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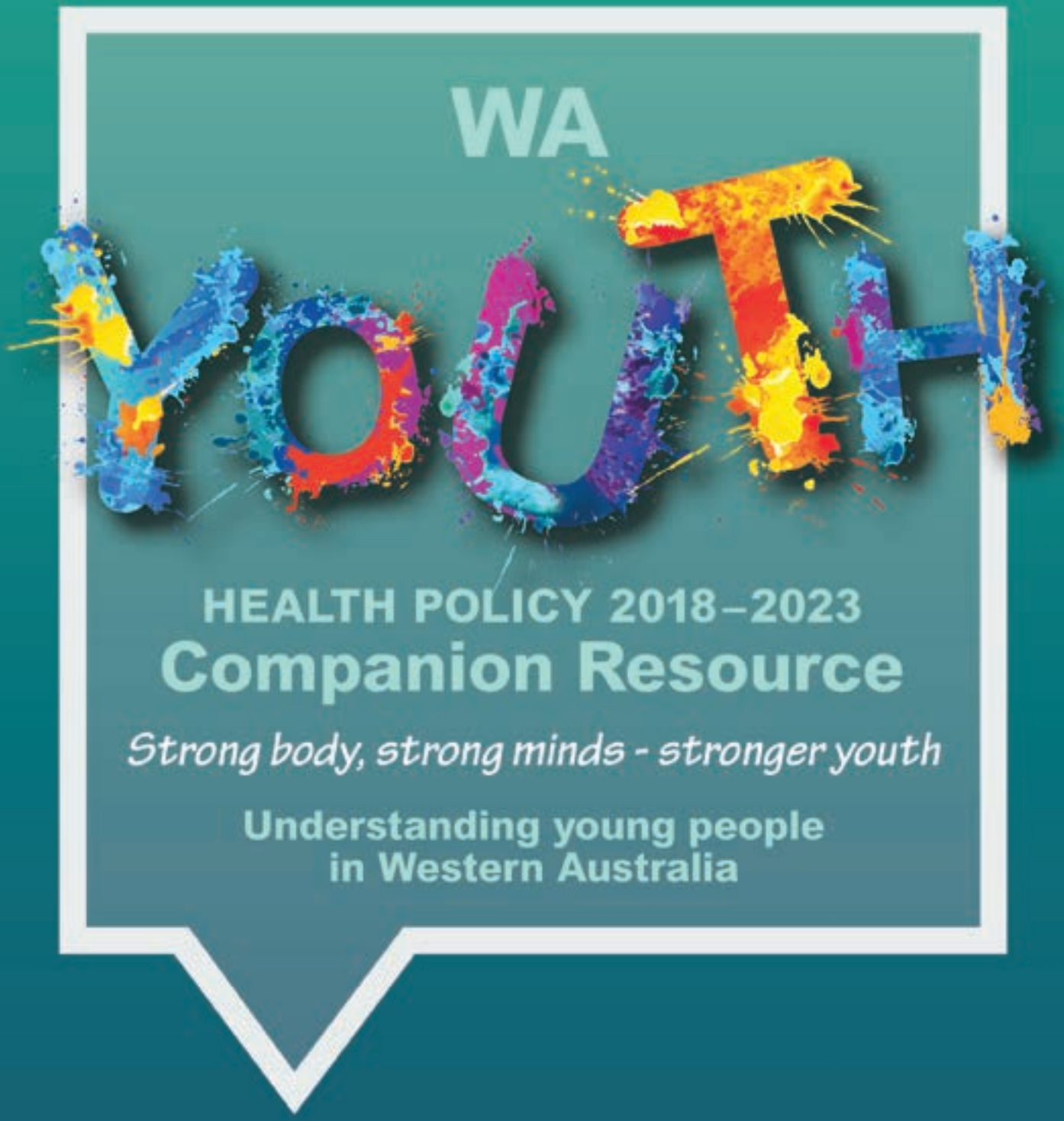
Department of **Health**



