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WA Youth Health Policy Companion Resource:

Understanding young people in Western Australia

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Introduction

The health and wellbeing of young people is important as it is through this period of physical and emotional growth that they develop their health-related behaviours that have consequences for their current and future health.[1] Young people have specific health needs, however, they are often among those least well supported by the current system of health services.[1]

This *Companion Resource* aims to provide an understanding of young people in Western Australia (WA) and their health. This is achieved through a discussion of:

- the developmental stages of youth
- a demographic overview
- priority populations of youth who are at higher risk of health issues
- the social determinants affecting young people's health.

Context

In recent years the needs of young people has gained increasing attention, most notably with the release of the following reports:

- World Health Organisation's (WHO) call for action on strengthening the health sectors response to adolescent health.[2]
- The Global Strategy for Women's, Children's and Adolescent Health 2016-2030.[3]
- Leading the realization of human rights to health and through health. Report of the High-Level working group on the health and human rights of women, children and adolescents.[4]

In 2013, the Commissioner for Children and Young People held consultations to determine what young people living in WA defined as health.[5] Across the consultations young people were consistently found to have a holistic view of health that encompassed physical, mental, emotional and social aspects. They identified that being healthy involved a range of aspects, including:

- eating healthy foods
- participating in physical activity
- being connected to friends, family and the community
- avoiding or being careful around drugs and alcohol
- finding inner contentment
- being resilient
- maintaining a good level of self-esteem.[5]

These findings suggest a need for health services to embrace a positive focus on fostering health and wellbeing through health promotion and building resilience, as well as managing the common health issues that arise among young people.

Age category

For the purpose of this *Companion Resource*, the terms 'youth' and 'young people' are interchangeable and defined as persons aged 10 to 24 years, which is consistent with the *WA Youth Health Policy 2018-2023* (the Policy).

Increasingly, age specific reporting, including data from the Australian Bureau of Statistics, collates data into five-year age categories as follows:

- Early adolescence 10 to 14 years
- Late adolescence 15 to 19 years
- Young adulthood 20 to 24 years.[6, 7]

The Lancet commission on adolescent health and wellbeing reinforces the significance of the 10 to 24 year age range and highlights that health and wellbeing underpins the crucial developmental tasks of this period. These tasks include:

- the acquisition of the emotional and cognitive abilities for independence
- completion of education and transition to employment
- civic engagement
- formation of lifelong relationships.[7]

Early intervention, engagement and promotion of healthy behaviours throughout this period assist in building the foundations for health which can shape the health trajectory of an individual across their life course and optimise health outcomes for future generations – the children of these individuals.[7]

Developmental stages and health

The period of youth is one of important changes and transitions, with three areas that highlight the significance of youth health:[7]

1. Health and wellbeing underpin the developmental tasks of adolescence including the acquisition of emotional and cognitive abilities for independence, completion of education and transition to employment, formation of relationships and engagement in society.
2. This period lays down the foundations for health that determine health trajectories across the life course.
3. Young people are the next generation of parents and their health reserves determine the healthy start to life they provide for their children.

The three phases of youth development: early adolescence, late adolescence and young adulthood are described below.[7]

Early adolescence (10 to 14 years)

Early adolescence is commonly when young people enter puberty and involves physical and hormonal changes.[1] It is a period of extensive developmental growth, including significant increases in height and weight, with growth spurts occurring earlier in girls than boys.[8] It is also during this period that more than half of peak bone mass is acquired.[9]

However, there are a number of factors that can influence the developmental growth of youth such as malnutrition, high rates of infection, stress and trauma. These factors can impact on physical (e.g. low height for age) and cognitive (e.g. learning difficulties) development as well as a young person's future risk of disease and productivity.[10]

It is also during this period that the adolescent brain is undergoing significant development, with changes occurring second to that during infancy.[11] Early adolescence is associated with exploration, experimentation and risk taking which inform young people's identity development.[12, 13] An important fact in understanding adolescent emotions and behaviour is that the areas of the brain associated with reward-seeking develop prior to those related to planning and self-regulation. Therefore heightened risk-taking, sensation-seeking and less reasoned decision-making in early to mid-adolescence may be attributed to this imbalance in brain development.[14, 15]

Early adolescence is a time when peer relationships and influences feature heavily. Peers can influence adolescents in both positive and negative ways and can have an impact on academic achievement and behaviours such as smoking, drug and alcohol use. Adolescents often choose their peers who are similar in behaviour, attitudes and identities and are influenced by peers because they admire and respect their opinions and are not as influenced through coercive

pressures.[14] Families and school environments also play an integral role in providing the stability and support that assist adolescents in developing their social and emotional skills.[7]

Late adolescence (15 to 19 years)

During late adolescence young people are more physically mature, with physical growth slowing for females. Their brains are actively developing, particularly in the areas of the prefrontal cortex.[14] This area is responsible for the regulation of behaviour and emotions and the ability to understand the short and long-term implications of actions and decisions.

It is during this period of late adolescence that they develop independence and autonomy and while young people are still in education and live at home there is a transition from a child-guardian relationship with their parents to a more equitable one. This stage is important for the development of decision-making for young people regarding their health and is an opportunity for empowering them around their capacity to consider risks and consequences and exercise self-determination in health and lifestyle issues.[7]

Young adulthood (20 to 24 years)

During the period of young adulthood the prefrontal cortex of the brain is more developed and young adults have greater skills in reasoning and self-regulation.[14] In previous generations this age group was characterised by taking on roles and responsibilities such as marriage and parenthood. However, this has been delayed in current generations with many young people still living in the family home and engaged in educational activities.[7]

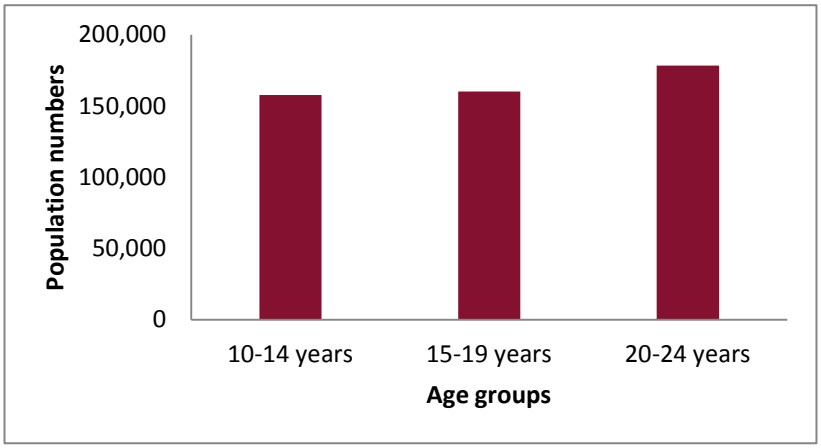
While delayed marriage and child birth have been associated with reductions in maternal mortality and morbidity there is also the possibility that it may bring increasing vulnerability such as sexual health issues (e.g. increased exposure to sexually transmitted infections due to a rise in the number of sexual partners before marriage) and a loss of the protective effect of marriage and parenthood in relation to reduced tobacco, alcohol and substance use. [7, 16]

Young adulthood is associated with a peak in physical fitness with research indicating that those who have good fitness levels during this period are more likely to be healthier throughout their life.[17] This has important implications for health promotion for young people to improve their health across the life course. Involving young people in the development of services and taking into account youth transitions, will ensure the relevance of services and interventions they engage with.

