



Department for Women

**Young women's health:
depression and risk taking
behaviour**

Published August 2001 by the Department for Women
Available only on the Department's website at <www.women.nsw.gov.au>

© Department for Women
ISBN 0 7310 5260 9 (On-line version only)

Contact: Bessie Tselos
Senior Policy Officer
Department for Women
Phone: 02 9287 1918
Fax: 02 9287 1823
Email: bessie.tselos@women.nsw.gov.au

Contents

1.0	Introduction	4
2.0	Status of women's health	4
3.0	Health of young women	7
3.1	Burden of disease	7
3.2	Depression and	8
3.3	Suicide	8
3.4	Road traffic accidents	8
3.5	Reproductive and sexual health issues	8
3.6	Substance use	9
3.7	Eating disorders	9
4.0	Depression and related risk-taking behaviour	11
4.1	Smoking	14
4.2	Body image and disordered eating	17
5.0	Conclusion	23
	Appendix A	
	Statistics on women's health in developed and developing countries	24
	Appendix B	
	Government and community activity	25

Young women's health: depression and risk taking behaviour

1.0 Introduction

The impact of mental illness within the Australian population is becoming a serious public health issue. It is estimated that one in five individuals will be affected by a mental health problem at some stage in their life. Depression in particular is estimated to become the second largest contributor to the world's disease burden by 2020. Depression usually has its first onset in adolescence and is often a recurring disorder. In fact, depression is the leading cause of the burden of disease¹ for young women and occurs at three times the rate than that for young men.² This gender difference persists throughout adulthood. The impact of depression is often greater as it usually co-exists with anxiety (again the rate for girls is much higher than for boys) and has been linked to a range of health risk behaviours such as smoking, alcohol use, illicit drug use, eating disorders and obesity.

This paper will examine the high prevalence of depression among women and girls and the risk taking behaviours associated with depression (eg smoking, eating disorders), which have also been identified as major causes of disease burden in young women and girls. Gender differences on these issues will also be examined. This facilitates analysis of the cause of these problems and has bearing on the approaches used for prevention and treatment. In order to evaluate the significance of these issues, it is necessary to first to view them in the context of women's health generally and young women's health specifically. This paper will therefore provide an overview of the status of women's health and the main areas of concern in young women's health.

2.0 Status of women's health

Key Points

- ◆ The most common causes of death for women are heart disease, stroke and cancer
- ◆ The main illnesses and health conditions among women are tooth decay/loss, hearing loss, asthma, periodontal disease, anaemia, osteoarthritis, depression, chronic back pain and urinary incontinence.
- ◆ *Burden of disease* is a measure of health that refers to the impact of illness, injury, disability and premature mortality on 'healthy' life and provide a different picture of population health.
- ◆ Mental disorders are now the third leading burden of disease, after cardiovascular diseases and cancers.

¹ *Burden of disease* refers to the impact of illness, injury, disability and premature mortality on 'healthy' life.

² Australian Institute of Health and Welfare 2000, *Australia's young people- their health and wellbeing 1999*, Cat. no. PHE-19, AIHW, Canberra, p87.

- ◆ The leading causes of disease burden are heart disease and stroke for both men and women. Depression, dementia and breast cancer are the next three leading causes in women.

According to ABS data³ the leading causes of death for women are heart disease and stroke (46.1%) and cancer (breast, lung and colon 24.9%). The most common cause of death from cancer for women is breast cancer (17% of all female cancer deaths).⁴

The Australian Institute of Health and Welfare's *Australia's Health 2000* reports that there were seven major causes of death for both men and women during 1998. These were heart disease, stroke, lung cancer, colorectal cancer, chronic obstructive pulmonary disease, and breast and prostate cancers. Table 2.1 shows the top 10 leading causes of death for women compared to men.⁵

Table 2.1: Leading causes of death, 1998

	Cause of death	Females	Cause of death	Males
1	Heart disease	12,801	Heart disease	15,021
2	Cerebrovascular disease (stroke)	7,170	Lung cancer	4,821
3	Dementia and related disorders	2,579	Cerebrovascular disease	4,812
4	Breast cancer/prostate cancer	2,542	Chronic obstructive pulmonary disease	3,325
5	Colorectal cancer	2,165	Colorectal cancer	2,579
6	Lung cancer	2,053	Prostate cancer	2,530
7	Chronic obstructive pulmonary disease	2,026	Suicide	2,150
8	Cancer of lymphatic tissue	1,600	Cancer of lymphatic tissue	1,870
9	Diabetes	1,327	Diabetes	1,424
10	Pneumonia	937	Dementia	1,294

Source: Australia's Health 2000 Report, 2000, p40.

Data on illness, morbidity and general health conditions show that the most prevalent health conditions for people in Australia during 1996 were tooth decay, hearing loss, total tooth loss and asthma. Depression was the seventh most prevalent condition for women. See table 2.2.

³ Australian Bureau of Statistics 1997, *Australian Women's Year Book*, Cat. No. 4124.0, ABS, Canberra.

⁴ Australian Bureau of Statistics 1998, *Deaths Australia*, Cat no.3302.0, ABS, Canberra.

⁵ Comparative international data shows that death rates from cancers and cardiovascular disease in Australia (and other developed countries) are significantly higher than in Asia and the Pacific region, Latin America and Africa, indicating that Australian women's health problems are a by-product of our culture and lifestyle rather than biological reasons. See Appendix A.

Table 2.2: The ten most prevalent conditions for women and men, 1996.

	Condition	Prevalence (no. of women)	Condition	Prevalence (no. of men)
1	Tooth decay	9,447,000	Tooth decay	9,567,000
2	Total tooth loss	1,004,300	Hearing loss	2,245,800
3	Hearing loss	842,500	Alcohol dependence and harmful use	538,500
4	Asthma	672,200	Asthma	533,900
5	Periodontal disease	532,500	Peridontal disease	494,700
6	Iron-deficiency anaemia	493,600	Total tooth loss	392,400
7	Osteoarthritis	383,500	Chronic back pain	300,500
8	Depression	374,100	Iron-deficiency anaemia	275,800
9	Chronic back pain	285,300	Type 2 diabetes	247,400
10	Urinary incontinence	257,000	Slipped disc	214,000

Source: Australia's Health 2000 Report, 2000, p46.

The report also looks at a new measure of health, the burden of disease, that combines information on the impact of premature death and of disability and other non-fatal health conditions. Information is combined from various aspects of disease and injury into a single measure, the disability adjusted life years (DALY). DALYs are calculated as the sum of years lost due to premature mortality (YLL) and the equivalent years of 'healthy' life lost due to poor health or disability (YLD). The DALY was developed as part of the 1990 WHO and World Bank Global Burden of Disease study and has been adapted by the AIHW for the Australian context.

The inclusion of non-fatal health outcomes provides a substantially different picture of population health from that provided by looking at mortality and disability statistics alone: mental disorders were the third leading cause of overall burden (14% of total) after cardiovascular disease (20%) and cancers (19%). The 15 leading causes of burden of disease is listed in table 2.3.

Table 2.3 The 15 leading causes of burden of disease, 1996.

		Per cent of DALYs
1	Ischaemic heart disease	12.4
2	Stroke	5.4
3	Chronic bronchitis and emphysema	3.7
4	Depression	3.7
5	Lung cancer	3.6
6	Dementia	3.5
7	Diabetes mellitus	3.0
8	Colorectal cancer	2.7
9	Asthma	2.6
10	Osteoarthritis	2.2
11	Suicide and self inflicted injuries	2.2
12	Road traffic accidents	2.2
13	Breast cancer	2.2
14	Hearing loss	1.9
15	Alcohol dependence and harmful use	1.8

Source: Australia's Health 2000 Report, 2000, p54.