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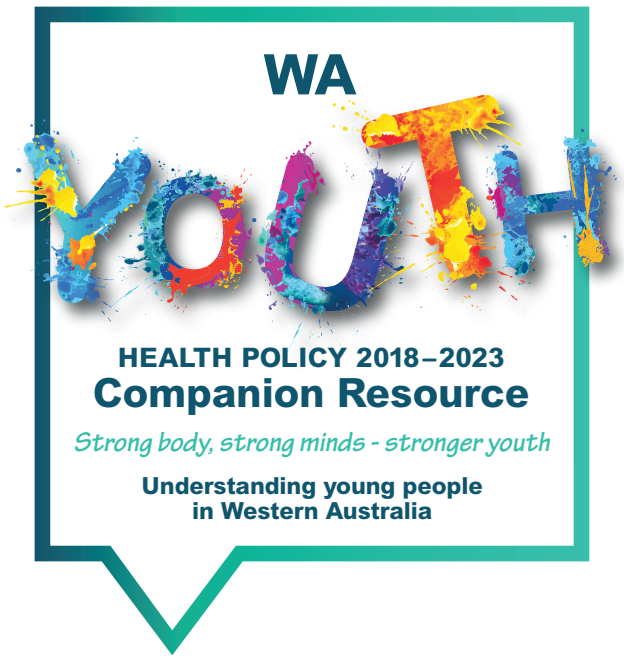

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Contents

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 adolescence
- a demographic overview
- priority populations of young people who are at higher risk of health issues
- access to health services
- the social determinants affecting young people's health.

Young people living in WA have a holistic view of health that encompasses physical, mental, emotional and social aspects.[2] Being healthy involves a range of aspects, including[2]:

- 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.

Health services should promote a positive focus on health and wellbeing through health promotion, health literacy and building resilience in young people, as well as managing the common health issues among young people.

Context

In recent years the needs of young people have gained increasing attention worldwide with a number of key reports.

International

- 2017 – 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, World Health Organization[3]
- 2016 – Our future: a Lancet commission on adolescent health and wellbeing[4]
- 2015 – The Global Strategy for Women's, Children's and Adolescent Health (2016-2030) – Every Woman Every Child[5]
- 2010 – Strengthening the health sector response to adolescent health and development, World Health Organization[6]

National

- 2015 – Healthy Safe and Thriving: National Strategic Framework for Child and Youth Health, Council of Australian Governments (COAG) Health Council[7]

State

- 2017 – NSW Youth Health Framework 2017-2024, NSW Health[8]
- 2017 – Queensland Youth Strategy – Building young Queenslanders for a global future[9]

Western Australia

- 2014 – Position Statement on Youth Health, Commissioner for Children and Young People Western Australia[10]
- 2014 – Young People's Experiences with Health Services: Final Report[2]
- 2012 – Let's Talk About Sex, Clinical Senate Meeting, Executive Summary Report & Recommendations[11]
- 2009 – Health and the 'Facebook' Generation, Clinical Senate Meeting[12]
- 2009 – Paediatric Chronic Diseases Transition Framework[13]

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).

This definition of youth is used by the World Health Organization (WHO)[5], the National Strategic Framework[6] for Child and Youth Health and the Lancet Commission on Adolescent Health.[3]

Increasingly, age specific reporting, including data from the Australian Bureau of Statistics, collates data into five-year age categories as follows[3,14]:

- Early adolescence 10 to 14 years
- Late adolescence 15 to 19 years
- Young adulthood 20 to 24 years.