Demographic overview

As of 2016, there were approximately 496 000 (19%) young people aged 10 to 24 years living in WA. There were slightly more males to females within this age group, with 106 males to every 100 females.[6] However, the number of young people in WA is expected to increase with a projection of the WA population doubling over the next 40 years.[18] Aboriginal youth account for approximately 6% of the population and make up more than 30% of the Aboriginal population in WA.[19]

Figure 1. Number of young people by age-group in WA, 2016



Most young people live in metropolitan Perth (73%) with 17% living in regional and 10% in remote areas.[20] Young people predominantly live with their parents, with an increasing proportion (60%) of 18 to 24 year olds living with their parents. Even when young people move out of home, almost a quarter (22%) will move back in with their parents for a period of time.[21]

WA has a diverse population with 35% of the population born overseas.[22] A large proportion of young people come from migrant families with estimates that more than half (52%) of the WA population has at least one parent born overseas and 75% had non-Australian ancestry. WA is linguistically diverse with 15% of the WA population speaking a language other than English at home and 13.5% of the WA Aboriginal population speaking an Australian Indigenous language at home.[22]

In young people aged 20 to 24 years the rate of marriage has continued to decline, falling by half for females during the period 1993 to 2013 (58 marriages per 1 000 and 25 marriages per 1 000, respectively), with a similar trend in males (36 marriage per 1 000 and 15 per 1 000 respectively). This decline in marriage is also reflected in a lower proportion of young people living with a partner (18.5%) and a decline in birth rates for this age group with only 17% of all births to mothers under 25 years of age.[21]

Priority youth populations

There is a wide range of diversity among youth and while most have relatively good health there are some groups who are at higher risk of certain health issues. These include youth who are:

- Aboriginal
- carers of others
- living with a chronic condition or a rare disorder
- culturally and linguistically diverse (CALD) including those with limited English proficiency (LEP)
- living with a disability
- homeless or at risk of homelessness
- involved in the justice system
- lesbian, gay, bisexual, transgender, intersex, queer or questioning (LGBTIQ)
- living with mental health or emotional wellbeing issues
- vulnerable migrants / refugees including asylum-seekers
- residing in out of home care
- pregnant or parenting
- living in regional and remote areas.

Aboriginal youth

Aboriginal youth face health inequalities that begin in childhood and continue to impact them throughout their life; they are at greater risk of reduced health, disability, and lower quality of life.[23]

Self-assessed health status by Aboriginal youth was mostly positive (Figure 2), with similar rates reported between remote and non-remote areas. Long-term health conditions or disability were reported by 35% of Aboriginal youth, with 5% requiring assistance with one or more core daily activities.[23]

Figure 2. Health status of Aboriginal youth aged 15–24 years

Mental health disorders were identified as a major health burden for Aboriginal youth aged 12 to 24 years.[21] Aboriginal youth were more likely to experience higher levels of psychological distress (one in three) compared to non-Aboriginal youth (one in five),[24] with approximately 40% of Aboriginal youth experiencing some form of mental illness before adulthood.[25]

Aboriginal self-harm and suicide is complex and cannot be easily attributed to just mental health disorders or depression but is likely a result of a combination of life circumstances, such as death of family member or friend, illness, employment and mental illness.[26]

In Australia, rates of intentional self-harm among Aboriginal youth (15 to 24 years) were five times higher than non-Aboriginal youth[27] and suicide is more common in younger aboriginal people, with the majority of deaths occurring before 35 years of age.[28] Rates of suicide in the Kimberley region of WA is one of the highest in Australia and the world, with rates as high as 74 per 100 000 residents.[29]

Aboriginal youth (12 to 24 years) reported similar prevalence of at least one long term health condition compared to non-Aboriginal youth (59% and 63% respectively).[30] These included:

- asthma
- type 1 diabetes
- cancer.

However, Aboriginal youth reported higher rates of communicable diseases, such as:

- rheumatic fever and rheumatic heart disease
- eye disease
- ear disease
- infectious diseases (e.g. pertussis, mumps, pneumococcal disease, hepatitis B and C, gonorrhoea, syphilis and chlamydia)
- skin diseases (e.g. scabies, particularly in remote communities).[30]

Injury and poisoning are leading causes of death and hospitalisation among young people. Aboriginal youth experience higher rates of injury and poisoning, land transport accidents and assault compared to non-Aboriginal youth.[30] In WA, rate of hospitalisations for transport accidents was double the rate for Aboriginal youth compared to non-Aboriginal youth (457 and 231 per 100 000, respectively). Rates of hospitalisation due to interpersonal violence was 10 times the rate compared to non-Aboriginal youth (360 versus 36 per 100 000).[20]

In 2012, the WA teen fertility rate for non-Aboriginal young women (15 to 19 years) was 18.6 per 1 000 population compared to Aboriginal women (15 to 19 years) with 105.7 per 1 000 population.[20]

Aboriginal youth are also discussed in other priority populations.

- Youth involved in the justice system
- Youth living with a chronic condition or rare disorder
- Youth residing in out of home care

Youth who are carers of others

A young carer is defined as 'children and young people up to 25 years of age who help care in families where someone has an illness, disability, mental health issue or who has an alcohol or other drug problem'.[31] It is difficult to estimate the number of young people who are carers as figures are most likely underestimated due to families seeking to keep care private or not recognising assistance provided by young person as 'care'.[32]

In Australia, approximately 7% of young people aged 15 to 24 years are a carer for a family member, with 1% being a primary carer.[33] Young carers are more likely to be female and are more prevalent in Aboriginal and CALD communities. Higher rates of young carers were found in regional areas such as Northern Territory and Kimberley region in WA.[32]

Young people who care for others have an increased risk of health issues due to:

- lack of sleep
- stress
- physical strains from lifting
- emotional and mental health issues.[34, 35]

Emotional issues can result from worry, grief, resentment and guilt, which can impact on psychosocial development due to reduced social interactions and limited time for themselves.[35]

While young carers often gain skills which are important for independence and the transition into adulthood, their caring role may limit opportunities such as education, employment and leaving home.[35]

Youth living with a chronic condition or rare disorder

Chronic diseases are generally defined as a disease that has a prolonged course, does not resolve spontaneously and for which a complete cure is rarely achieved.[36]

Chronic diseases affecting youth include, but are not limited to:

- asthma
- diabetes
- cancer
- Fetal Alcohol Spectrum Disorder (FASD)

Rare disorders are chronic and complex with around 80% having a genetic origin and are statistically rare (less than 1 in 2 000 people). Many rare diseases usually have their onset in childhood, have no effective treatment and are incurable.[37,38] There is a lack of information on the prevalence of chronic disease and rare disease in youth in Australia,[39] though it has been estimated that approximately 400 000 children are living with a rare disease.[40]

Youth living with a chronic condition face issues in a number of areas including:

- their development
- long term health, mental health and wellbeing
- participation in school
- employment
- education
- social activities
- overall quality of life.[41]

Young people living with a rare disease face significant burdens including delays in diagnosis, access to appropriate health care and face similar issues to their peers with other chronic conditions (e.g. asthma and diabetes) such as participation in school, employment and social activities.[39, 40]

Asthma is one of the most common chronic health conditions affecting young people in Australia. In the most recent National Health Survey it was estimated that in WA approximately 10.3% of young people aged 0 to 24 years have asthma.[42] In addition, young people have the highest burden of type 1 diabetes, with young people aged 10 to 19 years being the peak age of diagnosis (29 and 24 per 100 000 for males and females respectively).[43]

Whilst cancer is not as common in young people, there are significant long-term consequences and is a leading cause of death in youth.[30] An estimated 1 630 new cases of cancer will be diagnosed in 2017 in young people aged 0 to 24 years. The most common cancers include leukaemia, lymphoma and brain cancer. Young people aged 0 to 24 years die from different cancers compared to older populations; leading causes of cancer death in this age group are brain cancer, leukaemia and bone cancer. However, cancer survival rates were highest for those aged (20 to 24) and decreased with age.[44]

The importance of FASD is becoming increasingly recognised in Australia. The prevalence of FASD is difficult to estimate and is likely to be underestimated. Figures suggested it may be as high as 1.87 to 4.7 per 1 000 births. In particular, certain youth priority groups are likely to be overrepresented including youth in out-of-home care and youth involved with juvenile justice.[45] FASD is a preventable neurodevelopment disorder that occurs as a consequence of prenatal alcohol exposure. The impacts of FASD are life-long and young people with FASD require personalised treatment and support, particularly for those with concurrent mental health, alcohol and other drug problem/s.[45]

Those diagnosed with FASD face long-term issues such as:

- incomplete education
- involvement in criminal justice
- family and economic dependence
- poverty
- homelessness
- alcohol and other substance abuse
- sexual victimisation

- unplanned and early parenthood
- difficulty parenting and subsequent risks for their children.[46]

Work is required to ensure people with suspected or confirmed FASD receive appropriate treatment and support and do not fall through the gaps. Health services, together with disability, education and child protection services all play a role in the assessment, diagnosis and support provided to people with FASD.