The burdens of mental illnesses and non-fatal diseases have been underestimated by traditional approaches that only take into account deaths and not disability. Heart disease and stroke are the two leading causes of burden of disease for both men and women. Depression, dementia and breast cancer are the next three leading causes in women. Lung cancer, bronchitis and emphysema and suicide are respectively the third, fourth and fifth leading causes for men.⁶

Depression has risen from the tenth most common problem managed in general practice in 1990-91 to the fourth in 1998-99. More than 50% of those who had presented at general practitioners with depression were women. Prescriptions for antidepressants in Australia tripled over the past decade from 5.1 million prescriptions in 1990 to 8.2 million prescriptions in 1998.⁷

3.0 Health of young women

Key Points

- ◆ The major burden of disease among young people aged 15-24 years is from mental disorders and injury.
- ◆ The leading causes of disease burden among young people are alcohol dependence and harmful use, road traffic accidents, depression, bipolar affective disorder, heroin

⁶ Australian Institute of Health and Welfare 2000, *Australia's Health 2000*, Cat No. 19, AIHW Canberra, p54.

⁷ P. McManus et al 2000, Recent trends in the use of antidepressant drugs in Australia, 1990-1998, *Medical Journal of Australia*, Vol 173, pp458-461.

dependence/harmful use, suicide, social phobia, schizophrenia, borderline personality disorder and eating disorders.

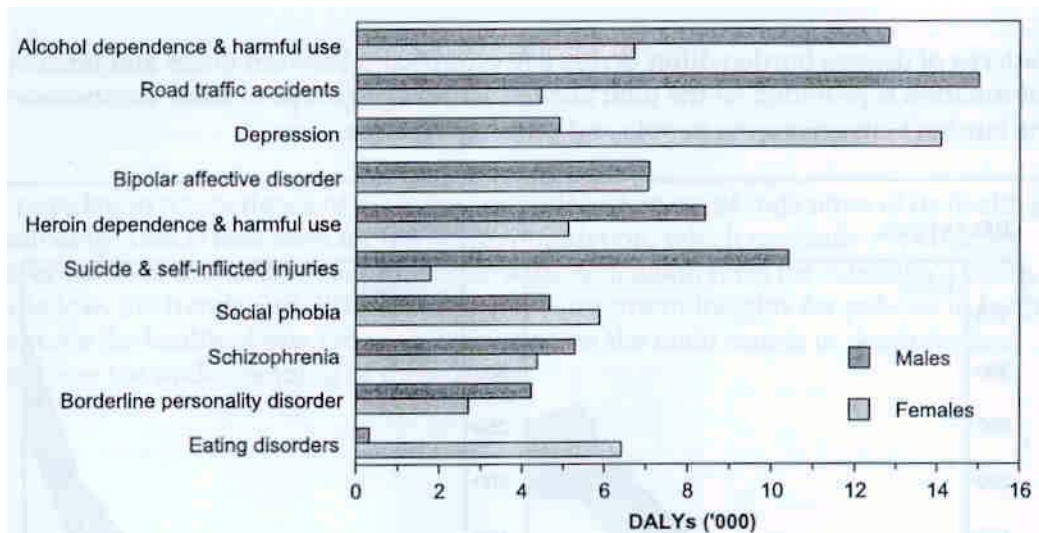
- ◆ Among young women the major issues are depression, which was the largest cause of burden among young women, attempted suicide, reproductive and sexual health, tobacco use and eating disorders.

The Australian Institute of Health and Welfare (AIHW) recently published its first report on the health of young people aged 12-24 years.⁸ This report included findings from the Burden of Disease Study mentioned earlier for 15 –24 year olds and other recent sources of data.

The AIHW report shows that young people in Australia are generally in good health but there are some areas for concern and there are gender differences. These findings are highlighted below.

3.1 Burden of disease

The major burden of disease for this age group is from mental disorders (this includes drug dependence and harmful use) which account for 55% of the total burden in young people (males 49%, females 63%). Injury was the next leading burden of disease in young people, accounting for 22% of the total burden of disease for young people (males 22.3%, females 9.9%).



Source: Australian Institute of Health and Welfare, Australian young people: their health and wellbeing, 1999, p35.

The leading causes of disease burden fall generally into the mental disorders category. Alcohol dependence and harmful use was the leading cause of overall burden accounting for 11% in males and 7% of the burden in females. The second highest cause of burden was from road traffic accidents (13% of males and 5% for females). Depression was the third leading cause of burden overall, and was by far the largest cause of burden among

⁸ Australian Institute of Health and Welfare, *Australia's young people – their health and wellbeing 1999*, p211.

young women (15% of the burden). The fourth to tenth leading causes of disease burden were bipolar affective disorder, heroin dependence/harmful use, suicide, social phobia, schizophrenia, borderline personality disorder and eating disorders. Eating disorders was also a substantially larger burden in women than in men (7% of females and 0.2% of males).

3.2 Depression

The rates of depressive disorders are three times higher for young women than for young men and depression among 18-24 year old women (10%) is higher than the overall female rate of 7%.

3.3 Suicide

There are three male deaths to every female death. Accidents and suicide account for the higher death rate in males. While the male suicide rate was four times the rate of females, the hospitalisation rate for attempted suicide among young women was greater at all ages and more than three times the rate for males at ages 15 and 16. The suicide rate for young males increased by 71% (from 14 per 100,000 to 24 per 100,000) over the period 1979 to 1997. The female rate increased from 4.5 per 100,000 to 5.9 per 100,000 over the same period. However, this increase is not considered statistically significant.

3.4 Road traffic accidents

Two thirds of all deaths in the youth population (aged 12-24 years) were attributed to some form of accidents (71% of males, 55% of females). Motor vehicle accidents alone were the cause of 17% of male deaths and 19% of female deaths. However the rate of death for males by motor vehicle accident is more than double that for females (males 16 deaths per 100,000 and females 6 deaths per 100,000).

3.5 Reproductive and sexual health issues

The major reproductive health issues for young women are unwanted pregnancies and sexually transmitted diseases. In 1998, there were a total of 85,499 live births in NSW of which 5% were to teenage mothers and 16% to women aged 20-24 years, a total of 17,880 births. According to the Health Insurance Commission, in 1999-00 there were approximately 32,289 terminations in NSW.⁹ In NSW, approximately 27% of all pregnancies end in abortion, the proportion for teenagers is 46%.

In 1996, 22% of Aboriginal and Torres Strait Islander births were to teenage mothers. This compares with 5% in the total Australian population.¹⁰

Teenage mothers are also more likely to have lower birthweight babies - 9% of births to teenage mothers (under 20 years of age) were classified as low birthweight (less than 2,500 g). This compares to 6% for all births.

⁹ This data includes the ACT and does not include terminations carried out in public hospitals.

¹⁰ Australian Institute of Health and Welfare, *Australia's young people – their health and wellbeing 1999*, p211.