This definition of youth aligns more closely with the developmental stages of adolescence and facilitates the development of appropriate polices and services for youth.[15]

Developmental stages and health

Adolescence is a period of important change and transition, with three areas that highlight the significance of youth health[3,16]:

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 builds on the early years that lay 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 determines the start to life they provide for their children.**

Early adolescence (10 to 14 years)

Early adolescence is when young people commonly enter puberty and involves physical and hormonal changes.[1] They experience extensive developmental growth, including significant increases in height, weight and bone mass.[17,18]

A number of factors can influence developmental growth such as malnutrition, infections, stress and trauma. These can impact on physical (e.g. low height for age) and cognitive (e.g. learning difficulties) development as well as future risk of disease and productivity.[19]

The adolescent brain undergoes significant development.[20] Early adolescence is associated with exploration, experimentation and risk taking which inform a young person's development of identity.[21,22] Areas of the brain associated with reward-seeking develop before those related to planning and self-regulation. Heightened risk-taking and sensation-seeking, plus less reasoned decision-making in early to mid-adolescence may be attributed to this.[23,24]

Peer relationships and influences are of increasing importance in early adolescence and can impact young people positively and negatively.[23] Adolescents often choose 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 by coercive pressures.[23]

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 the prefrontal cortex which is responsible for the regulation of behaviour and emotions and the ability to understand the short and long-term implications of actions and decisions.[23]

Young people develop independence and autonomy often while they are still in education and living at home, changing from a child-guardian relationship with their parents to a more equitable one. This stage is important for the development of decision-making by young people regarding their health and is an opportunity to empower them around their capacity to consider risks and consequences and exercise self-determination in health and lifestyle issues.[3]

Young adulthood (20 to 24 years)

In young adulthood the prefrontal cortex is more mature with development of greater skill in reasoning and self-regulation.[23] Previously this age group took on roles and responsibilities such as marriage and parenthood. Now these are delayed with many young people living in the family home and engaged in educational activities.[3]

Delayed marriage and childbirth have been associated with a reduction in maternal mortality and morbidity; however, have also been associated with 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.[3,25]

Young adulthood is associated with a peak in physical fitness and those who have good fitness levels are more likely to be healthier throughout life.[26] This has important implications for health promotion for young people to improve their health across the life course.

Demographic overview

In WA, young people (10 to 24 years) make up approximately 19 per cent (496 000) of the population, with 106 males to every 100 females (see Figure 1).[14] The number of young people in WA is expected to increase with a projection of the WA population doubling over the next 40 years.[27] Aboriginal youth account for approximately 6 per cent of the population and make up more than 30 per cent of the Aboriginal population in WA.[28]

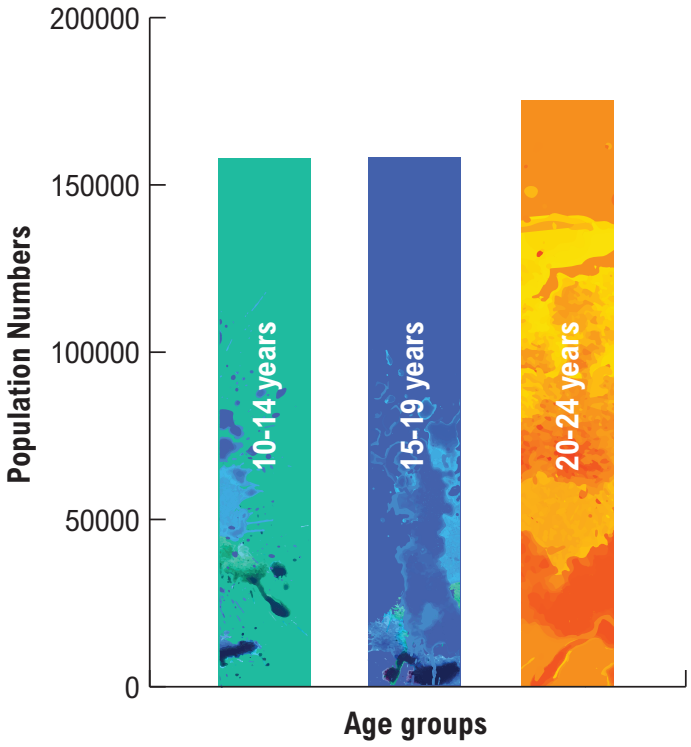


Figure 1. Number of young people living in WA in 2016 by age-group[14]