Youth who are culturally and linguistically diverse including those with limited english proficiency

According to the 2011 Australian Census, 25% of all youth (12 to 24 years) were from a CALD background with a total of 80 450 (8.7%) CALD youth residing in WA.[47]

Reports suggest that CALD youth can be reluctant to access health services due to language and cultural differences.[48] Issues accessing culturally appropriate services and programs especially in rural and remote areas as well as negative experiences may result in some CALD youth not accessing health services in the future.[47]

There are also barriers in relation to differences in understanding views of 'mental illness' and recognition of symptoms as well as language barriers in relation to expressing the seriousness of issues and need for support. Dealing with trauma and stress of resettlement can also increase the risk of substance misuse as a coping strategy.[47]

Limited English Proficiency (LEP) is term used to describe individuals who do not speak English as their primary language.[49] Addressing language barriers is important particularly for young people accessing medical care as this can limit their medical comprehension. LEP is associated with poor health outcomes as young people are:

- less likely to access usual source of medical care
- at increased risk of nonadherence to medication and/or adverse medication reactions.
- at higher risk of hospitalisations.[49]

CALD youth are also discussed in other priority populations

Youth living with a disability

It is estimated that 8.8% of young people aged 13 to 17 years are living with a disability, with 3.9% of those in the profound or severe range. Australian estimates suggest that the largest group of disability is intellectual (4.6%), followed by physical restriction (3.0%), psychological (2.6%), and sensory and speech (1.9%).[50]

Youth with disabilities have been found to have poorer health outcomes compared to those without disabilities.[51, 52] They are at greater risk for experiencing a number of health conditions which are secondary to their disability including: sensory problems (such as vision and hearing), thyroid problems, gastro-intestinal issues, obesity, osteoporosis, epilepsy, diabetes, mental health problems, and addictions.[51, 52]

Emerson and Hatton (2014) suggest a number of reasons for their increased risk, these include:

- increased risk of health issues associated with genetic or biological causes of disability (for example congenital heart problems for young people with down syndrome);
- health risks and behaviours such as lack of physical activities and balanced diet
- gaps in health promotion and care for this group
- greater risk of exposure to determinants of health such as poverty and poor housing

In addition, sexual and reproductive issues for people with disabilities are often overlooked.[53]

Youth who are homeless or at risk of homelessness

It is estimated that 44 000 young people under the age of 25 years were homeless in 2011 on Australia's census night, including those staying in boarding houses, hotels, or temporarily living with friends or extended family (i.e. couch surfing).[54]

Young people who are homeless have a high prevalence of previously living in homes with family violence, and experiencing out-of-home care. A large proportion of homeless youth have mental health issues, particularly mood and anxiety disorders, high levels of psychological distress, and high use of health and medical services.[55] Research also indicates that homeless youth also have high rates of sexually transmitted infections, dental problems, and dermatological, respiratory (including asthma) and nutritional issues.[56]

Youth involved in the justice system

Young people in the justice system come from the most disadvantaged groups in our community; many have language or literacy issues, have experienced complex intergenerational trauma and often suffer from health and psychosocial problems.[57] Research has recommended the need for coordinated health and welfare services and transitional care for those moving from custody to community health and social service.[58]

In WA during 2015-16, there were 1 740 young people under corrective services supervision with just under half having a period in custodial detention.[59] Young people aged 10 to 17 years make-up 13% of the total offender population in Australia, with WA having one of the highest proportion of youth offenders (16% of total offenders in WA).[59] Aboriginal young people are over represented in youth justice supervision in all states and territories. In WA Aboriginal youth are 27 times more likely to be in the justice system than non-Aboriginal youth (279 per 10 000 young people aged 10 to 17 years).[59]

For young people the main types of offences are:

- theft (including public transport evasion (35%)
- intention to cause injury (15%)
- illicit drug offences (11%)

While many types of offences such as homicide have decreased, there has been an increase in sexual assault and related offences.[59]

Youth involved in the justice system have complex health needs and this has been found for both young people on community based orders as well as those in custody. In health assessments of young people in custody, a large proportion (56%) were found to have depression or psychosis and 22% had deliberately self-harmed in the past six months.[58] In addition, suicide prevalence rates of young people in the justice system were four-times higher than other young people. Currently there is a lack of evidence on the effectiveness of policies and procedures to identify and manage at risk behaviours of young people in the system.[57]

Health assessments of a representative sample of sentenced youth in WA completed in 2017 found:

- high rates of intergenerational and complex lived trauma
- early school failure
- early uptake and misuse of substances

- multiple physical injuries and scarring which had been poorly rehabilitated, metabolic and nutritional disease,
- sleep disorders
- dental disease.[60]

Among the young people studied, 1 in 3 were diagnosed with FASD. For the overwhelming majority these difficulties had not been understood, sought for or diagnosed prior to participation in the study by education, health or child protection services, who were all previously involved in their care. Any neurodevelopmental impairment can impact on a child and young person's ability to participate successfully in education, social inclusion, developmental safety and employment.[61]

Sexual behaviour for custodial youth is also of concern with 85% having sex before the age of 15. A total of 14% of young people reported having greater than five sexual partners in past six months, 39% having a sexual partner who injects drugs and 15% having been sexually assaulted. High levels of substance use is commonly reported (34% of youth in community orders and 66% for youth in custody) with the majority regular tobacco smokers (88% community order, 85% youth in custody).[58]

Lesbian, Gay, Bisexual, Transgender, Intersex or Queer or Questioning youth (or otherwise diverse in their sexuality or gender)

There is very little data on the proportion of youth who identify themselves as Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or questioning (LGBTIQ). Estimates from previous reports indicate that the proportion could be up to 11%.[62] In 2012-14, 4.6% of Australian youth aged 14 to 19 years identified as homosexual and this rose to 6.5% for youth aged in their 20s.[63] While there are no estimates of young people who are transgender, a New Zealand study found that 1.2% of high school students reported being transgender and 2.5% reported not being sure about their gender.[64]

LGBTIQ people make up over 10% of the Australian population.[62] The umbrella term 'trans' is used to refer to people who identify as a gender that does not match the sex they were assigned at birth. This is in comparison to 'cisgender' people – those whose gender does match the sex they were assigned at birth. While there are no estimates of young people who are trans in Australia, international studies estimate that between 0.7% and 1.2% of young people identify as trans.[64, 65]

There is strong evidence that LGBTIQ young people have higher rates of psychological distress, mental health issues (e.g. depression and anxiety) and suicidal thoughts compared to the general population[66, 67] as a result of homophobic discrimination and marginalisation.[68]

A national Australian survey of gender variant and sexually diverse youth aged between 16 to 27 years found that 41% had thought about self-harm while 42% had thought about suicide.[69] Further research has also found a large proportion of LGBTIQ young people (16 to 24 years) reported being diagnosed or treated for a mental health disorder in the past three years.[70] More recent research on mental health of trans young people in Australia reported the 75% of participants had been diagnosed with depression and over 70% with anxiety. Alarmingly almost 80% of participants had self-harmed and 48% had attempted suicide.[71]

LGBTIQ youth also experience higher rates of bullying and exclusion than their heterosexual and cisgender peers.[72] In addition, many LGBTIQ young people in Australia feel isolated, and face higher rates of homophobia and transphobia in rural and remote areas of Australia.[69] There is also evidence that they often feel they are unsupported by peers and family members, are more likely to leave school due to discrimination and many have experienced abuse.[73]

LGBTIQ young people are also more likely to use alcohol and drugs with researchers suggesting that this could be due to the higher incidence of mental health problems, and a way of dealing with abuse and discrimination.[66] LGBTIQ young people have difficulty accessing relevant sexual health education as it is focused predominantly on heterosexual relationships and reproduction and doesn't address gender diversity and same-sex attraction.[68]

Health services need to be accessible and sensitive to the needs of LGBTIQ young people. Research has shown that 42% of young trans people had reported reaching out to service that did not understand, respect or have experience with trans young people. Trans youth reported higher rates of self-harm and suicide if they had experienced feeling isolated from medical and mental health services.[71]

Primary health providers should reassure individuals about issues of confidentiality; offer information about safer sex options; and, if appropriate, offer counselling or referral to counselling. In addition, dedicated mental health teams need to offer services to people who require support around their gender identity.[74]

Youth living with mental health or emotional wellbeing issues (including self-harm and suicide)

Mental health and emotional wellbeing issues

Mental health disorders are more prevalent in younger people and decline with age.[75] It is important to focus on mental health and wellbeing during this period, not only to prevent mental health issues but is also an opportunity to provide early intervention to reduce the severity of mental health issues that may develop.[76]