Chlamydia is the main sexually transmitted disease among young people, especially young women; notifications of this disease increased from 105 to 292 per 100,000 over the period 1991-1998. Notifications of chlamydia were 2.4 times greater for young women than for men in 1998 compared to 1.6 times for the total population.¹¹

3.6 Substance use

In 1998, 25% of young persons aged 14-19 (25% males and 26% females) and 40% of those aged 20-24 years (40% males and 38% females) were regular or occasional smokers.¹²

Young men tend to drink alcohol more frequently than young women and in greater quantities. On a day when alcoholic drinks are consumed 60% of males (aged 14-24 years) reported usually having five or more drinks compared with 39% of females. Of those who reported drinking alcohol recently, 62% of males (aged 14-24 years) drank alcohol only one day or less per week, whereas 80% of females reported drinking one day or less per week. The proportion of occasional and regular young women drinkers, however, appears to be increasing slightly - from 74% in 1995 to 78% in 1998.¹³

3.7 Eating disorders

Over the five years from 1992 to 1997, there were eight deaths amongst 12-24 year olds due to eating disorders. The prevalence of anorexia nervosa and bulimia nervosa in Australia is estimated at 0.5% and 0.5-1% of the population respectively. However, disordered eating, restrained eating, binge eating, fear of fatness, purging and distortion of body image are common among young people.¹⁴ A recent study found that 29% of girls used fasting or crash dieting strategies, 9% used cigarettes, and 6% - 8% used vomiting and diet pills or laxatives at least occasionally to lose weight.¹⁵ Findings consistent with these have been reported in other studies.¹⁶ A study of over 1,300 secondary school students showed that 57% of girls and 18% of boys had dieted at some time.¹⁷

Being underweight can have serious health effects. Of those who are outside the acceptable range of weight, a higher proportion of males are overweight or obese (25% of

¹¹ Many communicable diseases are notifiable. This means that diagnosis of the disease must be reported to the relevant State/Territory health authority. Chlamydia is not notifiable in NSW. This data is an Australian estimate based on notifications in other States.

¹² Australian Institute of Health and Welfare, *Australia's young people – their health and wellbeing 1999*, p126.

¹³ Australian Institute of Health and Welfare, *Australia's young people – their health and wellbeing 1999*, p127-128.

¹⁴ National Health and Medical Research Centre (NHMRC) 1995, cited in Australian Institute of Health and Welfare, *Australia's young people – their health and wellbeing 1999*, p146.

¹⁵ D. Maude et al 1993, *Body dissatisfaction and weight loss behaviours, and bulimic tendencies among Australian adolescents*, in National Health and Medical Research Centre (NHMRC) 1995, *Acting on Australia's weight*, p146. NHMRC 1995.

¹⁶ G. Huon 1994, *Dieting and binge eating, and some of their correlates among secondary school girls*, in National Health and Medical Research Centre (NHMRC) 1995, *Acting on Australia's weight*, p146.

¹⁷ D. Crawford & T. Selwood 1983, *The nutritional knowledge of Melbourne high school students*, in National Health and Medical Research Centre (NHMRC) 1995, *Acting on Australia's weight*, p151.

males compared to 19% of women), and a higher proportion of females are underweight (26% compared to 19%).

Associated with body weight, body image and dieting issues is the level of exercise undertaken by young people. The proportions of young people who reported exercising for sport or recreation declined with age, from 61% of males aged 15-17 to 44% of males aged 20-24 and from 41% of females aged 15-17 to 31% of those aged 20-24.

The above information shows that young people's main health issues relate to injuries and mental disorders. Among young men, dangerous driving, alcohol use and suicide are the major concerns. For young women, issues such as depression, smoking and eating disorders are of particular concern. These issues for young women are discussed in more detail below and how they interrelate with each other.

4.0 Depression and related risk-taking behaviour

Key Points

- ◆ Depression is the leading cause of the burden of disease for young people.
- ◆ Among young women depression occurs at three times the rate than that for young men.
- ◆ For girls there is a progressive rise in the incidence of depressive symptoms from the onset of puberty and menstruation and this gender difference persists until menopause.
- ◆ The leading causes of disease burden among young women are interrelated as depression co-exists with a number of other health risk-taking behaviours such as smoking, use of drugs and alcohol and eating disorders.
- ◆ Depression has been shown to predict alcohol use and addiction in later life among young drinkers and bulimia nervosa among dieters.

In 1997 27% of 18-24 year olds were found to have a mental disorder.¹⁸ Almost one out of five children and adolescents suffer from a mental health problem within any 6-month period. The onset of most mental disorders occurs in mid-to-late adolescence. Mental health problems developed in this period are more likely to become chronic and to impact on future psychological development. Mental health problems and disorders among children and adolescents are depression and anxiety, disruptive behaviours, self-injury, first onset psychosis and body image and eating disorders.¹⁹

The child and adolescent component of the National Survey of Mental Health and Well-being, *Mental Health of Young People in Australia*, is the first national study on mental

¹⁸ Australian Bureau of Statistics 1998, *Mental health and wellbeing: profile of adults, Australia, 1997*, Cat. no. 4326.0, Canberra, ABS.

¹⁹ Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1999, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p13.

illness among children and adolescents aged 4 to 17 years of age.²⁰ The survey found a high prevalence of mental health problems (14%) in children and adolescents aged 4-17 years. Depression is the leading cause of the burden of disease for young people. Among young women depression occurs at three times the rate than that for young men. Depression is defined and diagnosed by the following set of symptoms:²¹

1. Depressed mood for most of the day.
2. Loss of interest or pleasure, in all or most activities, most of the day.
3. Large increases or decreases in appetite (significant weight loss or gain).
4. Insomnia or excessive sleeping.
5. Restlessness as evident by hand wringing or slowness of movement.
6. Fatigue or loss of energy.
7. Feelings of worthlessness, or excessive or inappropriate guilt.
8. Inability to concentrate or indecisiveness.
9. Recurrent thoughts of death or suicide.

A major depressive disorder is characterised by the presence of at least five of the symptoms listed above, including symptom no. 2.

Risk factors which make it more likely for adolescents to develop depression are: symptoms of anxiety, behavioural problems, substance use, being female, being an older adolescent (15-17 years old), having a depressed parent and having a previous history of depression or depressive symptoms. Other possible risk factors include: poor self-esteem and inadequate social skills, divorced/separated parents, early childhood sexual and physical abuse, being of Aboriginal or Torres Strait Islander descent, living in rural areas, low socio-economic status, being homeless or in custody, being of non-English speaking background or a refugee or having an intellectual disability.²² Protective factors which could ameliorate the symptoms of depression have been identified as having good peer relationships, good relationships with parents and being employed.²³ For children and young people, having a positive and rewarding school environment and a sense of connectedness to their school and/or community; personal academic or sporting achievements and involvement in social peer groups could also have a protective effect against mental health problems.²⁴

These risk and protective factors have implications for strategies aimed at young women, as low self esteem and poor body image, sexual abuse and lack of involvement in sport

²⁰ Commonwealth Department of Health and Aged Care, *The mental health of young people in Australia*, Mental health and special programs branch, Canberra, 2000.

²¹ American Psychiatric Association (APS) 1994, *Diagnostic and statistical manual of mental disorders: DSM-IV*, Ed 4th, APS, Washington DC.

²² National Health and Medical Research Council 1997, *Clinical Practice Guidelines: Depression in young people*, AGPS, Canberra, p29.

²³ National Health and Medical Research Council 1997, *Clinical Practice Guidelines: Depression in young people*, AGPS, Canberra, p39.

²⁴ Raphael, B (2000) Promoting the Mental Health and Wellbeing of Children and Young People. Discussion Paper: Key principles and directions. National mental Health Working Group, Department of Health and Aged Care, Canberra, pg 17.

are characteristics associated more with girls and young women than with boys and young men.

Around 20% of young people suffer from depressed mood, with up to 43% reporting feeling sad for at least two weeks in the past year. Five per cent of young people suffer from a depressive disorder. The prevalence of current major depressive disorder among young people is 2.7%. Incidence rates are much higher than they are for adults.²⁵

Other studies show that for girls there is a progressive rise in the incidence of depressive symptoms from the onset of puberty and menstruation.^{26, 27} This gender difference persists until menopause.²⁸ The reasons for this gender difference include the influence of hormonal and psychological changes in adolescent girls during puberty and changes in social roles and expectations.

