%	64%
Went to a psychiatrist/mental health professional	11%	42%	47%
Talked to a friend/close one	2%	44%	54%
Counsellor	0%	59%	41%
Did some internet search about online resources	10%	58%	33%

Of those who sought help, the main reason cited for not finding it helpful, was due to a lack of tailor-made support services specifically designed for women with perimenopausal anxiety and depression (reported by 24%). Moreover, 17% reported that the person they spoke to could not empathise with them or trivialized their condition.

- *“A lot of doctors don’t understand perimenopause.”*
- *“I guess cause it’s in my head and I feel like no one actually completely understands. Also, my GP focuses more on the physical rather than mental effects of perimenopause.”*
- *“It’s all about getting a counsellor that GETS it, and I haven’t found one yet, not in regional NSW.”*

Logistical concerns were also reported, with 18% of women reporting that the support they received was not worth the cost, and 17% stating that long waiting lists to see a mental health professional was a barrier.

- *“Appointments take so long to get (weeks to months) to see my GP. I’m overwhelmed with internet information - not sure what/who to trust.”*
- *“I feel more concerned about the cost of going and so I find it difficult to continue or go regularly.”*
- *“The resources felt unhelpful: long wait times for professional help, generic advice that didn’t fit my issues, unempathetic responses from hotlines, confusing online self-help info, and unaffordable paid programs.”*

Challenges related to communication and connection were also reported, with women citing difficulties expressing themselves or opening up (18%) and feeling that the person they spoke with could not relate to their situation or background (14%).

- *“Female psychologists are hard to get appointments with. Men are great but they will never truly understand the day to day struggles of being a mum and a woman.”*

Of those who did not seek help for their perimenopausal anxiety and depression, the main reasons were centred around wanting to self-manage, with 28% of women saying that they could manage their mental health on their own and 22% of women saying that they did not perceive their mental health issues as serious enough to warrant seeking support. Competing priorities and life pressures also played a role, with 19% of women saying they had more important things to focus on. These findings reinforce the ongoing challenge of recognising and validating one's own mental health needs during this life stage. Moreover, financial concerns were reported by 1 in 4 (26%) women as a barrier for seeking help.

This was also highlighted in quotes provided by the participants:

- *"Because I always put myself last and feel like I'm being a drama queen when I try to talk."*
- *"Because it fluctuates so much and I think is linked to my hormones I feel like there's really not much that can be done about it except ride it out."*

- *"Don't have the time or money to seek support, not knowing where to start or what is most effective so don't want to waste money trying to figure it out."*
- *"I think there is a view around menopause and all its associated issues that 'it's just the way it is' and you just have to put up with it and get through it. I am on a low dose of HRT and the only support I have been offered is to make the dose higher. No mental health support has ever been suggested or offered by health professionals."*
- *"As a breast cancer survivor, there are no options for someone like me who is going through menopause as we cannot take any HRT so we just have to deal with it."*

Similarly to the PMDD findings, there is a pressing need for greater awareness and understanding of perimenopausal mental health conditions across the community and health systems. Improved training for health professionals is a vital next step; as well as accessible, targeted and evidence-based supports that consider the unique experiences of women in perimenopause.

These findings reinforce that female-specific mental health conditions remain an overlooked component of Australia's mental health system. Across both PMDD and perimenopausal anxiety and depression, women consistently reported difficulties finding health professionals who understood their experiences, a lack of tailored services, financial barriers to care, and feeling that their symptoms were dismissed or minimised.

Women are not only managing the psychological impacts of hormonal change, but also navigating an Australian health system that separates physical and mental health, leaving many without integrated care that recognises the relationship between the two. This mirrors findings throughout this report showing that women's physical health and mental wellbeing are deeply interconnected.

To truly improve outcomes for women, there needs to be a commitment to improving awareness of female-specific mental health conditions across the community, strengthening education and training for health professionals, investing in evidence-based and condition-specific models of care, and embedding mental health assessment and support within women's physical healthcare across the lifespan.



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Appendix A: Research Participant Demographic Breakdown

Age and location quotas were implemented in order to ensure the sample was representative of the population.

This survey aimed to obtain profiling and incidence rates of different mental health issues impacting women in Australia. Data was collected through a natural fallout, via an online panel in April 2026 and consisted of a sample size of n=9,000 participants. This sample consisted of cisgender women, transgender women, and gender-diverse people, who were aged 18 years and over, and located across all states and regions in Australia.