Mental health is an important consideration for the health and wellbeing of young people in WA. Approximately 16% of boys and 13% of girls aged 12 to 17 years have a mental health disorder.[77] In WA there have been significant increases in young people with hospital admissions for mental health diagnoses. The use of treatment and support services in school and health services for children with mental health problems has increased to over 50%.[78]

In 2014 the second Australian Child and Adolescent Survey of Mental Health and Wellbeing was conducted and reported on the mental health issues for young people.[77] Findings showed that one in five adolescents had high or very high levels of psychological distress. For young people aged 12 to 17 years of age, 15.9% of boys and 12.8% of girls were assessed as having a mental health disorder in the last 12 months. Table 1 lists the common mental health disorders for young people aged 12 to 17 years. Comorbidity was common with a third of young people with a mental disorder having two or more disorders within the previous 12 months.[77]

Table 1. Common mental health disorders for young people aged 12-17 years in Australia[77]

Mental health disorder	Prevalence among 12-17 year olds (%)
Anxiety disorders	7
Major depressive disorder	5
ADHD	6.3
Conduct disorder	2.1

Young people with mental illness may also experience stigma, which can lead to discrimination and isolation.[79] In 2016, headspace reported that 26% of young people aged 12 to 25 years would not tell anyone if they had a mental health problem with 52% who identified having mental health problems in the last 12 months reported being too embarrassed to discuss the problem with anyone.[80]

A total of one in five (21%) 12 to 17 year olds had used a service for emotional or behavioural problems in the past 12 months.[77] A range of health service providers were used by young people with a mental health disorder. Most young people aged 12 to 17 years saw a:

- General practitioner (41.6%)
- Psychologist (29%)
- Counsellor or family therapist (29%)
- Paediatrician (19%).[77]

Hospital emergency, outpatient or inpatient services were accessed by 8.1% of young people aged 12 to 17 years who had a mental disorder in the last 12 months, with 5.7% accessing a specialist mental health service.[77]

Mental health services provided for young people in community and hospital settings need to have the capacity, capability and expertise to deliver effective, evidence-based care for a range of complex conditions such as personality disorder, conduct disorder, mood disorder, emotional dysregulation and those with a history of trauma.[77]

Self-harm & suicide

In Australia's National Mental Health and Wellbeing Survey approximately one in ten young people (10.9%) reported having ever self-harmed with 8.0% preferring not to say when asked about self-harm. Self-harm is more prevalent among older adolescents (12 to 15 years: 8.2% versus 16 to 17 years: 16.1%) and more common among females than males (females: 15.3% versus males: 6.8%).[27]

Of young people aged 12 to 17 years, 7.5% had stated that they had seriously considered attempting suicide in the previous 12 months, with females more likely to state this compared to males (10.7 and 4.5% respectively). A total of 3.2% of young people had ever attempted suicide, with more females (4.5%) attempting suicide compared to young males (1.9%). In 2013, the suicide-related death rate for young people aged 15 to 24 years was 16.1 per 100 000

young people. Males had a higher rate of suicide related death than females aged 15 to 24 years (11.2 and 6.1 per 100 000 young people respectively).[27]

Accurate, timely and localised data on suicide, suicide attempts and self-harm is required to improve suicide prevention planning, service delivery and program development. Data may be used to help identify early warning signs in at-risk communities or population groups, allowing relevant services to coordinate an appropriate response and effectively focus their resources.[26]

Youth who are vulnerable migrants/refugees including asylum-seekers

Youth refugees are a vulnerable population with complex health care needs. They may have encountered multiple stressors, including:

- economic hardship
- interrupted education
- social upheaval
- loss of home
- death of family members
- exposure to warfare
- political persecution
- violence
- sexual abuse.[81]

Adolescent refugees are at greater risk of communicable diseases, nutritional deficiencies and chronic disorders as well as increased risk of mental health disorders. Adolescent refugees encounter a number of barriers to accessing healthcare such as:

- culture and language
- health literacy
- unfamiliarity with healthcare systems
- transport
- finance
- alternate priorities (e.g. housing and employment).[81]

Prolonged detention for young people who are refugees has been found to have detrimental effects on their emotional health and development.[82] Assessments conducted on young people in detention found that 34% had mental health disorders in the clinical range, and following release into the community, they may have ongoing social and emotional issues.[82]

Youth residing in out-of-home care

Children who have experienced child abuse and neglect are at risk of a range of adverse outcomes in the areas of health, mental health, education, and corrective services. In WA during 2015-16 there were 18 446 children notified to child protection services for emotional, psychological, physical, sexual abuse or neglect.[83] Substantiated abuse or neglect was found following 4 335 safety and wellbeing assessments last year with 4 658 children in out-of-home care on the 30 June 2016.[83] Aboriginal children are over-represented in out-of-home care, making up 53% of the WA children in care on 30 June 2016 despite only comprising six per cent of the WA youth.[84]

There is consistent evidence[85] that child maltreatment, neglect and those who have experienced child abuse have an increased risk of:

- behavioural problems including criminal behaviour
- depression
- post-traumatic stress disorder
- self-harm and attempted suicide
- health issues (e.g. obesity, teenage pregnancy, and alcohol and drug misuse).

WA research has found that children with disabilities are at increased risk of child abuse and neglect, particularly those with intellectual disability and conduct disorder.[86] It is therefore imperative that health services are aware of the issues faced by youth with disability so their complex needs are met. This requires interagency collaboration.

In 2009 the Australian Government released the National Framework for Protecting Australia's Children 2009-2020.[87] Under the National Framework, protecting children is everyone's business. The National Framework includes six supporting outcomes:

- Children live in safe and supportive families and communities.
- Children and families access adequate support to promote safety and intervene early.
- Risk factors for child abuse and neglect are addressed.
- Children who have been abused or neglected receive the support and care they need for their safety and wellbeing.
- Indigenous children are supported and safe in their families and communities.
- Child sexual abuse and exploitation is prevented and survivors receive adequate support.[87]

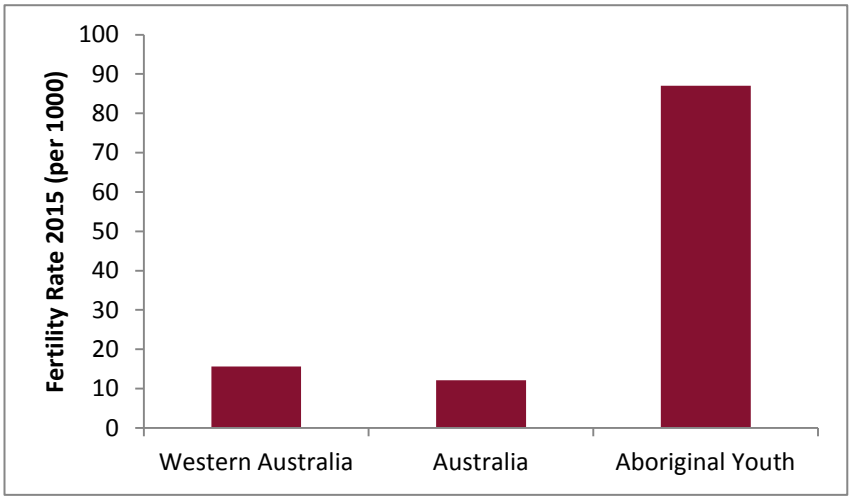
The number of children and young people from CALD and refugee backgrounds coming to the attention of child protection authorities in Western Australia is unknown. However, a Victorian research study showed that approximately 13% of children in out-of-home care were from CALD or refugee backgrounds.[88]

International research has identified a lack of consistency in identification and intervention of child protection concerns for CALD and refugee families, based on cultural ignorance and the over or under consideration of cultural norms when assessing child-rearing practices and child abuse.[88]

Youth who are pregnant or parenting

Whilst the birth rate in young mothers has declined, Aboriginal birth rates in young mothers have remained high (Figure 3).[89] Differences are also seen in rural and remote areas were higher pregnancy rates are reported compared to urban areas. This is most likely due to a number of factors including; lack of access to sexual health services, lower education levels, employment opportunities and possibly a stronger priority for family formation.[90]

Figure 3. Fertility rate of young women aged 15-19 years



Research shows that young people are at greater risk of unplanned pregnancy if they commence sexual activity at an earlier age. Risk factors for early sexual activity include:

- early puberty
- social disadvantage
- dysfunctional family relationships
- childhood sexual abuse
- depression
- low self-esteem.[91]