Depression is likely to co-exist with anxiety (approximately half of the people with depression also have an anxiety disorder)²⁹ and to be associated with a number of other health risk-taking behaviours such as smoking, use of drugs and alcohol and eating disorders.³⁰ These behaviours are seen by some as coping strategies for psychological pain and depression. A recent study found a positive correlation between mental health problems, functional impairment and risk taking behaviours such as marijuana smoking, alcohol use, unprotected sexual intercourse, fighting, cigarette smoking and suicidal thoughts or attempts.³¹

There is growing evidence that depression predicts progression of alcohol use and addiction in later life in young drinkers³² and in dieters, predicts the development of bulimia nervosa.³³

²⁵ Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p47.

²⁶ G C Patton 1996a, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p47.

²⁷ A Angold 1998, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p47.

²⁸ R C Kessler 1994, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p47.

²⁹ Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p42.

³⁰ Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p43.

³¹ A. J. Flisher et al, Risk Behaviour in a Community Sample of Children and Adolescents, *Journal of American Academic Child and Adolescent Psychiatry*, 39:7, July, 2000.

³² C. B Nelson et al 1996, *Patterns of DSM III alcohol dependence syndrome progression in a general population survey*, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p44.

The *Mental Health of Young People in Australia* survey found a strong relationship between emotional and behavioural problems and rates of smoking, drinking and marijuana use and suicidal thoughts and behaviour among young people (13-17 years of age).³⁴ Suicidal thoughts and behaviour and weight loss/control behaviour were more prevalent among adolescent girls (13-17 years). The rate of suicidal thoughts and behaviour was 30.5 % among adolescent girls compared to 21.5% among adolescent males. 73% of adolescent girls dieted or exercised to lose or control weight compared to 40% of adolescent boys.³⁵

It has been suggested that women tend to use drugs to help them cope with internal problems such as depression whereas boys use drugs to help them cope with external pressures. Researchers have found that women use heroin for psychological reasons such as depression and women who are dependent on alcohol are more likely to have attempted suicide than men. There is also a belief that risk taking behaviour among young women is increasing and that women perceive smoking and drinking as less risky to themselves than boys do. There is concern that women have increased health risks from smoking, alcohol and drug use because of the gender differences in metabolism. The level of alcohol consumption by young women aged 18-24 has been steadily increasing since 1977.³⁶

Women's Health Australia, in the *Report of the first five years of the Australian Longitudinal Study on Women's Health, 1995-1999*, reported that among young women (18-23 years of age), frequent dieting and a history of beginning to diet before the age of 15 years were associated with poorer physical and mental health, including depression.

There is also a considerable amount of research that examines the relationship between risk taking, risk behaviour and young people's driving behaviour.³⁷ Dangerous driving among women has received recent attention by the media, however, it must be viewed in the context of the data which shows that men outnumber women 3:1 in road fatalities and serious casualties in NSW. Men tend to report more risky driving, such as speeding and not wearing seat belts, whereas women tend to be more vulnerable as passengers.³⁸ A sub study of the Women's Health Australia Longitudinal study showed riskier driving behaviour among young women was associated with stress and habitual alcohol

³³ G. C. Patton et al 1999, *The onset of adolescent eating disorders: A population based cohort study over three years*, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p44.

³⁴ Commonwealth Department of Health and Aged Care, *The Mental Health of Young People in Australia*, Mental Health and Special Projects Branch, Canberra, 2000, pg 49.

³⁵ Commonwealth Department of Health and Aged Care, *The Mental Health of Young People in Australia*, Mental Health and Special Projects Branch, Canberra, 2000, pg 38.

³⁶ McCallum, T., 1998 in Noffs, W., *Treatment needs of young women, towards a better model*, Keynote Address Australian Drug Foundation Conference, 5 April, 2001.

³⁷ Risk behaviour is defined as both conscious and subconscious behaviours that can cause harm.

³⁸ B. Elliot 1997, *A review of risk behaviour among 15-24 year olds*, in Roads and Traffic Authority NSW 2000, *Youth road safety in NSW: A discussion paper*, RTA, p10.

consumption. The study also showed that women born in non-English speaking countries had significantly higher risk of accidents compared to Australian-born women.³⁹ The trends indicate that risky behaviour among women is on the increase and women's involvement in road accidents may increase in the future.

Aboriginal young women

There is a very limited amount of data on depression and mental health among the Aboriginal population, especially among young women. However, data that is available can be construed to apply to adolescent and young women also. According to the ABS, during 1997-98 indigenous women were admitted to hospital for a mental disorder 1.5 times more than non-indigenous women.⁴⁰ Depression, anxiety, substance use disorders and high-risk behaviours are believed to be highly prevalent in Aboriginal and Torres Strait Islander communities. A high proportion of people presenting to Aboriginal medical services have mental disorders or are psychologically distressed.^{41, 42} The *Ways Forward: National consultancy report on Aboriginal and Torres Strait Islander mental health* highlighted that the most significant and frequent problems identified by indigenous people are grief, trauma and loss, all of which are risk factors for depression.

Women from non-English speaking backgrounds

Studies to determine prevalence rates of mental disorders among people from non-English speaking backgrounds are few in number because of sample size problems and cultural differences in definitions, conceptualisation, experience and reporting of depression. However, refugees, the majority of whom are women and children (75%), have often suffered torture and violation of human rights. Torture and trauma survivors have a high level of depressive symptoms.⁴³

4.1 Smoking

Key Points

- ◆ Smoking is associated with depression and or anxiety.

³⁹ A. Dobson 1999 et al, Women drivers' behaviour, socio-demographic characteristics and accidents, *Accident Analysis and Prevention* 31, pp 525-535.

⁴⁰ Australian Bureau of Statistics 1997-98, *Hospital statistics, Aboriginal and Torres Strait Islander Australians*, Cat. No. 4711.0, ABS, Canberra..

⁴¹ J H McKendrick et al 1992, *The pattern of psychiatric morbidity in a Victorian urban Aboriginal general practice population*, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p51.

⁴² P Swan & P Fagan 1991, *The New South Wales mental health report*, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p51.

⁴³ Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p52.

- ◆ Young girls report using tobacco as a way to control weight, as a stress release or calming mechanism. Stress, anxiety and depression and weight control are reasons women also find it harder to quit.
- ◆ More girls are smoking than boys and on average are smoking about 20 cigarettes per week.
- ◆ Smoking rates among girls have increased.
- ◆ Smoking rates are substantially higher among young Indigenous women compared to non-Indigenous women.
- ◆ The earlier the onset of smoking, the more the risk of developing smoking related diseases and the less likelihood of being able to quit smoking.
- ◆ Cigarette smoking causes around 20% of deaths of women (before age 65) annually.
- ◆ There is a link between smoking and miscarriages and menstrual problems among young women.

Smoking has been shown to be associated with symptoms of depression and or anxiety. One longitudinal study reports that depression in adolescents may predict smoking in adulthood⁴⁴ and an Australian study has shown an association between smoking and both depression and anxiety in teenagers.⁴⁵ Furthermore, depressed smokers are less likely to give up smoking than those who are not depressed.⁴⁶ Young girls report using tobacco as a way to control weight, as a stress release or calming mechanism and as a means to portray a certain image.⁴⁷ Stress, anxiety and depression and weight control are reasons women find it harder to quit.

While adult levels of smoking have fallen in recent years, the level of smoking by teenagers has not mirrored this decline. Among NSW secondary school students, the prevalence of smoking has increased since 1990. More girls are smoking than boys and on average are smoking about 20 cigarettes per week. Conservative estimates indicate that more than 131,000 boys and 145,000 girls at school aged 12-17 years were current smokers. The survey found that 8% of boys and 7% of girls aged 12 years had smoked on at least one of the seven days prior to the survey. Among 17-year-old students this proportion rose to 28% of young males and 34% of young females.⁴⁸ There is a continuing trend for more females to take up smoking than males. Between 1992 –1996,

⁴⁴ D B Kandel and M Davies 1986, *Adult sequelae of adolescent depressive symptoms*, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p47.