Most young people live in metropolitan Perth (73%), 17 per cent regional and 10 per cent in remote areas.[29] Young people predominantly live with their parents, with an increasing proportion (60%) of 18 to 24 year olds living with their parents. Almost a quarter (22%) will move back in with their parents for a period of time after leaving home.[30]

A large proportion of young people come from migrant families, with 52 per cent of the WA population having at least one parent born overseas and 75 per cent having non-Australian ancestry. WA is linguistically diverse, with 15 per cent of the WA population speaking a language other than English at home and 14 per cent of the WA Aboriginal population speaking an Australian Indigenous language at home.[31]

Marriage rates in young people aged 20 to 24 years have declined from 58 marriages per 1 000 females in 1993 to 25 marriages per 1 000 in 2013, with a similar trend in males. Additionally, a lower proportion of young people live with a partner (19%) and birth rates for this age group have declined, with only 17 per cent of all births to mothers under 25 years of age.[30]

Youth in WA

19% of Western Australians are 10-24 years

106 Males to every **100** Females

Population of Young People predicted to double in 40 years

Young Aboriginal People make up

6% of the WA population

30% of the WA Aboriginal population

73% live in metropolitan Perth

17% live in regional WA

10% live in remote WA

60% 18-24 year olds live with parents

22% move back in with parents after living out of home

19% Young people live with a partner

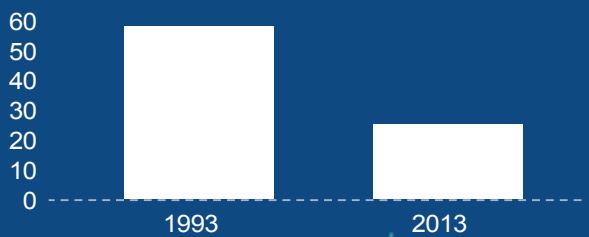
52% have at least 1 parent born oversees

75% have non Australian ancestry

14% Aboriginal people speak an Aboriginal language at home

15% Speak a language other than English at home

Marriage rates for 20-24 year olds (per 1000)



Declining birth rates with only

17%

of all birth mothers under the age of 25 years

Priority youth populations

Most young people have relatively good health; however, some groups are at higher risk of certain health issues.[32] Vulnerable young people who are at higher risk of poor health and wellbeing, greater barriers to access, and/or higher health risk behaviours, include those who are:

- Aboriginal
- carers of others
- culturally and linguistically diverse (CaLD) including those with limited English proficiency (LEP)
- homeless or at risk of homelessness
- in contact with the justice system
- Lesbian, Gay, Bisexual, Transgender, Intersex or Queer +
- living with a chronic condition or a rare disorder
- living with a disability
- living with mental health or emotional wellbeing issues
- living in regional and remote areas.
- residing in or have left out-of-home care
- migrants / refugees
- pregnant or parenting.

Aboriginal

Aboriginal people face health inequities that are 'avoidable and systematic'. They do not have the same opportunities in accessing health services and in some communities there is inadequate provision of health infrastructure.[33,34] Aboriginal young people 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.[35]

Self-assessed health status by Aboriginal youth was mostly positive (Figure 2), with similarities between remote and non-remote areas. Long-term health conditions or disability were reported by 35 per cent of Aboriginal youth, with 5 per cent requiring assistance with daily activities.[36]

Aboriginal youth (12 to 24 years) reported similar prevalence of at least one long-term health condition (asthma, type 1 diabetes and cancer) compared to non-Aboriginal youth (59% and 63% respectively).[32]

However, Aboriginal youth reported higher rates of communicable diseases, such as[32]:

- 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).