Adolescent knowledge of effective contraceptive use is poor, with young people reporting a number of barriers to accessing contraceptive such as embarrassment, concerns regarding confidentiality and expense. This is further exacerbated for young people in rural and remote regions who have limited providers.[91]

Young parents and their babies face significant long-term risks. Young mothers are at higher risk of medical complications during pregnancy and childbirth than older mothers, which can be due to a number of factors including:

- lack of healthcare knowledge which may lead to delay in confirming their pregnancy and /or seeking antenatal care
- higher rates of cigarette smoking, alcohol and drug use
- poor nutritional choices
- high levels of emotional stress.[92]

In addition, young parents are particularly vulnerable and at greater risk for reduced education and employment opportunities, poverty, mental health issues and relationship difficulties.[92] Comprehensive interventions pre and post-birth are essential to support young parents to address these issues.[90]

Babies born to young mothers have an increased risk of preterm delivery, low birth weight and associated complications. There is now increasing evidence that an individual's health can be programmed very early in life and may be linked to non-communicable diseases such as cardiovascular disease, obesity, diabetes and asthma in later life. The concept of *Developmental Origins of Health and Disease* states that a healthy start to life can help to reduce the risk of diseases in adult life which can be achieved through changes to parental lifestyle including, smoking and obesity.[60]

Young mothers may not always receive the support they need pre and post pregnancy. Research shows that intensive postnatal support (e.g. teenage-specific antenatal clinics) can reduce the incidence of preterm births as well as improve postnatal outcomes. It also provides an opportunity for education and support for contraceptive use to reduce the risk of further pregnancies.[93]

However, not all births to young parents lead to negative outcomes. Research indicates that pregnancy offers a unique motivation to lead to healthier lifestyle changes such as reduced drug use[93] and can be a motivation for young mothers to become more mature and responsible and have aspirations for the future.[94]

Youth living in regional and remote areas

Overall Australians who live in regional or remote areas have worse health than those who live in major cities.[95] Young people in remote areas have higher rates of injury related hospitalisations compared to their peers living in metropolitan areas. Whilst deaths rates are 2.5 times higher among youth who live in remote and very remote areas compared to those who live in the city. Higher death rates in remote areas are related to transport accidents and suicide which are three times higher among youth in remote areas.[30]

Chronic health conditions do not vary to a large degree across youth from rural and remote areas; however, there is evidence that asthma-related hospital admissions are higher for remote youth. While the incidence of cancer does not seem to vary for youth for regional areas, there is a lower survival rate of cancer for youth in regional and remote areas, which may be a result of greater difficulty in access to treatment services.[30]

Youth living in remote areas demonstrate higher rates of risky drinking and have a greater likelihood of using an illicit substance in the past 12 months. Young women in remote areas are also five times more likely to give birth as a teenager compared to those in the city.[30]

A New South Wales study[96] compared health issues raised between urban and rural youth and found that both raised similar issues (e.g. alcohol and illicit drugs, bullying, body image, sexual health, stress and depression). However, youth from rural areas more frequently mentioned issues such as depression, youth suicide and teenage pregnancy. Other issues faces by youth living in rural areas include issues in accessing health services, limited number of health services, lengthy wait times, limited female doctors, lack of bulk billing, and concerns about confidentiality.[96]

Social determinants of health

The specific health needs of young people stem from the ongoing process of physical, behavioural, psychological and cognitive development.[97]

The social determinants of health are defined by the World Health Organization as ‘the conditions’ in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life’. Young people are impacted by the societies and communities they grow up in, the families that they are raised in and individual factors that can lead to health enhancing or health damaging conditions and behaviours.[98]

The social determinants of health also underpin the Australian Research Alliance for Children and Youth's (ARACY) national plan (the Nest action agenda)[99] for improving child and youth wellbeing with a vision that: 'all children and youth:

1. are loved and safe
2. have material basics
3. are healthy
4. are learning and participating
5. have a positive sense of cultural and identity.[99]

1. Youth are loved and safe

Young people who feel safe and loved are more confident, have higher self-esteem and are resilient. Factors that affect youth feeling loved and safe include:

- family relationships – family functioning and child protection issues
- friendships and peer influence
- communities and community connectedness.[99]

Family relationships – family functioning and child protection issues

Families play a central role in the lives of young people with positive family relationships linked to young people's health and wellbeing. Family support and cohesiveness is related to better educational outcomes, social skills, healthy behaviours and life satisfaction.[30] Poor family stability, cohesion and conflict are related to worse outcomes and can result in higher levels of risk taking behaviour, such as drugs and alcohol, and mental health issues including self-harm and suicide.[30]

There have been major changes in the structure of families with a rise in the proportion of single parent families with dependent children to 22%. Parental separation can impact on families emotionally but also financially. One parent families with dependent children are primarily headed by mothers, and are often worse off financially.[100]

A large proportion of young people rate their relationship with their parents as highly satisfactory (93%) or completely satisfactory (25%). However for some young people there are a number of challenges confronting their families including parent's with poor health, mental health issues, substance use issues and family violence.[30]

Among young people aged 12 to 24 years, approximately 16% were living with a parent who rated their health as fair or poor. Approximately 25% of young people (15 to 24 years) lived with a parent with a disability and 7% of young people were caring for a family member with a disability.[30]

Survey results indicate that 19% of parents had poor mental health with research showing that children of parents with mental health issues are at greater risk of developing their own mental health problems.[30] While most families who have poor health, disability or mental health issues will not adversely affect young people there are families in which this may impact on the families ability to meet the needs of young people increasing the risk of negative impacts on health, wellbeing and educational outcomes.[30]

In the most severe cases, young people may suffer abuse or neglect, as 18.2 per 1 000 young people in WA were the subject of an investigation of child abuse or neglect in 2015-16, and 9.8 per 1 000 young people were on care and protection orders. Aboriginal children are over-represented in involvement in the child protection system and in WA, Aboriginal children are subject to a child protection substantiation over 11 times the rate of non-Aboriginal children.[59]

Increasing attention is being focused on young people who witness family violence. Research indicates there have been rise in the number of family and domestic violence incidents attended by police in WA.[20] Worryingly, in 59% of cases a child had witnessed the incident.[101] For young people who either experience or witness family violence, research indicates that they are at increased risk of mental health issues, physical injury, health issues, poor educational outcomes, and engagement in risky behaviour.[87]

Friendships and peer influence

Young people consistently say that friendships are one of the top three things they valued. Friends are also the top source of where young people go for help with important issues in their lives (83%).[102] Research indicates that coercive peer pressure for young people is less of an issue, adolescents are influenced in positive and negative ways by peers who they respect and admire and they often choose friends who are similar in behaviour, attitudes and identities.[14]

Communities and community connectedness

Being connected to your community and participating in community activities and organisations is important for young people to feel like they belong and feel valued. Communities include:

- physical community (e.g. schools, residential care homes, and correctional facilities)
- faith-based
- recreational and sporting groups
- on-line community.[103]

Community organisations can have a beneficial impact on the health and wellbeing of young people. A community which values diversity and is socially inclusive is important for all young people, but particularly for the priority populations of this policy. In a safe community, young people should live free of discrimination, safe from bullying or exploitation.

Factors that compromise a young person's ability to form these connections within their communities can affect their ability to overcome health and wellbeing issues include:

- abuse
- violence
- homelessness
- incarceration
- isolation
- caring responsibilities
- mental illness
- poverty.[92]

Schools must be a safe community for young people. They have a primary role of educating young people, and an important role as a provider of health information and helping young people develop health literacy and life skills. Prolonged absence from school is associated with poor outcomes in adulthood, including increased risk of mental health disorders and chronic illness. High quality education is a key health determinant, with completing education the most impactful intervention for the future wellbeing of adults.[104]

For young people aged 15 to 17, approximately 51% had daily face-to-face contact with family or friends outside of their household but this dropped to 24% for those aged 18 to 24 years although 55% had contact at least once a week. Young people aged 15 to 17 years also had the highest rates of volunteering with 42% having done voluntary work in the last 12 months but this was much lower in the 18 to 24 year old group at 26%.[105]

Actively participating in groups provides both emotional and social benefits and young people aged 15 to 17 years have high levels of participation with 66% involved in a social group and 36% involved in a community support group. Young people aged 18 to 24 years were less likely to be participating in social groups (49%) and community support groups (28%).[105]

The latest social survey conducted in Australia has found that access to services is an important issue for those living in outer regional and remote areas. One in three surveyed in these areas stated they had difficulty accessing services including doctors, dentists, telecommunication and government services.[105]

2. Youth have material basics

All youth should have access to material basics including safe homes and environments.