⁴⁵ G C Patton 1996a, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p43.

⁴⁶ R F Anda 1990, in Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998, *National health priority areas, mental health: A report focussing on depression*, Cat. No. PHE 13, Health and AIHW, Canberra, p43.

⁴⁷ Department of Health and Human Services, USA, 2000, www.inwat.org/young.htm. 3 November, 2000.

⁴⁸ D. Hill et al 1999, *Tobacco use among Australian secondary school students in 1996*, in Australian Institute of Health and Welfare, *Australia's young people – their health and wellbeing 1999*, p135.

the prevalence of non-smokers decreased for females by 37% and for males it was 26%.⁴⁹ A recent article suggested that stress was the biggest reason for the uptake of smoking in girls and young women.⁵⁰ There could be some weight to this suggestion as the Australian Longitudinal Study on Women's Health found that women aged 18-23 years were the most stressed compared to those aged 45-50 and those aged 70-75 years. The younger aged group were stressed mainly about study, employment and money.⁵¹

Smoking rates are substantially higher among young Indigenous people compared to non-Indigenous. In 1995 47% of young Indigenous women smoked compared with 28% of non-Indigenous young women. Similarly for young Indigenous males, 54% smoked compared with 32% of non-Indigenous males.⁵²

Whilst there is no data on smoking rates among young non-English speaking people, data on non-English speaking populations generally show that smoking rates among non-English speaking women are well below the NSW average. For males the rates are very high among certain non-English communities (44% among Vietnamese males and 43% among Lebanese males).⁵³

Research indicates that smoking behaviour is well established before the end of the teenage years and that the earlier the onset of smoking, the more the risk of developing smoking related diseases. The early onset of smoking is also a predictor of success in quitting- the younger the person is when they start to smoke the less likely they are to ever quit.⁵⁴

While men currently smoke more than women do, they are also quitting at a faster rate, and by 2003 more women are expected to be smoking than men. In NSW, about 22% of women smoke and the rate is much higher in younger age groups with 33% of women aged 20-24 years smoking. There has been no significant decline in the rate of pregnant women smoking since 1994. The proportion of mothers in NSW reporting smoking during pregnancy has varied little from 1994 (22.1%) to 1997 (20.6%). Only 3% of those who smoked during pregnancy, stopped smoking in the second half of their pregnancy and about 50% smoked more than 10 cigarettes per day.⁵⁵

Tobacco is a major contributing factor to a number of diseases including coronary heart disease and lung, mouth and cervical cancer and chronic lung disease. More women than

⁴⁹ W. N. Schofield et al 1998, *Self-reported tobacco and alcohol use among NSW secondary school students. The 1996 Australian school students' alcohol and drugs survey*, NSW Cancer Council and NSW Health Department, Sydney, p38.

⁵⁰ Gora, B., *The Girls light up*, Sunday Telegraph, 3 December 2000.

⁵¹ Brown, W. et al, 1998 *Is life a party for young women?*, in Women's Health Australia, What Do We Know? What do we need to know? Progress on the Australian longitudinal study on women's health 1995-2000, p19.

⁵² Australian Bureau of Statistics 1999, *National Health Survey 1995: Aboriginal and Torres Strait Islander results*, Cat no. 4806.0, ABS Canberra.

⁵³ NSW Health 2000, *NSW Tobacco Action Plan 2000-2004*, unpublished draft May 2000, p18.

⁵⁴ NSW Health 2000, *NSW Tobacco Action Plan 2000-2004*, unpublished draft May 2000, p16.

⁵⁵ Action on Smoking and Health Australia 2000, *Tobacco Facts for MPs, information pamphlet, March 2000, No 6*.

men will develop lung cancer in NSW by the year 2006, according to a report recently released by the Cancer Council, *Cancer in NSW Incidence and Mortality 1997*.⁵⁶

A study of 11 years of lung cancer data from NSW shows that the percentage of cases in women aged over 70 years went up from 37% to 48%. This reflects increased incidence of smoking not just an ageing population. Of the 26,710 cases of bronchogenic cancer reported from 1985 to 1995, some 7270 were women. While the annual incidence rates in men declined by 16%, they increased by 38% for women.⁵⁷

Cigarette smoking causes around 20% of deaths of women (before age 65) annually. During 1994/95 1,800 women died in NSW from diseases caused by smoking; 486 deaths from lung cancer, and 397 deaths from ischaemic heart disease.⁵⁸

A sub study from the Women's Health Australia Longitudinal Study has also found a strong positive relationship between smoking and the probability of miscarriage. Three or more miscarriages were reported by 7.4% of current smokers, 5.3% of ex-smokers and 3.7% of never-smokers in the middle age group (14,200 women aged 45-49 years). Among young women, one or two miscarriages were reported by 6.2% of current smokers, 4.7% of ex-smokers, and 1.4% of never smokers (14,780 women aged 18-22 years). A link was also found between the number of miscarriages, age at which smoking started and the number of cigarettes smoked.⁵⁹

The study also showed evidence that young women who smoke are at higher risk of having a range of menstrual problems such as heavy periods, irregular periods and menstrual tension and severe period pain than women who had never smoked. The risk of developing most of the menstrual symptoms was greatest for those who had started smoking by the age of 13.

There is also evidence that there is an increase in girls using cannabis. According to Dr Bill Pring, a public health spokesperson of the Australian Medical Association, young Australian women are now more likely to use cannabis than young men. Research conducted by the Australian Institute of Health and Welfare (Statistics and drug use in Australia, 1998) shows that female teenage cannabis users have increased by 20% in three years.⁶⁰

⁵⁶ N. Higgins 2000, Lung cancer rates among women continue to rise, report reveals tragic end, *Border Mail (Albury/Wodonga)*, 12 July, p12.

⁵⁷ K. Hill 2000, Lung cancer to top list of women killers, *Sydney Morning Herald*, 19 June, p 7.

⁵⁸ Action on Smoking and Health Australia 2000, Tobacco Facts for MPs, newsletter, March 2000, No 6.

⁵⁹ Schofield M, et al, 2000, *Probability of miscarriage among smokers: Women's Health Australia baseline survey*, Women's Health Australia, www.fec.newcastle.edu.au/wha/public/presentations/probmiscarry.html

⁶⁰ *Sunday Telegraph*, Greater risk of mental illness from smoking marijuana, 15 October, 2000, p21.

4.2 Body image and disordered eating

Key Points

- ◆ Disordered eating is seen as a continuum of eating problems ranging from normal concerns about weight and body shape to partial and clinical forms of anorexia nervosa and bulimia nervosa.
- ◆ Risk factors in the development of eating disorders include gender, restrictive dieting, body image and mass media/popular culture, depression, social anxiety, past psychiatric history, an external locus of control, and a previous episode of an eating disorder.
- ◆ A significant correlation exists between dieting and poor body image, depression and disordered eating behaviour.
- ◆ There is some evidence that poor body image, an attempt to emulate fashionable stereotypes and low self esteem appear to predispose some young women towards an eating disorder and disordered eating behaviour.
- ◆ Preventive programs should aim to raise self-esteem rather than trying to directly address the syndromes of eating disorders.
- ◆ Treatment programs should include a more balanced continuum of care, involving prevention, early intervention and non-inpatient management.

Concern about body image⁶¹ usually leads to a desire to be thinner. The membership of gyms and dieting centres and use of cosmetic surgery is testament to the growing concerns about body appearance. *Disordered Eating* refers to eating problems such as dieting and overeating. Both body dissatisfaction and disordered eating are common in the community.