The survey was then taken by a quota controlled sample size of 6000 women who are currently facing a mental health issue. Data was then weighted to be nationally representative of the Australian population. The sample excluded anyone who works in a mental health institution or organisation that supports the awareness of women's mental health, including Women's Mental Health Australia. Social workers, psychologists and counsellors for mental health issues were also excluded. Respondents for this research were recruited via a panel partner. All respondents were randomly selected and were paid a monetary incentive for their time.

This research was conducted by Women's Mental Health Australia with approval from the UNSW Human Research Ethics Committee (IRECS10209).

Methodological refinements for 2026

As Women's Mental Health Australia's annual research program continues to mature, our methodology is continually refined to reflect best practice in research design, ethics and population representation. Several methodological refinements have been introduced in the 2026 report to strengthen the quality, representativeness and ethical integrity of the research. These updates align with the requirements of our approved Human Research Ethics Committee (HREC) protocol and support the ongoing evolution of our annual research program.

Aboriginal and Torres Strait Islander women from Indigenous communities

Indigenous women are included within the overall nationally representative sample and contribute to the national findings presented throughout this report. However, findings specific to Indigenous women are not reported separately in the 2026 edition.

Women's Mental Health Australia is committed to exploring the ability to report on this cohort by undertaking a dedicated Aboriginal and Torres Strait Islander research approach, including further engagement and co-design with Aboriginal and Torres Strait Islander women to ensure findings are interpreted and presented in a way that is meaningful, respectful and beneficial to the community.

Women under 18 years of age

The 2026 survey includes women aged 18 years and over. Unlike previous editions, women aged 14 to 17 years were not included in the sample.

This change reflects the ethical considerations associated with collecting sensitive mental health information from minors, including parental consent requirements. The 2026 sample has also been strengthened through the introduction of quota controls for age and geographic region, based on Australian Bureau of Statistics population distributions for women aged 18 years and over, resulting in an even more representative adult sample.

These methodological refinements have been implemented in accordance with the study's ethics approval and are intended to strengthen the reliability, representativeness and long-term sustainability of Women's Mental Health Australia's lived experience research program.



Age Groups	%	n
18–24 years	11%	895
25–34 years	19%	1917
35–44 years	18%	1756
45–54 years	16%	1428
55–64 years	14%	1349
65–74 years	16%	1202
75+ years	6%	453
NET	100%	9000

States	%	n
NSW	31%	2923
VIC	26%	2307
QLD	20%	1800
SA	7%	694
WA	11%	947
TAS	2%	183
ACT	2%	105
NT	1%	41
	100%	9000

Region	%	n
Metro	68%	6092
Regional	32%	2908
	100%	9000

Priority Populations and Minority Groups	%	n
CALD Communities	18%	1612
Indigenous Communities	12%	1039
Facing Poverty/Homelessness	8%	709
LGBTQIA+ Women	9%	802
Currently Pregnant	2%	183
Those with comorbidities	59%	5255
Those with disability	10%	882

Highest level of education attended	%	n
School certificate or lower	18.6%	1,675
Trade certificate	10.0%	899
Diploma	16.5%	1,486
Bachelor's degree	34.4%	3,094
Graduate diploma	9.8%	884
Higher degree	9.0%	806
Other qualification	1.7%	156

Current work status	%	n
Employed full-time (30 hours/week or more)	45.8%	4,118
Retired	17.4%	1,564
Employed part-time (29 hours/week or less)	16.1%	1,452
Home duties	5.0%	448
Self-employed	4.3%	386
Not currently in workforce	3.7%	330
Full-time student	3.2%	285
Disability/sick leave	2.2%	202
Maternity/parental leave	0.9%	83
Part-time student	0.9%	78
None of the above	0.5%	48
Prolonged unpaid leave	0.1%	6

Total household income (before tax)	%	n
Under \$20,000	2.2%	200
\$20,001–\$35,000	7.2%	647
\$35,001–\$50,000	9.0%	806
\$50,001–\$80,000	15.3%	1,377
\$80,001–\$100,000	16.4%	1,475
\$100,001–\$150,000	22.3%	2,011
\$150,001–\$200,000	12.0%	1,080
More than \$200,000	8.2%	735
Pension only	1.9%	175
Don't know / Prefer not to say	5.5%	494

The precision of this survey is measured by the standard error of the estimate. Nielsen uses the relative standard error (RSE) for analysis, which is the standard error divided by the estimate. This shows how different the population mean is likely to be from the sample mean, and how much the sample would vary if the study were repeated with new samples.