- Socioeconomic disadvantage and poverty
- Housing
- Environment.

Socioeconomic disadvantage and poverty

There is strong evidence that poverty and socioeconomic disadvantage is associated with poorer health outcomes in childhood, adolescence and the life-course. Life-course studies have found that low socioeconomic status adversely impacts young adult health in the areas of physical, dental and mental health.[106] According to the ARACY Nest outcomes, the material basics that are necessary for children and youth include:[99]

- adequate and stable housing
- adequate clothing
- healthy food
- clean water
- the materials to participate in education and training.

In Australia in 2013-14, there were 4 million people living in low income households, 20% were children under 15 years of age and 11% were young people aged 15 to 24 years.[107] In WA, low income households with dependent children are more likely to be composed of single-parent families (22%) compared to couple families (11%).[20]

The Aboriginal population face the highest levels of socioeconomic disadvantage in Australia. The 2011 census identified that 37% of the Aboriginal population lived in the most disadvantaged areas compared to 9% of the non-Aboriginal population. What is also evident is that as communities get more remote there is increasing socioeconomic disadvantage.[108] The Council of Australian Governments have set targets to close the gap in outcomes in health, education and employment between the Aboriginal and non-Aboriginal population. However in the latest Closing the Gap report, most of these outcomes are not on track and further work is required at all levels of government (i.e. regional, state, and commonwealth).[109]

Housing

Safe homes provide stability for young people to maintain their health. Most young people do live in safe homes, however many young people are vulnerable and domestic violence is the leading cause of homelessness for children in Australia.[101, 110]

Unfortunately, affordable housing remains out of reach for many young people. The 2011 census found that in WA the rate of homelessness was 43 per 10 000 people. Young people make up a large percentage of homeless people with 60% of those who are homeless under the age of 35 years.[54]

Temporary housing makes it difficult to access education, employment, health care and social services. Young people are more likely to live in substandard or overcrowded dwellings and are at increased risk of poor health outcomes.[55] Homeless young people, in particular, have high levels of physical and mental health problems, including alcohol and drug misuse. They are more likely to be homeless in adulthood, and have increased risk of long-term poverty, unemployment, and ill health.[55, 56]

Overcrowding is also an issue for the health and wellbeing of young people as it can result in increased infection risk, stress, and mental health issues. In WA, the rate of overcrowding for children and young people (0 to 17 years) is 6.7%, however it is much higher for Aboriginal children and young people at 34% (15 to 24 years), with rates much higher in remote areas.[20]

Environment

Environmental factors that influence food choices physical activity and social connection include neighbourhood layout, perceptions of neighbourhood safety, access to facilities or public open space, climate and public transport.[111, 112] Enduring legislation and policy relating to water quality, air pollution, land use, building standards, waste management, child protection and labour laws are necessary to ensure a safe environment.[113]

3. Youth Are Healthy

Overall, the majority of young people consider themselves to have relatively good health.[20] Key factors to youth health include:

- immunisation
- smoking, drug and alcohol use
- sun smart
- getting enough sleep
- sexual and reproductive health
- mental health and emotional wellbeing
- body image and eating disorders
- physical activity
- nutrition
- injury and poisoning
- overweight and obesity.

Immunisation

Communicable diseases are conditions caused by infectious organisms which can result in illness and disability and can be spread by a variety of means. Immunisation is important to reduce the risk of contracting vaccine preventable illnesses and also reducing their transmission.

In 2016, the rate of full immunisation of young children in WA was 91.47% which is slightly lower than the Australian rate of 93.19%.[114] Recent figures regarding the human papillomavirus (HPV) vaccine indicate that while the take-up rate for the first dose (administered in schools) is relatively high (99% for girls, and 98% for boys) those that have received dose three is much lower (92% for girls and 86% for boys). All three doses are essential to gain full and effective protection from HPV.[115]

In 2008, 73 per 100 000 young people aged 12 to 24 were notified for a vaccine preventable disease across Australia. The most common notification was for pertussis (64 per 100 000) with low rates of notifications for tetanus, diphtheria, Hib or poliomyelitis, invasive pneumococcal disease, invasive meningococcal disease, mumps, measles and rubella among young people.

However, rates for mumps have increased from 0.9 to 3.1 per 100 000, following an outbreak in 2007 in the Kimberley region.[30]

Measles remained relatively steady at 0.9 per 100 000 young people. Hepatitis notifications declined in young people over time with a combined rate in 2008 of 67 per 100 000 in the 12 to 24 age group. Hepatitis C was the most commonly reported newly diagnosed hepatitis among young people (36 per 100 000) followed by hepatitis B (29 per 100 000). In WA, young people aged 15 to 24 years made up 12% of Hepatitis C notifications.[30]

Smoking, drug and alcohol use

According to the Australian school students' alcohol and drug survey the rate of alcohol use among 12 to 17 year olds has declined over the last 10 years with 44% of students reporting drinking in the past year, 24% in the past month and 14% in the past week. There has also been a rise in the proportion of students who never drink to 31%. While rates of alcohol use have declined, for those who do drink the proportion that do so at risky levels is still high at 30%.[116] The National Drug Strategy Household Survey identified that young people aged 18 to 24 years were the most likely to drink at harmful levels on a single occasion and more males were likely to drink at harmful levels compared to females.[117]

The preferred drink for most students was premixed spirits (45%) and spirits (31%), with 12% of students drinking premixed alcohol energy drinks. Friends (30%) and parents (30%) were the source of alcohol for students who drank in the past week.[116]

While surveys have found that there is a decline in alcohol use among young people the rate of hospital admissions among young people for alcohol-related harm have risen. Western Australian research has identified that admissions for alcohol related harm in 13 to 17 year olds has increased by 2.3% per year, with the largest increase in 16 to 17 year old boys. However, girls aged 13 to 15 years have had increases in admissions by 2.7% per year and girls aged 16 to 17 years have increased by 3.2% per year.[118]

The Australian School Students' survey also collected information on tobacco and illicit drug use. Smoking has declined among young people with 14% of 12 to 17 year olds smoking in the past year, the lowest among 12 year olds (3%) but rising with increasing age to 31% among 17 year olds. Five percent of young people are current smokers with 1% of 12 year olds currently smoking but rising to 12% for 17 year olds.[119] Research has also found that the onset of smoking has been delayed with the average age of people smoking their first cigarette at 15.9 years.[117]

In WA the proportion of students who use illicit drugs has also declined with 19% having ever used, 17% using in the past year, 10% in the past month and 6% in the past week. The most commonly used drugs were cannabis (16%), tranquilisers (13%) and inhalants (10%).[119] The National Drug Strategy Household Survey found that drug use is relatively stable in Australia however those aged 20 to 29 years were most likely to have used an illicit drug in the last 12 months at 27%.[117]

The Household Survey found that while drug use has remained stable there have been changes in certain types of drugs with an increase in pharmaceutical misuse, falls in ecstasy and GHB, stable use of methamphetamine but changes from a decline in the powder form to increases in ice (or crystal methamphetamine). Young people aged 14 to 19 years were most likely to use synthetic cannabis at 2.8% and only recent surveys are monitoring the use of these and other new emerging psychoactive substances.[117]

Sunsmart

Australia has the highest prevalence of skin cancer in the world with two out of three Australians estimated to be diagnosed with skin cancer by 70 years of age. While family history and genetic susceptibility does increase risk for skin cancer ultraviolet radiation from the sun is the main cause of skin cancer.[120]

In young people melanoma is the most commonly diagnosed cancer accounting for more than 25% of cancers in young people aged 15 to 29 years.[30] However, there is a need to balance enough sun exposure to maintain adequate vitamin D levels and reduce the risk of skin cancer by avoiding excessive sun exposure.[120] It is reported that 24% of 12 to 17 year olds and 19% of 18 to 24 year olds have been sunburnt in summer on weekends through forgetting to take precautions, such as using sunscreen.[30]

Getting enough sleep

Sleep is important for young people and sufficient sleep is key for stimulating growth, brain development, memory, alertness and strengthening of the immune system. The amount of sleep required varies and is dependent on the young person's age and individual requirements.[121] Limited data from Australia shows that young people may not be getting enough sleep, with data suggesting that approximately 35-40% of young people experience some form of sleep problem.[122]