Eating disorders⁶² affect a small percentage of the population, however, they are chronic diseases that require long term treatment and can be fatal. In comparison with clinical eating disorders, disordered eating and concerns about body image affect a much larger proportion of the population. It is now considered more appropriate to view disordered eating as a continuum of eating problems ranging from normal concerns about weight and body shape to partial and clinical forms of eating disorders.

Links between frequent dieting, physical health problems and mental health problems such as depression have been demonstrated.^{63, 64} There are additional health problems from behaviours such as smoking and over-exercising which are common behaviours among young girls striving for the “ideal” low weight.

⁶¹ *Body image* is the mental picture people have of their bodies and their perceptions of size, shape, weight and other aspects of their bodies relating to body appearance.

⁶² *Eating disorders* are clinical syndromes (such as *Anorexia Nervosa* and *Bulimia Nervosa*) characterised by extreme eating behaviours and concerns about body weight.

⁶³ J. Kennardy 1998, *The Australian Longitudinal Study of Women's Health: weight, shape and dieting in Report on NSW Ministerial Advisory Committee on Body Image and Disordered Eating*, 1998, p50.

⁶⁴ S. Sawyer & M. Humphrey 1997, *Dieting and media images – a dangerous 'double whammy' for teenagers* in *Report on NSW Ministerial Advisory Committee on Body Image and Disordered Eating*, 1998, p50.

What causes eating disorders

There is significant debate about the aetiology of eating disorders but most research shows that it is a combination of biological, psychological and cultural factors.

The impact of family dysfunction, especially in adolescents, social conventions of perceived acceptable body image; and sexual abuse have all been suggested as causes of eating disorders. Research has also found links between some eating disorders and substance abuse, personality disorders, depression and anxiety, although the relationships between eating disorders, depression and anxiety disorders are often difficult to determine.⁶⁵

Incidence and prevalence

Reported prevalence rates vary widely from 0.12:100,000 for 12 –18 year old females to 69.4:100,000 among girls aged 15-19.⁶⁶ The male to female ratio for the development of an eating disorder is reported at 1:10.⁶⁷

Studies in South Australia have found the prevalence rate of anorexia nervosa to be 1.05:1,000 (of the 5,705 pupils in girls schools surveyed). The incidence of bulimia nervosa is generally considered greater than that of anorexia nervosa and is estimated to be within 1-2% of women aged 12-25 years, a similar level identified in international studies.⁶⁸

Beaumont estimated that in NSW, 570 cases of bulimia and 400 cases of anorexia could be anticipated each year.⁶⁹

Changes in diagnostic criteria may account for the differences in reported prevalence rates. Over the last five-year period, incidence and prevalence rates were estimated using both the DSM III and DSM IV criteria. Also the DSM IV added a category *Eating disorder not otherwise specified* which allowed recognition of atypical, 'sub-clinical' eating disorders and which did not fit the categories of anorexia nervosa and bulimia nervosa. For example, restrictive dieting, compulsive over-eating or binge eating would be classified in this additional DSM IV category.

⁶⁵ C. Cranny & V. Tippet 1999, *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, NSW Health, p6.

⁶⁶ C. Cranny & V. Tippet 1999, *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, NSW Health, p16.

⁶⁷ C. Cranny & V. Tippet 1999, *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, NSW Health, p11.

⁶⁸ C. Cranny & V. Tippet 1999, *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, NSW Health, p9.

⁶⁹ P.J. Beaumont et al, 1994, *Eating disorder patients at a NSW teaching hospital*, in Cranny, C., Tippet, V., *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, May 1999, p10.

O' Kearney et al reported that as many as 50% of patients with symptoms of an eating disorder would be considered as "sub clinical".⁷⁰ Given the evidence that the risk for dieters to develop an eating disorder was eight times higher than for non-dieters⁷¹ and the high prevalence of restrictive eating behaviour, the identification of sub-clinical cases has important implications for more early intervention and prevention programs.

Risk factors

It is important to understand the risk factors in the development of eating disorders for appropriate early intervention and prevention strategies. Gender, restrictive dieting, body image and mass media/popular culture, depression, social anxiety, past psychiatric history, an external locus of control, and a previous episode of an eating disorder have all been highlighted as risk factors.

Adolescent girls and young women are at highest risk for the development of eating disorders and there is sufficient evidence to suggest that the prevalence of bulimia nervosa is increasing (the prevalence of anorexia nervosa is relatively static). The population most at risk for anorexia nervosa are women aged 15 and 25 years of age and for bulimia nervosa those most at risk are a little older 15-30 year old women.⁷²

Many studies agree that dieting is a major risk factor in the development of an eating disorder. Patton et al found that the risk for dieters to develop an eating disorder was eight times higher than non-dieters.⁷³ A Sydney study of adolescents aged 11 to 15 years found that 16% of girls and 7% of boys were showing restrictive eating or purging behaviour to control their weight.⁷⁴ Several sub studies conducted from the Women's Health Australia longitudinal survey, demonstrated a significant correlation between dieting and poor body image, depression and disordered eating behaviour.⁷⁵ Of great concern was the finding that more than 11% of the sample 14,810 women aged 18 to 22 years) engaged in their first diet before age 13. These women had a greater risk of disordered eating (bingeing and purging) behaviour, poorer physical and emotional health and greater usage of the health system than women who started dieting later or who had

⁷⁰ O'Kearney et al, 1995, in Cranny, C., Tippet, V., *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, May 1999, p10.

⁷¹ Patton et al 1990, in Cranny, C., Tippet, V., *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, May 1999, p8.

⁷² P Butow et al 1988, in Cranny, C., Tippet, V., *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, May 1999, p7.

⁷³ Patton et al, 1990, in Cranny, C., Tippet, V., *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, May 1999, p8.

⁷⁴ C. Cranny & V. Tippet 1999, *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, NSW Health, p52.

⁷⁵ K. Ball 2000, *Predictors of body dissatisfaction and disordered eating in a community sample of young Australian women*, Women's Health Australia, www.fec.newcastle.edu.au/wha/public/presentations/bodydiss.html, 9 February, 2000.

never dieted. This has important implications for preventive and early detection and intervention strategies.⁷⁶

The extent to which the stereotypical images of women portrayed by the media/fashion and advertising industries impact on the development of poor body image and disordered eating is unclear. However, there is evidence that poor body image, an attempt to emulate fashionable stereotypes and low self esteem appear to predispose some young women towards an eating disorder and disordered eating behaviour.⁷⁷

Prevention of disordered eating

While there is much research on the treatment of eating disorders, the prevention of disordered eating and promotion of healthy body image is a relatively new field. However there is evidence that some approaches commonly used are ineffective and can actually be harmful. For example, education about eating disorders can glamorise the problem and inadvertently give young girls information about new methods to control weight, including laxative abuse, vomiting, smoking, slimming pills.^{78, 79} It is now recommended that approaches be adopted which build self-esteem rather than trying to address directly the syndromes of eating disorders.

More research is needed to clarify trends in the prevalence and incidence of disordered eating and to explore the outcomes of early intervention and treatment programs.

Treatment programs and services

*The Eating Disorders: Strategic Service Development Plan Discussion Paper*⁸⁰ makes the following conclusions about the approach needed for the prevention and treatment of eating disorders:

- **Prevention strategies for eating disorders** are important given that gender, dieting and poor body image and low self esteem appear to be relevant risk factors in the development of an eating disorder. While not all dieters go on to develop eating disorders, there are clearly very mixed messages about health, fitness, body image and normal physiological development being conveyed to children and adolescents at a time of great self consciousness.