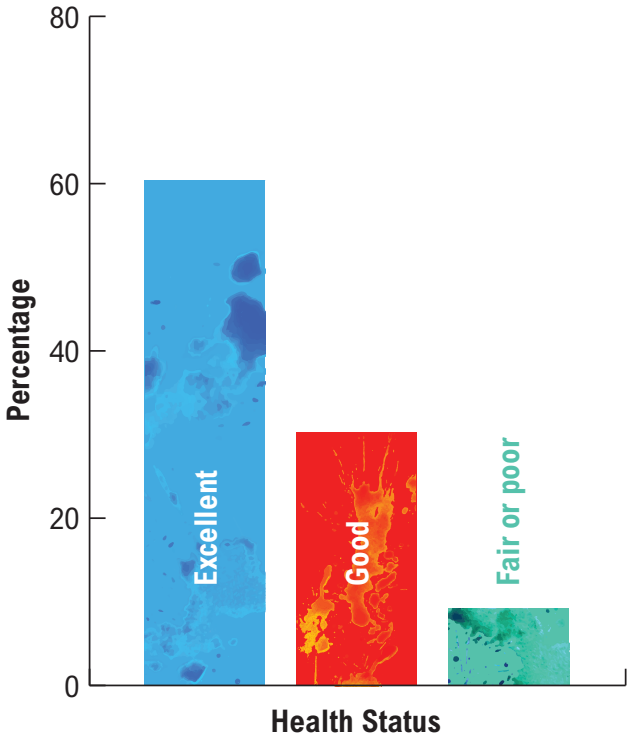


Figure 2. Self-assessed Health status of Aboriginal youth aged 15–24 years[36]

Mental health issues are a major health burden for Aboriginal young people,[30] with approximately 40 per cent experiencing mental health issues before adulthood.[37] Aboriginal young people are more likely to experience higher levels of psychological distress (one in three) compared to non-Aboriginal young people (one in five).[38]

Aboriginal youth self-harm and suicide is complex, likely a combination of life circumstances, such as death of family member or friend, illness, unemployment and mental illness.[39]

In Australia, rates of intentional self-harm among Aboriginal young people were five times higher than non-Aboriginal young people.[40] Suicide is more common in younger Aboriginal people,[41] with rates of suicide in the Kimberley region of WA one of the highest in Australia and the world, as high as 74 per 100 000 residents.[42]

The health and wellbeing issues experienced by Aboriginal people will increase, given the high proportion of Aboriginal youth and will require significant increases in services and programs to keep pace with demand.[33]

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'.[43] Data on the number of young people who are carers is likely to be underestimated due to families seeking to keep care private or not recognising assistance provided by a young person as 'care'.[44]

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.[45] 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 the Northern Territory and Kimberley region in WA.[44]

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.[46,47] Worry, grief, resentment and guilt can impact on psychosocial development due to reduced social interactions and limited time for themselves.[47]

While young carers often gain important skills for independence and adulthood, their caring role may contribute to low levels of poor health, difficulties in participation in education and employment, limited friendships; isolation and issues with leaving home.[47]

A whole of family approach to service development and provision is important. Health services must recognise the close connections between support for carers and support for family members they care for.[48]

Culturally and linguistically diverse including those with limited English proficiency

In Australia, 25 per cent of young people are from a CaLD background, 9 per cent (80 450) of which reside in WA.[49] CaLD young people can be reluctant to access health services due to language and cultural differences.[50] Issues accessing culturally appropriate services and programs, especially in rural and remote areas, as well as negative experiences at health services, may result in some CaLD young people not accessing health services.[49]

There are also barriers in relation to differences in the understanding of 'mental illness' and recognition of symptoms for CaLD young people as well as language barriers in relation to expressing the seriousness of issues and need for support. Dealing with trauma and stress of resettlement for CaLD youth can also increase the risk of substance misuse as a coping strategy.[49]

Limited English proficiency (LEP) describes individuals who do not speak English as their primary language.[51] 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[51]:

- less likely to access usual source of medical care
- at increased risk of non-adherence to medication and/or adverse medication reactions
- at higher risk of hospitalisations.