Sleep problems can affect wellbeing and functioning. Insufficient sleep can impact on learning and school performance, motor skills, mood disorders, overall health and has been linked with an increased risk of overweight in young people.[123] Sleep problems can be intrinsic (e.g. nightmares, bedwetting, snoring, puberty or changes in body clock) or extrinsic (e.g. anxiety related insomnia, inability to fall asleep, environmental or social problems, social pressure, use of electronic devices, using alcohol or drugs.[122]

Sleep is important for good mental health: lack of sleep can increase feelings of sadness and hopelessness, increase chance of suicidal thoughts or behaviour, increase chance of using tobacco, alcohol or marijuana.[124]

Insufficient sleep, inadequate sleep quality and irregular sleep patterns are associated with daytime sleepiness, negative moods, increased likelihood of stimulant use, higher levels of risk taking behaviours, poor school performance and increased risk of unintentional injuries. Lack of sleep related to poor-self rated health and psychological distress.[125] Factors for not getting enough sleep:

- Hormonal time shift and early school start times
- After school schedule – homework, sports, extra-curricular activities
- Leisure activities – television, internet, computer gaming
- Light exposure – television, mobile phones, computers
- Sleep patterns and attitudes – poor sleep hygiene, keeping active more valued then sleep
- Sleep disorders – restless leg syndrome, sleep apnoea.[125]

Sexual and reproductive health

Sexual health is a topic of high importance for young people but also for public health practitioners due to the increasing rates of sexually transmitted infections (STIs) among youth (Table 4).

In the 2013 National Survey of Australian Secondary Students and Sexual Health, of the Year 10, 11 and 12's surveyed, 69% had experienced some form of sexual activity and 34% had experienced sexual intercourse.[126] Young people are a high risk group for STIs due to lack of knowledge regarding sexual health, condom use and negotiation of use, and immature immune systems.[127]

Table 2. Notification rates of sexually transmitted infections in WA in 2016[128]

Sexually transmitted infection	Rate of notifications per 100 000 people	Percentage (%) of notifications amongst young people aged 15-24
Chlamydia	447	53
Gonorrhoea	127.7	40
Syphilis	12.8*	-
HIV	4.3	12

*Rate doubled from 2015 to 2016

Knowledge about HIV, STI and use of condoms and contraception varied, with 59% reported using a condom the last time they had sex.[126] Health professionals are well placed to support education of young people at higher risk of early age sexual activity. Access to health services is an issue for youth living in rural and remote areas. Young people face issues such as distance, expensive, lack of services and workforce.[129]

Mental health and emotional wellbeing

Young people view their health as holistic with both physical and emotional wellbeing identified as integral components. Evidence of the importance of wellbeing is highlighted in the fact that coping with stress was rated by youth as the top issue of concern in the Mission Australia Youth Survey 2016. A large proportion of young people (44%) were extremely concerned or very concerned about this issue.[102] In the most recent Australian Child and Adolescent Mental Health Survey 20% of young people (aged 11 to 17) had high to very high levels of psychological distress.[77]

Older adolescents had higher psychological distress than younger adolescents and females had greater distress than males. Psychological distress has a strong relationship with mental health issues with 80% of young people with major depressive disorder reporting high to very high levels of psychological distress.[77] Issues which impact on young people's stress include:

- worries about academic performance
- family arguments
- worries about family relationships.[130, 131]

Importantly while stress impacts on young people's life satisfaction research has found that by increasing individual's self-efficacy (i.e. goal setting, persistence and constructive approaches to challenges) this can improve young people's ability to cope with life's demands and perceived stress.[131]

Body image and eating disorders

Body image is one of the top three concerns for Australian young people according to the Mission Australia 2015 youth survey.[132] A large proportion of young people aged 11 to 24 years have a high level of dissatisfaction with their appearance, with 28% of young men and 35% of young women dissatisfied. Concerns around dissatisfaction with body image can result in an increased risk of unhealthy dietary and weight control methods and excessive exercises.[133]

The Second Australian Child and Adolescent Survey of Mental Health found that for those aged 11 to 17 years, 1.6% of males and 3.2% of females had low weight problem eating behaviours (e.g. were underweight and practicing weight controlling behaviours) or were binge eating and purging.[77]

Eating disorders can result in gastrointestinal problems, menstrual and fertility issues, kidney failure and osteoporosis;[133] and can impact upon growth and development of young people.[133] Eating disorders have one of the highest mortality rates of mental health disorders with 55% of those admitted with an eating disorder to WA public hospitals aged 16 to 25 years.[134]

Physical activity

Physical activity in young people is integral for healthy growth, development and wellbeing, with those who are physically active more likely to have positive adjustment, social competence and self-control.[135] Reports suggest that less than half of young people meet the recommended amount of physical activity (at least 60 minutes of activity per day for young people aged 5 to 17).[136] A large proportion of young people (over 76%) did not meet the recommended amount of screen-based activity (no more than two hours per day of screen based activity for entertainment purposes).[136] Screen based activity is a strong indicator of sedentary behaviour with reports indicating that 63% of young people aged 12 to 14 years and 74% of those aged 15 to 17 years have at least one screen based item in their bedroom.[136] Youth is associated with a peak in physical fitness and those who have good fitness levels during this period are more likely to be healthier throughout their life.[17]

Nutrition

Young people require good nutrition for physical growth, development and eating habits across their lifespan are often formed during this period of life.[30] Approximately 5% of young people (12 to 24 years) met the daily recommended serves of both fruit and vegetables. What is of concern is that young people consume more soft drinks, chips and burgers than any other age group, with 44% of young people aged 14 to 18 years drinking soft drink and flavoured mineral water.[137]

Injury and poisoning

For young people, injury and poisoning is the leading cause of death and a major cause of hospital admissions.[138] Injury deaths account for 30% of deaths for 10 to 14 year olds and 70% of deaths for 15 to 19 year olds. In WA, for those aged 13 to 17 years, the majority of deaths due to injury and poisoning were caused by transport accidents (45.9%) and intentional self-harm (32.6%).[20] Overall young males are more likely to die from injury and poisoning than females, particularly in the 15 to 19 year age group.[139]

The rate of injury hospitalisations has remained relatively steady over time for young people although there has been an increase in the rate of injury hospitalisations for 15 to 19 year olds. Over 2002-11 the rate of injury hospitalisation in WA was highest for 15 to 19 year males (See Table 2). Table 3 demonstrates differences in causes of injury hospitalisation by age group.

Table 3. Injury hospitalisation rates by gender and age group in WA 2002-2011[139]

	Rates per 100,000 person years		
Age group (years)	**Males**	**Females**	**Total**
10-14 years	2173.8	994.8	1603.1
15-19 years	3447.1	1511.2	2508.3

Table 4. Leading causes of injury hospitalisation by age group in WA 2002-2011[139]

Rank	**10-14 years**		**15-19 years**	
1	Accidental falls	31.9%	Transport Accidents	21.4%
2	Mechanical forces	21.8%	Mechanical forces	21.2%
3	Transport accidents	21.7%	Other unintentional	14.4%
4	Other unintentional	11.1%	Accidental falls	11.3%
5	Intentional self-harm	2.2%	Interpersonal violence	11.0%

Overweight and obesity

In consultations with young people in WA obesity was frequently mentioned by young people as an important health issue for them.[5] Overweight and obesity increase young people's risk of poor health and the development of serious health conditions in the short and long term, including type 2 diabetes, heart disease and certain cancers.[30]

Being overweight and obese can also affect young people's psychological wellbeing and the development of poor body image,[30] it can also be associated with social isolation reduced education and income into adulthood.[140] In Australia's Health 2016 findings, 26% of young people (5 to 14 years) were overweight and 19% were obese.[141] Overweight and obesity increased with age with young adults more likely to be overweight (37% for 18 to 24yrs; 31% for 12 to 17 years) and obese (13% 18 to 24 years; 9% 12 to 17 years).[30]

4. Learning and participating

- Education and employment
- Technology
- Privacy, confidentiality and consent
- Bullying and violence
- Internet and social media: cyberbullying and sexting.