⁷⁶ J. Kenardy 2000, *The health impact of dieting in young Australian women: The Australian Longitudinal Study on Women's Health*, Women's Health Australia, www.fec.newcastle.edu.au/wha/public/presentations/impactdieting.html, 9 February, 2000.

⁷⁷ C. Cranny & V. Tippet 1999, *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, NSW Health, p8.

⁷⁸ J. O'Dea 2000, School based interventions to prevent eating problems: First do no harm, *Eating Disorders*, Vol 8, pp123-130.

⁷⁹ J. C. Carter et al 1996, *Primary prevention of eating disorders: might it do more harm than good?*, Oxford University.

⁸⁰ C. Cranny & V. Tippet 1999, *Discussion Paper: Strategic Service Development Plan for NSW – Eating Disorders*, NSW Health, p17.

- A strong **interagency approach is needed to address the issues of media and peer group pressure** and to build self-esteem and personal coping skills in adolescents at risk of disordered eating.
- **Early detection** is important to prevent sub clinical becoming chronic cases.
- Achieving a **balanced continuum of care** has implications for the roles and responsibilities of the general practitioners and generalist and specialist staff in the community and hospital settings.
- A more balanced **continuum of care, prevention, early intervention and non-impatient management** across the state that could provide a broader range of networked treatment options for people with eating disorders.

5.0 Conclusion

It is clear that among young women, depression is the major health issue. Other major health problems are those that result from health risk-taking behaviours such as tobacco use and unhealthy body image and disordered eating. These behaviours have been shown to be associated with depression and to interrelate with each other. Young women report using tobacco as a way of suppressing appetite and therefore controlling weight. Young smokers tend to also exhibit depression, stress and anxiety and show other risky health behaviour such as drug and alcohol use and engaging in unsafe sex. Dieting and depression are known risk factors in the development of eating disorders. Whilst more research is needed to understand the causal relationships between these issues, it is important to recognise and take in to account the gender differences and the interrelationships of these issues in any policies and programs to address them. The prevention and treatment of mental health problems must take into account that young people often have many problems that need to be addressed. This has implications for health services to young people. For example, GPs, school counsellors, mental health services and drug and alcohol services must all work together to identify and address all the problems a young person may present with. In addition, young women and young men exhibit different types of mental disorders and associated risk-taking behaviours which means different approaches may be needed for girls and young women and boys and young men. The NSW Government has shown its commitment to addressing mental health through additional funding over the next three years.⁸¹ Given that strategies to address these issues are at the initial stages (for example the NSW Tobacco Action Plan and the Mental Health Implementation Group) there is opportunity for the Department for Women to ensure that these strategies and programs are gender inclusive. Whilst this paper concentrated on depression and related risk-taking behaviour, other health issues for young women such as cannabis use, unplanned pregnancies and sexually transmitted diseases (eg Chlamydia), also warrant further attention.

⁸¹ An overview of Government and community activity to address some of these issues is provided in Appendix B.

APPENDIX A

Estimated percentage distribution of deaths by cause, 1990

	Women	Men
Developed regions		
Communicable, maternal & perinatal	4.9	5.7
Noncommunicable	90.7	84
Malignant neoplasm	(20.2)	(24.4)
Cardiovascular diseases	(54.9)	(43.3)
Injuries	4.4	10.3
Northern Africa and Western Asia		
Communicable, maternal & perinatal	48.7	44
Noncommunicable	45.8	44
Malignant neoplasm	(6.7)	(8.2)
Cardiovascular diseases	(24.2)	(21.3)
Injuries	5.5	12
Sub-Saharan Africa		
Communicable, maternal & perinatal	69.3	67.3
Noncommunicable	26	22
Malignant neoplasm	(3.8)	(3.9)
Cardiovascular diseases	(13.9)	(9.9)
Injuries	4.7	10.7
Latin America and Caribbean		
Communicable, maternal & perinatal	32.4	32.2
Noncommunicable	62.9	55
Malignant neoplasm	(12.8)	(10.3)
Cardiovascular diseases	(29.1)	(24)
Injuries	4.8	13.9
Asia and Pacific		
<i>China</i>		
Communicable, maternal & perinatal	16.1	14.3
Noncommunicable	73.2	73.5
Malignant neoplasm	(12.9)	(18.3)
Cardiovascular diseases	(30.7)	(27.4)
Injuries	10.7	12.2
<i>India</i>		
Communicable, maternal & perinatal	44.6	42.1
Noncommunicable	49.7	50.6
Malignant neoplasm	(7.2)	(9.2)
Cardiovascular diseases	(26)	(25)
Injuries	5.7	7.3
<i>Other Asia and Pacific</i>		
Communicable, maternal & perinatal	42.6	41.1
Noncommunicable	53	46.7
Malignant neoplasm	(9.2)	(10.2)
Cardiovascular diseases	(27.6)	(21.9)
Injuries	4.4	12.1

Source: United Nations, *The World's Women 1995: Trends and Statistics*, Social Statistics and Indicators, Series K, No 12, New York, 1995, pg 71.

Government activity/initiatives

Key Points

- ◆ Mental health is a priority area for both the Commonwealth and NSW Governments.
- ◆ NSW has provided an increase in the budget for mental health of \$107.5 million over three years.
- ◆ NSW Health has developed a Draft NSW Tobacco Action Plan 2000-2004.
- ◆ Anti-smoking campaigns aimed at women have not been very successful.
- ◆ Anti-smoking campaigns that use the concept of being “sucked in” by the tobacco industry (rather than long term health effects) seem to be very successful, particularly those aimed at young people.
- ◆ A Working Party on Eating Disorders has been established under NSW Health’s Mental Health Implementation Group.
- ◆ Queensland conducted an awareness campaign aimed at boosting young girls’ self-esteem and providing them with a new role model for a healthy body image. An evaluation of the campaign revealed that many girls particularly from the younger age group (8-14 year olds) were positive about the campaign. Some girls had negative views and the 15-16 year olds felt the campaign was more applicable to younger girls.

Mental health

- Mental health is one of five priority areas identified under the National Health Priority Areas initiative. The initiative emphasises collaborative action between **Commonwealth and State and Territory governments, The National Health and Medical Research Council, the Australian Institute of Health and Welfare, non-government organisations**, experts, clinicians and consumers.
- In February 2001, a co-ordinated national approach to addressing mental health problems was launched by the Mental Health Promotion and Prevention Working Party: a policy framework and an action plan for the promotion, prevention and early intervention for mental health. Depression and anxiety, particularly among women and children and eating disorders have been highlighted as specific disorders that need to be addressed.
- On 6 October 2000, **Australian Federal Health Minister** Michael Wooldridge released details (MW 90/00) of a new framework for guiding community activities to help reduce the high incidence of suicide and self harming behaviours in our community. Living Is For Everyone (LIFE): A framework for prevention of suicide and self-harm in Australia has been developed to reduce the rates of suicide and suicidal behaviour among the Australian community.⁸²

⁸² M. Wooldridge, Minister for Health and Aged Care, *Minister Declares “Living is for everyone”*, media release MW 90/00, 6 October 2000, www.fed.gov.au.

- **NSW Health Minister** announced during Mental Health Week (9-13 October 2000) an increase in the budget for mental health of \$107.5 million over three years. This will include more than \$3 million for *Young People's Mental Health* including suicide prevention and addressing depression, disruptive behaviours, attention deficit disorders, psychosis and eating disorders in young people. A Mental Health Implementation Group has been established to oversee this program. The Group's first meeting was held in August 2000.