Using this statistic, Table 1 below shows the RSE for a range of sample incidence rates, and Table 2 indicates the reliability of the survey estimates according to the RSE%.

Table 1

Survey incidence rate %	Standard error %	Relative standard error %
50	0.80%	1.60%
40	0.80%	1.90%
30	0.70%	2.40%
20	0.60%	3.20%
15	0.60%	3.80%
10	0.50%	4.70%
5	0.30%	6.90%
1	0.20%	15.70%

Table 2

RSE	Indicator
<5%	Excellent
6%–30%	Acceptable
31%–49%	Use with caution
50+%	Unreliable for analysing

Appendix B: Clarification of key terms

Mental Health Related Terms	
KEY TERMS	DEFINITION
Alzheimer's	a major neurocognitive disorder and subtype of dementia that is categorised by progressive memory loss and cognitive decline.
Anorexia nervosa	is characterized by distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat.
Anxiety & Generalised Anxiety Disorder (GAD)	Anxiety is a broad term encompassing various levels of worry or unease, while Generalized Anxiety Disorder (GAD) is a mental health condition characterized by excessive, persistent worry and anxiety about everyday situations, significantly impacting daily life and functioning.
Attention-Deficit/Hyperactivity Disorder (ADHD)	ADHD is a neurodevelopmental disorder characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.
Autism Spectrum Disorder (ASD)	Autism Spectrum Disorder (ASD) is a lifelong neurodevelopmental condition that impairs social skills and communication.
Binge eating disorder	recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control.
Bipolar Affective Disorder	a mental health condition that causes extreme mood swings. It's characterized by alternating periods of mania and depression.
Body image issues	the mental and emotional feelings a person associates with their own body. Negative body image or dissatisfaction can lead to a variety of mental illnesses such as eating disorders, body dysmorphia, anxiety and depression.
Borderline Personality Disorder	a pattern of instability in self-image, relationships, and emotions, along with impulsivity.
Bulimia nervosa	characterized by frequent episodes of binge eating followed by inappropriate behaviours such as self-induced vomiting to avoid weight gain.
Dementia	a major neurocognitive disorder that results in a decline in brain function and cognitive abilities including attention, memory, language, or executive function.
Depression	a mood disorder that causes a persistent feeling of sadness and loss of interest.
Dysthymia	a chronic depressive disorder that involves a depressed mood that lasts for most of the day, for more days than not. It is also referred to as persistent depressive disorder.
Gender dysphoria	psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.
Illness Anxiety Disorder or Health Anxiety	illness anxiety disorder (IAD) is a psychiatric disorder characterized by excessive and persistent fear of having a serious illness.
Insomnia or other sleep-wake disorder	insomnia as a sleep disorder that involves difficulty falling or staying asleep. Other sleep-wake disorders include hypersomnolence disorder, narcolepsy, breathing-related sleep disorders, circadian rhythm sleep disorders, non-REM (NREM) sleep arousal disorders, nightmare disorder, REM sleep behaviour disorder, restless legs syndrome, and substance- or medication-induced sleep disorder.
Obsessive-Compulsive Disorder (OCD)	A disorder characterised by obsessions (persistent, recurring, unwanted thoughts and urges) and compulsions (repetitive behaviours or mental acts) that an individual feels driven to perform in response to an obsession.
Panic Disorder	a mental health condition characterized by repeated, unexpected panic attacks.
Perimenopausal Anxiety/Depression	Perimenopausal Depression (also known as Major Depressive Disorder with perimenopausal onset) or Anxiety is a subtype of depression or anxiety experienced by women during the perimenopausal period, defined as the interval when a woman's menstrual cycles become irregular.
Perinatal Anxiety (including Antenatal and Postnatal periods)	generalized anxiety disorder (GAD) that occurs during pregnancy or within the perinatal period. It's characterized by excessive and difficult-to-control worry that causes clinically significant distress or impairment.
Perinatal Depression (including Antenatal and Postnatal periods)	a major depressive episode that occurs during pregnancy or within the perinatal period, involving feelings of extreme sadness, indifference and/or anxiety, as well as changes in energy, sleep, and appetite.
Perinatal Obsessive-Compulsive Disorder (OCD) (including Antenatal and Postnatal periods)	If a woman has OCD during pregnancy or after birth it is called Perinatal OCD. This disorder is characterised by obsessions (persistent, recurring, unwanted thoughts and urges) and compulsions (repetitive behaviours or mental acts) that an individual feels driven to perform in response to an obsession - revolving heavily around the baby and the stresses of caregiving.