Education and employment

Education for young people is essential to gain literacy and numeracy skills, to participate in society and obtain employment. Educational attainment also has an influence on young peoples' health and wellbeing with more education being linked to healthier lifestyle choices, such as reduced rates of smoking, alcohol, and inactivity.[30]

In 2016 over 60% of young people aged 15 to 24 years were engaged in study, with 86% of 15 to 19 year olds studying. Of young people aged 15 to 24 who were not enrolled in school level education, 35% were employed full time and 35% were in full time study with 12% not in employment or study. Full time employment for young people aged 17 to 24 years had decreased to 35% from (47% 10 years ago).[142]

Technology

Most Australians have access to internet and mobile devices, and for some groups such as young people, technology may be the preferred method of communication. Research suggests that even marginalised groups are using technology in their everyday lives.[143]

Young people have increasing access to the internet with 97% of households with children under 15 years having access to the internet. Young people aged 15 to 17 years had the highest proportion of internet users (99%) and they spent on average 18 hours per week on the internet. Young people most commonly went online for social networking, entertainment, and formal educational activities.[144]

Technology can have positive impacts on young people by increasing young person's social networks and providing access for disabled youth to information on disabilities and support services. Technology can also be an effective alternative mode of delivery for some health services, especially for access to groups in rural and remote regions, however, clients may still prefer face to face interactions.[143]

Technology is increasingly playing a significant role in access to mental health services such as telepsychiatry.[145] For example, eheadspace provides a confidential, free and secure space for 12 to 25 year olds or their family to email, chat online or speak on the phone with a qualified youth mental health professional.[146] The use of technology allows mental health information and support to become anonymous, accessible, informative, engaging and timely.[147]

Privacy, confidentiality and consent

Between infancy and adulthood, a parent's powers and responsibility reduce in proportion with the young person's maturity, intellectual capacity, understanding of concepts and ability to make decisions.[148] Generally, a young person under the age of 18 years can:

- consent to medical treatment and make other health care decisions
- authorise the sharing of his or her confidential information
- demand confidentiality (in relation to anyone including his or her parents or guardian) if assessed to be sufficiently mature and intelligent to make such decisions on his or her own behalf.[149]

The law in Australia recognises this concept of the 'mature minor', which is founded in common law. Consequently, health workers must assess each young person's competence on a case-by-case basis, informed by appropriate resources.[149] A number of factors may be important when assessing a child's competence, these include:

- age of youth
- nature of the problem
- ability of the youth to understand the complexity of the proposed health care or action
- consequences of proposed health care or action
- level of independence from parental care.[149]

A young person who would otherwise be competent to make decisions about his or her health, but who has a mental illness that affects his or her competency, may not be able to make his or her own medical or other health care decisions. If the child is an 'involuntary patient', there are special provisions under the *Mental Health Act 2014 (WA*)[150] that provide for the provision of mental health and medical treatment without consent in certain circumstances.

If a young adult over the age of 18 years is not competent to make his or her own health care decisions, an application may need to be made to the Court for the appointment of a guardian under the *Guardianship and Administration Act 1990 (WA).*[151]

Healthcare workers must take all reasonable care for the welfare of young people who are their clients, providing a duty of care. Healthcare workers have a duty to clients to maintain the confidentiality of all information obtained in the course of providing health care. There may be times when a young person's confidential information may need to be shared, and young people should be informed of this from the outset.[149] Situations include:

- a risk of suicide
- sexual, physical or emotional abuse
- serious risks to others.[149]

Some statutory provisions require that information must be shared, for example, mandatory reporting of notifiable diseases to the Department of Health under the *Health Act 1911 (WA*)[152] and the mandatory reporting of child sexual abuse by doctors, nurses and midwives under the *Children and Community Services Act 2004 (WA).*[153]

Bullying and violence

According to the Australian Mental Health Survey of Children and Adolescents, 42% of young people aged 11 to 17 years had been bullied every few months or less often in the previous year. One in ten young people had been bullied every week or more often, with a slightly higher proportion of younger adolescents (aged 11 to 15) experiencing more frequent bullying then 16 to 17 year olds. Bullying has the risk of impacting on young people's self-esteem and mental health, with 11% of young people stating they were upset (either 'a lot' or 'extremely') following bullying in the last 12 months.[77]

Young people are the age group most likely to be victims of violence which can impact their physical health and emotional wellbeing. In the most recent Australian Crime Victimisation Survey, 7% of young people aged 15 to 24 years were victims of physical assault and 9% experienced threatened assault.[154] Males are more likely to be victims of physical assault.

Incidents of assault for young people are more likely to occur:

- on the street or in an open space
- work or a place of study
- entertainment and recreation space.

In survey interviews, 0.5% of young people aged 18 to 24 years experienced sexual assault in the previous 12 months, with young people (10 to 24 years) eight times more likely to be a victim of sexual assault (238.4 persons per 100 000) than person aged 25 years and over as recorded by police reports.[138]

Internet and social media: Cyberbullying and sexting

Cyberbullying

The online environment offers many positive opportunities for young people including greater access to information, employment, education, and extended social networks. However the online environment does have risks in terms of the safety.[155]

Cyberbullying has emerged as an important issue for young people with 10-20% of young people affected.[156] However, young people frequently underreport cyberbullying experiences to parents or other adults, for fear of having their access to technology restricted.

It can take many forms including:

- sending mean messages or threats
- spreading rumours
- posting hurtful messages
- stealing a person's account information
- taking unflattering pictures of someone and posting them online.[156]

Cyberbullying victimisation is associated with social and emotional harm and poor academic outcomes, and can be harder to prevent or escape due to its:

- 24/7 nature
- the possibility of anonymity
- a lack of clear authorities online
- permanence of information shared online.[157, 158]

Young people who experience cyberbullying are at risk of depression, anxiety and loneliness, as well as poorer academic outcomes.[157, 158] Research shows that cyberbullying needs to be addressed in schools and communities as part of broader efforts to prevent peer bullying and aggression and young people need to be included in efforts to prevent it.[158, 159]

Lack of familiarity with the online environment and technologies being used by young people by parents and schools has limited the development of strategies and resources to respond to cyberbullying. It is important that a collaborative approach is used by parents and schools and that young people are involved in the planning and the development of resources to address cyberbullying.[158, 159]

Sexting

Sexting is becoming increasingly prevalent among young people. Sexting is the act of 'creating, sharing, sending or posting of sexually explicit messages or images via the internet, mobile phone or other electronic devices'.[160] In a recent Australian survey of young people over 67% of young people had received a sexual picture or video with 48% having sent a sexual picture or video of themselves.[161]

There are a number of negative outcomes of sexting including;

- its effect on mental health and wellbeing
- legal ramifications (e.g. child pornography charges)
- social and employment consequences
- non-consensual distribution of sexts
- online harassment
- damage to relationships.[160]

Education has not kept pace with changes in social media and there is a need to inform young people about risks and consequences, and the difference between consensual and non-consensual image-sharing (e.g. not sharing images of others without explicit permission). It is important for young people to promote their own sexual safety by engaging in protective behaviours, assertive communication and respectful relationships.[160]

Health service providers should promote sexual safety, which refers to the respect and maintenance of an individual's physical (including sexual) and psychological boundaries. Health service providers can foster a compassionate, sensitive and open culture that encourages reporting of incidents relating to the sexual safety of young people. The potential of multiple vulnerabilities amongst young people who access services must be considered by health professionals throughout the care pathway, whether due to age or developmental stage, potential for cognitive impairment from mental illness.

5. Positive culture and identity

A strong culture and identity is essential for young person's health and mental wellbeing. Young people are impacted by the conditions of daily life. Having a positive cultural identity provides the young person with a sense of belonging and helps build self-esteem and resilience.

Acronyms and terms

Aboriginal	Includes Aboriginal and Torres Strait Islander people
ARACY	Australian Research Alliance for Children and Youth
CALD	Culturally and linguistically diverse
FASD	Fetal Alcohol Spectrum Disorder
HIV	Human immunodeficiency virus
LEP	Limited English Proficiency
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex, queer and questioning or otherwise diverse in their sexuality or gender. We recognise that many people and communities have additional ways of describing their distinct histories, experiences, and needs beyond the six letters in 'LGBTIQ'
STI	Sexually transmitted infection
Trans	"Trans individuals describe their gender in different ways. We use the word trans to be open to people who describe themselves as transgender or transsexual or as having a transgender or transsexual experience or history. Trans people generally experience or identify their gender as not matching their sex assigned at birth. This includes people who identify as transgender, non-binary, agender, genderqueer and more" – reference
WA	Western Australia
WHO	World Health Organization

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