NSW policies and strategies in place to promote positive mental health and well being of children and adolescents include:

- Promoting the Mental Health and Wellbeing of Children and Young People Discussion Paper: Key principles and directions (2000)
 - Caring for mental health: A framework for mental health care (1998)
 - NSW Strategy: Making mental health better for children and adolescents (1999)
 - The start of good health: Improving the health of children in NSW (1999)
 - Young people's health: Our future (1998); and
 - Focus on young people: NSW youth policy (1998),
 - the Families First Initiative.
 - Better Futures: An action framework for vulnerable young people in NSW.
 - The School-link Initiative
 - Getting in Early: A framework for early intervention and prevention in mental health for young people in New South Wales.
- Some examples of community projects funded by Government, include **BIG hART's** project on addictive behaviour within families and **Streetwise Comics'** on young women and depression rural areas.

BIG hART has been funded by the NSW Partnership against Violence and Department for Women to conduct a multi-layered project exploring addictive behaviour within families. The first part currently underway involves families producing a radio piece on inter-generational addiction. The second part is a longer-term film project and will involve young women at risk within regional NSW documenting their stories about out of home experiences which may touch on issues such as depression, smoking and eating disorders.

Streetwise Comics was funded under the Women's Grants Program to produce a comic which highlights the concerns and issues surrounding young women in rural areas and the taboo subject of depression. Its aim is to raise awareness among 15 –25 year old women in rural areas of services available to them to treat crisis and chronic depression in a safe and entertaining way.

Smoking

- **NSW Health** has developed the Draft NSW Tobacco Action Plan 2000-2004. The Action Plan identifies 5 priority groups; children, young people, Aboriginal people, the mentally ill and NESB communities with high smoking rates.
- The **Commonwealth Government** together with the US Government participated in a global anti tobacco campaign aimed at sending the anti-tobacco message to an international audience. The campaign includes a poster featuring members of the Australian Women's Soccer Team, The Matildas, with the message, *Be Strong, Be Free*, promoting healthy non-smoking lifestyles in response to a concern about the number of young women taking up smoking. World Health Organisation and the Federation of International Football Associations endorse the campaign, which was launched on 17 September 2000.
- **QUIT Victoria** conducted a quit smoking campaign in 1990 aimed at young women, *Quit and Miss Nothing*. However, according to QUIT Victoria, the campaign was not very successful. The campaign involved a television advertisement, *You'll never know*, in conjunction with **NSW QUIT For Life**, radio advertisements designed to challenge some of the myths about smoking and information in women's magazines. Evaluation of the campaign showed women recalled another campaign, *Poison*, aimed at a general audience, better than the one aimed at women.

Due to the large amount of money required for anti smoking campaigns there has been very little aimed specifically at women and girls. Anti-smoking organisations tend to put money into campaigns that aim to reach the widest possible audience.

- A successful media campaign in **Western Australia**, *Smarter than Smoking*, aimed to reduce the prevalence of smoking amongst 10-15 year olds in WA has had some success in reducing smoking among young people. The objectives of the campaign were to:
 - deglamourise the image of smoking and encourage young people to question the social desirability of smoking.
 - make the immediate and short-term consequences of smoking relevant to 10-15 year olds (fitness, relationships, cosmetic appearance and finances).
 - increase awareness of social factors that influence their decision to smoke and provide knowledge and skills that will help them attain a permanent smoke free lifestyle.

These objectives were based on qualitative research and two advertising concepts were developed. One showed young people discussing the negative effects of smoking and the second concept was based on an animated talking cigarette and featured the concept of being "sucked in" by the tobacco industry. This concept has also been very successful in anti-smoking campaigns in the United States, particularly those aimed at young people. Evaluation of the media campaign showed that after 3 years, the campaign achieved over 90% awareness, a decrease in the uptake of

smoking (from 33% to 42% among 14 year olds) and a decrease in the proportion of those who reported smoking in the previous month (from 43% to 26% among 15 year olds). The campaign also included the development of *OxyGen Website*, a youth oriented web site with interactive activities and relevant information and a series of school curriculum resources and publications. In 1997 The Smarter than Smoking project, together with QUIT South Australia, set up the Australian Network on Young People and Tobacco as an opportunity for agencies across Australia to form partnerships to address teenage smoking.

Body image and disordered eating

New South Wales

Background

In 1996 The NSW Ministerial Advisory Committee (MAC) on Body Image and Disordered Eating was formed as a response to a growing concern about the health problems associated with disordered eating among young women, adolescents and children. A joint initiative by the then Minister for Health, Dr Andrew Refshauge and Minister for Women, the Hon Faye Lo Po', the main focus of the MAC was on the prevention of disturbances in body image and disordered eating including anorexia nervosa and bulimia nervosa. A report was produced in 1998.

Outcomes of the MAC were:

- the production of a video *Unreal Images* and educational resource materials to assist young people in understanding, questioning and evaluating messages about socially desirable body images transmitted through the mass media. The video is suitable for high school students, community groups, the media and fashion industries and students of fashion design and media studies.
- a poster promoting positive body image. Captioned *It isn't your body you need to change its your mind*, the poster encourages young people to be more accepting of their body shape. The poster received a lot of coverage by the media and won a major industry award. Since 1997 the poster has been available as a teaching resource in all primary and secondary schools in NSW as a component of the *No Body is Perfect* curriculum.
- The discussion paper, *Strategic Service Development Plan for NSW: Eating Disorders* which reviews treatment and service models and provides a summary of the range and mix of models of care for the treatment and management of eating disorders available internationally. The Paper also examines the trends in demand and use of services for the treatment of eating disorders.
- A recommendation for the establishment of a statewide association to ensure co-ordination for member organisations (rural and urban community organisations), sharing of resources and having a united voice to Government for resources and support. The Association would also work on the promotion of healthy body image, prevention of disordered eating and support for people with eating disorders.

Current Activities

NSW Health want to progress the outcomes and recommendations made by the MAC through the recently established Mental Health Implementation Group, which had their first meeting in August 2000. A Working Party under the Implementation Group has been established to work on issues relating to body image and eating disorders. The Department for Women is represented on the Working Party.

Education and Training and NSW Health are currently finalising the *Unreal Images* video's accompanying resource material and will soon release the video and resources to all NSW secondary schools.

Queensland

The Office of Women's Policy in Queensland launched *Girl Genius*, an awareness campaign for eating disorders in 1999. The campaign was aimed at boosting young girls' self-esteem and providing them with a new role model for a healthy body image. The campaign involves a cartoon character called *Girl Genius* aimed at giving girls (10-14 years old) the ability to deflect comments that can harm their self-image and lead to eating disorders. The first stage of the campaign involved posters and postcards which were included in two editions of *Girlfriend* magazines and were distributed to the schools, community groups and interested individuals. Stage two of the campaign involves the development of a cinema advertisement featuring *Girl Genius*. Negotiations are still underway with a number of corporate sponsors to secure the necessary funds to proceed with this part of the campaign.

An evaluation of *girl genius* showed that:

- generally girls liked the *Girl Genius* character
- some girls felt *Girl Genius* had a body that was too perfect and was too revealing
- some felt she could be improved by being more like a "real" girl.
- the 15 and 16 year olds felt the character was more applicable to younger girls
- the eating disorder associations felt that *Girl Genius* was more appropriate to the 8-13 year age group.
- the main message that the 10-14 year old girls obtained from *Girl Genius* was that girls should be confident with the way they look and that they should stand up for themselves.

Initiatives by community

While support groups exist across the state, NSW does not have a central statewide support association for people affected by Eating Disorders. Victoria, Queensland and South Australia have government-funded associations which provide information, education and support. A **NSW Association for Healthy Body Image** was established with a seeding grant from DFW's 1999 Women's Grants Program. The Executive Committee is trying to secure funding for ongoing operation of the *Peak Body*.