Perinatal Psychosis (including Antenatal and Postnatal periods)	is a rare but severe mental health disorder characterized by a sudden onset of psychotic symptoms, such as hallucinations, delusions, and paranoia that can occur after childbirth. It's also known as puerperal psychosis or postpartum psychosis.
Post-Traumatic Stress Disorder (PTSD)	a disabling condition that develops following exposure to a stressful or traumatic event or situation of an exceptionally threatening or catastrophic nature.
Premenstrual dysphoric disorder (PMDD)	a mood disorder characterized by dysphoria, mood lability, irritability, and anxiety that occur repeatedly during the premenstrual phase of the cycle and resolve around the time of (or after) menses.
Psychological distress	a general term used to describe a range of unpleasant feelings or emotions that impact levels of functioning
Psychosis and Psychotic disorders	a collection of symptoms like hallucinations and delusions that show a loss of touch with reality.
Schizophrenia	A psychotic disorder that includes periods of psychosis as well as disorganized thinking, difficulties in speech and movement and changes in emotional responding.
Social phobia	Also known as social anxiety disorder, it is categorised by a marked fear of one or more social situations where the individual is exposed to scrutiny by others.
Specific Phobias or Agoraphobia	Agoraphobia is the fear or anxiety of certain situations such as; using public transportation, being in open spaces, being in enclosed spaces, standing in line or being in a crowd, or being outside the home alone. Other Specific Phobias include fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood etc).
Substance use disorders (drug and alcohol abuse)	Categorised by a pattern of substance use that causes significant impairment or distress. Most commonly drug and alcohol abuse or dependency.
Suicide and self-harm	Includes suicidal ideation and behaviours of self-harm that a person believes will result in their own death.

Sex and Gender Related Terms

Sex	A person's sex is based upon their sex characteristics, such as their chromosomes, hormones and reproductive organs. While typically based upon the sex characteristics observed and recorded at birth or infancy, a person's reported sex can change over the course of their lifetime and may differ from their sex recorded at birth. (ABS, 2025)
Gender	Gender is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, woman or non-binary person. (ABS, 2025)
Transgender	a person whose gender identity does not correspond with the sex assigned to them at birth
Non-binary	a person who doesn't feel their gender can be defined within the margins of the gender binary. They understand their gender in a way that goes beyond exclusively identifying as male or female.
Cisgender	a person whose gender identity corresponds with the sex assigned to them at birth
Gender-diverse or fluid	an umbrella term to describe gender identities that are beyond the binary framework or non-fixed gender identity that shifts over time or depending on the situation.
Intersex	a person who was born with natural variations in sex characteristics that do not align with male or female norms

Research Related Terms

Confidence interval	a range of values so defined that there is a specified probability that the value of a parameter lies within it
Relative standard error	a percentage that shows how precise an estimate is compared to its size, giving an idea of the reliability of the estimate
Standard error	a measure of how much an estimate is likely to differ from the actual value, indicating the uncertainty around the estimate
Survey incidence rate	the rate at which individuals or units from a population are chosen to participate in a survey
General female population	Refers to the overall sample of women captured in this study, statistically representative of the broader female population in Australia. When referring to this population as a comparison to other groups, it is in reference to scores higher or lower than the overall group of women in this study at a 95%/90% confidence interval."

Appendix C: Women's Mental Health Australia - Detailed Recommendations and Policy Asks:

1. Commit to gender-responsive mental healthcare		
	ACTION	DETAIL
1.1	Integrate targeted psychological support alongside women's physical healthcare to provide holistic, wrap-around care. By investing in a national minimum standard requiring all Endometriosis and Pelvic Pain Clinics to assess psychological wellbeing, establish mental health referral pathways and report on access to psychological support as part of the program's existing monitoring and evaluation framework.	Women's physical and mental health cannot be treated in isolation. Women with female-specific physical health conditions are experiencing significantly greater psychological distress than women without physical health conditions, recording an average K10 score of 25.5 compared with 20.4. The burden is even greater for women with endometriosis (28.3), women experiencing perimenopause (24), or women with female-specific health conditions. For women with endometriosis, almost one in two experience depression (48%) and anxiety (47%), while suicide and self-harm is 3.3 times more common than across the overall female population. Women with PMOS face a similarly elevated burden, including significantly higher rates of depression, anxiety, PTSD, eating disorders and suicide and self-harm. Importantly, it was uncovered that nearly 1 in 2 (49%) women in the perimenopause stage were suffering with perimenopausal anxiety and depression. From 2022-23 to 2027-28 the Government has invested \$37 million to roll out 33 Government-funded Endometriosis and Pelvic Pain Clinics (Australian Government Department of Health, Disability and Ageing, 2025). With the expansion into perimenopause and menopause care in 22 of these clinics this year, there is an immediate opportunity to embed gender-responsive mental health support into women's reproductive healthcare; building a framework for how this care can be successfully delivered across other women's health services and conditions in future. Currently, women receive inconsistent/varied approaches to their care depending on which clinic they attend, as there are no mandated or standardised frameworks for how clinical care is delivered to patients. Therefore, Women's Mental Health Australia is calling for the development of a national minimum standard requiring all Endometriosis and Pelvic Pain Clinics to assess psychological wellbeing, establish mental health referral pathways and report on access to psychological support as part of the program's existing monitoring and evaluation framework. Utilising the 'Australian Living Evidence Guideline: Endometriosis' (RANZCOG, 2025), which already mentions the mental health aspects to endometriosis care is a great starting point to build these frameworks. With this in place, a more consistent model of care can be developed and implemented for women seeking endometriosis, pelvic pain, perimenopause or menopause related healthcare.
1.2	Invest in tailored mental health services for women across key life stages and transitions, including puberty, pregnancy, birth, motherhood, perimenopause and menopause. By embedding preventative and responsive mental health support across women's healthcare.	Women experience distinct biological and hormonal transitions across the lifespan that can increase vulnerability to mental ill-health. The research shows that among pregnant women 1 in 6 (17%) were experiencing perinatal anxiety and 1 in 7 (14%) reported perinatal depression. Women who had experienced physical birth trauma were also suffering higher levels of psychological distress, recording an average K10 score of 28.6, compared to a score of 22.8 among women who had not experienced birth trauma. The menopause transition represents another clear point for targeted support, as the research found nearly 1 in 2 women experiencing perimenopause (49%) reported perimenopausal anxiety or depression. Women's Mental Health Australia is calling for embedded preventative and responsive mental health support across women's healthcare at key life stage transition points, including antenatal and postnatal care, and perimenopause and menopause care. This position is supported in the 'National Women's Health Strategy 2020-2030 under Priority area 4: Mental health' (Australian Government Department of Health, Disability and Ageing, 2019) – but what it requires is targeted investment to translate it into consistent services at the life stages where women are demonstrably at greater risk of mental ill-health.

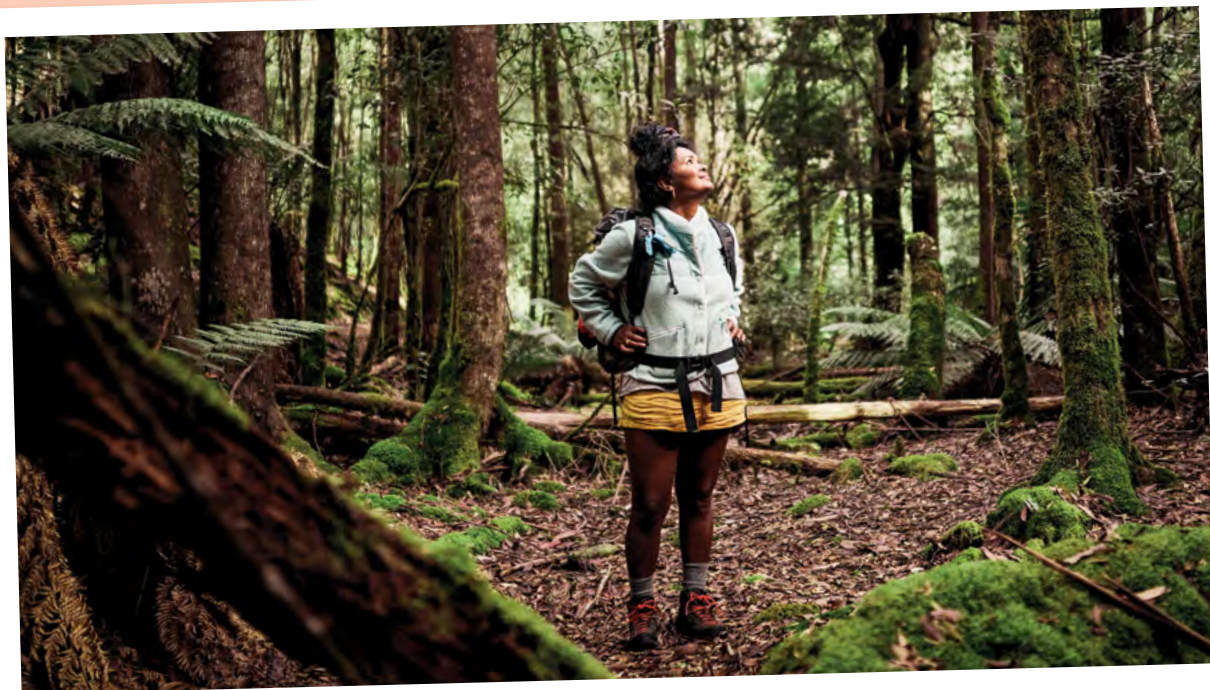
ACTION	DETAIL
1.3 Embed mental health considerations to become a standard component within the design, funding, implementation and evaluation of Australian Government policies and services focused on women’s sexual, reproductive and physical health. Treating psychological wellbeing as an integral component of health.	Women are increasingly reaching out for mental health support, with two in three (66%) women experiencing mental health issues seeking help in 2026. However, accessing care does not guarantee that women receive support that responds to their needs. Among women who sought help but did not find it helpful, nearly one in four (23%) said there were not enough tailored support services available specifically for women for their issue. Women’s Mental Health Australia is calling for mental health considerations to become a standard component of the design, funding, implementation and evaluation of Australian Government initiatives focused on women’s sexual, reproductive and physical health. This would ensure that major investments in women’s health treat psychological wellbeing as an integral component of health, ensuring tailored support that looks at women’s health holistically. This direction is consistent with the National Women’s Health Strategy 2020–2030, government efforts to address sex and gender bias in healthcare, and clinical guidance recognising the psychological impacts of conditions including endometriosis and menopause. Yet there is currently no consistent requirement for women’s health policies and funding models to assess psychological risk, provide mental health pathways or measure mental health.



2. Strengthen training, education and gender-responsive capability across the health workforce

ACTION	DETAIL
2.1 Embed sex- and gender-responsive mental health education within medical, nursing, midwifery and allied health curricula, accreditation standards and continuing professional development. By building capability across the health workforce to recognise how sex, gender and life stage shape women's mental health and treatment.	Women need a workforce capable of recognising and responding to the circumstances shaping their mental health. Among women who sought help but did not find it effective in 2026, almost one in four (24%) said the person they spoke to could not relate to their situation or background, 22% felt their condition had been trivialised or that the provider could not empathise with them, and 21% said the provider was unable to, or did not know how to, help them. The research found that women continue to rely heavily on healthcare professionals for mental health support – with GP's the most common professional source of support, used by 49% of women seeking help, while 38% accessed a psychiatrist or other mental health professional. These findings reinforce the importance of building sex- and gender-responsive capability across the full health workforce; including medical practitioners, nurses, midwives and allied health professionals. The Australian Government is increasingly investing in optional and condition-specific professional education, such as menopause training now available to clinicians (Australasian Menopause Society, 2026), but workforce capability should not depend on clinicians choosing to undertake specialist women's health education after qualification. Women's Mental Health Australia is calling for gender-responsive mental health education to be embedded throughout health professional training, from undergraduate curricula and professional accreditation through to continuing professional development. Building this capability into the foundations of the health workforce would help ensure that clinicians recognise how sex, gender, reproductive health and life stage can influence mental health presentation and treatment, reducing the risk that women's symptoms are misunderstood, minimised or managed without appropriate consideration of their wider health context.
2.2 Fund and implement a nationally consistent perinatal mental health screening, referral and follow-up pathway across public and private maternity care systems. Including training for health professionals so every woman is routinely offered evidence-based mental health and psychosocial assessment during pregnancy and after birth.	Pregnant women are especially vulnerable to experiencing mental ill-health, especially perinatal anxiety – which is occurring in one in six (17%) pregnant women. The research shows that pregnant women are actively looking for support. 86% of pregnant women experiencing mental health concerns sought help in 2026. They were also particularly likely to use accessible digital options, with 37% searching for online mental health resources, 33% accessing online counselling and 32% using online support groups. Women's Mental Health Australia is calling on the Australian Government to work with states and territories to fully implement a nationally consistent perinatal mental health screening, referral and follow-up pathway across public and private maternity care. This should build on existing national guidelines and infrastructure and include training for health professionals – ensuring that every woman is routinely offered evidence-based mental health and psychosocial assessment during pregnancy and after birth, with clear referral pathways and appropriate follow-up when concerns are identified. A Commonwealth-commissioned evaluation of the Perinatal Mental Health and Wellbeing Program and National Perinatal Mental Health Check, released in June 2026, further reinforces this position. The evaluation report found the uptake and integration of digital screening remains uneven across jurisdictions and that inconsistent data collection prevents national comparison and effective service planning (Boyle, Lohan & Dean et al., 2025). The evaluation also found that Australia does not currently have a system capable of consistently tracking follow-up and outcomes from screening through to service provision; and recommended nationally consistent collection of both antenatal and postnatal screening data and referral pathways.

ACTION	DETAIL
2.3 Ensure national clinical guidelines and standards of care for women's health conditions and reproductive life stages integrate associated mental health needs - including assessment, management and referral pathways, supported by appropriate workforce training. Starting with the new Australian Perimenopause and Menopause Guidelines.	Almost 1 in 2 women experiencing perimenopause (49%) reported perimenopausal anxiety or depression in 2026. Women experiencing perimenopause also reported significantly higher rates of anxiety, insomnia, PTSD, PMDD and substance use disorders, demonstrating that psychological health must be considered a core component of menopause care, rather than treated separately from the physical symptoms of the menopause transition. The Australian Government has recently funded the Australian Living Evidence Collaboration (ALEC) to develop the new Australian Perimenopause and Menopause Guidelines (ALEC, 2026) - providing a timely opportunity to further embed an integrated approach within the national standard of care for women. Women's Mental Health Australia is calling for the new guidelines to explicitly address the identification, assessment, management and referral of mental health conditions associated with the menopause transition, including perimenopausal anxiety and depression. This should be supported by practical guidance and education that equips GPs and other health professionals to recognise psychological symptoms, differentiate between menopause-related and other mental health presentations, discuss appropriate treatment options and refer women for specialist mental health support where required. While perimenopause and menopause present an immediate opportunity, this principle should extend to national clinical guidelines developed or updated for all female-specific health conditions and reproductive life stages where evidence demonstrates an associated mental health burden. Australia is already moving towards a more sex- and gender-responsive health evidence base. From 2026, most National Health and Medical Research Council (NHMRC) and Medical Research Future Fund (MRFF) funding opportunities require researchers to consider sex and gender throughout research design, conduct, analysis, reporting and translation, or provide an evidence-based justification where these factors are not relevant (NHMRC, 2025). This recognises that consideration of sex and gender is fundamental to research quality, equity and the applicability of evidence to healthcare. The same principle should extend to the clinical guidelines that translate this evidence into practice. Where sex- or gender-specific evidence identifies an associated mental health burden, national clinical guidance should equip practitioners to recognise and respond to it through appropriate assessment, management and referral pathways, supported by workforce education and training.



3. Improve the affordability and accessibility of the support women find most effective

ACTION	DETAIL
3.1 Invest in a nationally accessible, fully funded telehealth pathway through Medicare Mental Health, providing continuity of care with professionals trained in sex- and gender-responsive mental healthcare.	Affordability and accessibility continue to prevent women from getting the mental health support they need. In 2026, almost 1 in 3 women (31%) who did not seek help said they could not afford support or considered it too costly. Women also reported difficulty accessing services, long waiting times and being unable to find the right support. Geographic inequity compounds these barriers. In 2026, women living in regional areas reported significantly higher rates than metropolitan women across depression (36% vs 27%), anxiety (29% vs 18%), insomnia (21% vs 14%), PTSD (13% vs 7%) and several other conditions. Importantly, women's experiences show that access to mental health professionals were among the sources of support women found most effective, with 59% of women who saw a psychologist and 57% who saw a psychiatrist rating their support as very helpful. Yet almost 1 in 4 women (23%) who sought help but did not find it helpful said there were not enough tailored support services available specifically for women for their issue. The Australian Government's expansion of Medicare Mental Health Centres provides an important foundation for improving free access to mental healthcare. However, publicly available information shows considerable variation in how the specialist workforce is described and delivered across individual Centres. While the Government has funded on-call access to psychologists and psychiatrists, there is no nationally visible pathway connecting women to clinicians with expertise in female-specific or differently presenting mental health conditions, such as PMDD, perimenopausal anxiety and depression, or female presentations of ADHD and autism. Women's Mental Health Australia is calling for a nationally accessible, fully funded telehealth pathway through Medicare Mental Health to connect women with psychologists, psychiatrists and other regulated mental health professionals based on their individual needs. This should include access to practitioners appropriately trained in sex- and gender-responsive care and areas such as reproductive and perinatal mental health, PMDD, menopause-related mental health, trauma, and female presentations of neurodevelopmental conditions.
3.2 Provide access to up to 20 Medicare-subsidised mental health treatment sessions each year under Better Access for people who require ongoing care. Where a treating practitioner determines that continued care is clinically required.	For women who have found professional mental healthcare that works, affordability should not become a barrier to continuing that care. Mental health professionals were among the most effective sources of support identified by women in 2026, with 59% of women who saw a psychologist rating their support as very helpful. The value of this care was particularly evident for women experiencing female-specific mental health conditions. Among women seeking help for perimenopausal anxiety and depression, 47% accessed a psychologist and almost 4 in 5 (79%) rated this support as very helpful. Women described financial pressure making it difficult to continue or regularly attend professional support, highlighting the risk that cost can interrupt an established therapeutic relationship even where treatment is working. Under the Better Access initiative, Australians can currently access up to 10 Medicare-subsidised individual mental health treatment sessions each calendar year. Women's Mental Health Australia is calling for access to up to 20 Medicare-subsidised sessions where a treating practitioner determines that continued care is clinically required. The continuity of effective care is an investment in prevention of mental ill-health. For women already engaged with a trusted clinician and benefiting from treatment, additional sessions provide an opportunity to maintain mental wellbeing and intervene earlier if symptoms deteriorate, rather than waiting until more intensive care is required.

ACTION	DETAIL
3.3 Broaden and better utilise the mental health workforce available to women. By completing the implementation of the national regulation for counsellors and psychotherapists, exploring Medicare funding pathways for suitably qualified practitioners and improving access to existing Medicare-supported mental health social workers, occupational therapists.	Improving access to mental healthcare requires Australia to make better use of the full mental health workforce. The 2026 findings show that women are drawing on a broader range of professional and community-based mental health support. Among women who accessed a mental health professional, 13% saw a counsellor, 10% saw a mental health occupational therapist and 7% saw a mental health social worker. Use of occupational therapists increased from just 3% in 2025 to 10% in 2026, while use of mental health social workers increased from 4% to 7%. Women are also increasingly turning to community-based and relational forms of support. Use of community agencies increased from 9% in 2025 to 14% in 2026, online support groups from 6% to 13%, and in-person support groups from 9% to 12%. This growing use of community support reinforces the value of a diverse mental health workforce that can provide connection, practical support, recovery-oriented care and earlier intervention alongside specialist clinical services. Australia has recently taken important steps towards strengthening the diverse mental health workforce. In 2025, the Australian Government introduced the first National Standards for Counsellors and Psychotherapists, and in 2026 the Australian Association of Peer Workers was established based on the National Lived Experience Workforce Development Guidelines. Continued reform is required to broaden and better utilise Australia’s mental health workforce. Women’s Mental Health Australia is calling for the complete implementation of the national regulation for counsellors and psychotherapists and explore Medicare funding pathways for suitably qualified practitioners. Additionally, we recommend improving access to existing Medicare-supported mental health social workers and occupational therapists; and sustainable funding and workforce pathways for appropriately trained lived experience peer workers. Expanding the range of recognised and funded practitioners would give women greater choice in the type of support they access, relieve pressure on an already stretched specialist workforce, and create more opportunities for timely, relational, gender-responsive care.



Investigating the *Mental Health Realities* for Australian Women Beyond the Surface 2026

Beyond the Surface 2026: Investigating the *Mental Health*

Realities for Australian Women Beyond the Surface 2026: Investigating the *Mental Health*