Homeless or at risk of homelessness

In Australia, an estimated 44 000 young people under the age of 25 years were homeless in 2011, with the majority living in severely crowded dwellings. In WA, 9 592 people were classified as homeless, with 24 per cent aged 12 to 24 years of age.[52] These figures likely underestimate homeless in young people as those with transient living arrangements or couch surfers may not access homelessness services.[53]

The most common reasons for youth to access specialist homelessness services were family violence and family relationship breakdown.[54] Young people who are homeless have a high prevalence of previously living in homes with family violence, and experiencing out-of-home care.[55] Approximately one in seven young people felt that they couldn't return home.[53] A large proportion of homeless young people have mental health issues, high levels of psychological distress, and high use of health and medical services.[55] Homeless young people also have high rates of sexually transmitted infections, dental problems, dermatological, respiratory and nutritional issues.[56]

In contact with the justice system

Young people in contact with 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] There is a need for coordinated health and welfare services and transitional care for those moving from custody to community health and social services.[58]

In 2015-16, there were 1 740 young people under corrective services supervision with just under half having a period in WA custodial detention.[59] Young people aged 10 to 17 years make-up 13 per cent of the total offender population in Australia, with WA having one of the highest proportions of youth offenders (16% of total offenders).[59] Aboriginal young people are over represented in youth justice supervision in all states and territories.[60] 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[59]:

- 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]

Young people involved in the justice system, including those in custody and on community-based orders, have complex health needs. A large proportion (56%) of young people in custody had depression or psychosis, and 22 per cent had deliberately self-harmed in the past six months.[58] Suicide prevalence rates of young people in the justice system were four times higher than other young people. 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 justice system.[57]

Health risk behaviours of custodial youth are of concern[58]:

- 14% of young people in custody reported having greater than five sexual partners in the past six months
- 85% had sex before the age of 15
- 39% had a sexual partner who injects drugs
- 15% had been sexually assaulted
- 66% reported high levels of substance abuse (34% of youth in community orders)
- 85% were regular tobacco smokers (88% of youth in community orders).

Health assessments of a representative sample of sentenced young people in WA in 2017 found[61]:

- 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.

Multidisciplinary assessment of young people (10 -17 years) in youth detention in WA found that 89 per cent had neurodevelopment impairment and 36 per cent were diagnosed with Fetal Alcohol Spectrum Disorder (FASD). The majority of these difficulties had not been understood, sought for or diagnosed prior to participation in the study by education, health or child protection services, previously involved in their care. Neurodevelopmental impairment can impact on a young person's ability to participate successfully in education, social inclusion, developmental safety and employment.[61]

Fetal Alcohol Spectrum Disorder

- The importance of FASD is becoming increasingly recognised in Australia.
- FASD is a preventable neurodevelopmental disorder that occurs as a consequence of prenatal alcohol exposure.
- The prevalence of FASD is difficult to estimate. Figures suggest it may be as high at 1.8 to 4.7 per 1 000 births.
- Those diagnosed with FASD face long-term issues such as[62,63]:
  - 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.

Lesbian, Gay, Bisexual, Transgender, Intersex or Queer +

Over 10 per cent of the Australian population identify as Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or questioning (LGBTIQ+). There is little data on the proportion of young people who identify themselves as (LGBTIQ+).[64] In 2012-14, 5 per cent of Australian youth aged 14 to 19 years identified as homosexual and this rose to 7 per cent for youth aged in their 20s.[65]

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.[66,67]

International studies estimate that between 0.7 per cent and 1.2 per cent of young people identify as trans. There are no estimates of young people who are trans in Australia.[66,67]

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[68,69] as a result of homophobic discrimination and marginalisation.[70]

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.[71] Over a third (41%) of gender variant and sexually diverse young people aged between 16 to 27 years had thought about self-harm while 42 per cent had thought about suicide.[72] Around 75 per cent of trans young people in an Australian study had been diagnosed with depression and over 70 per cent with anxiety. Almost 80 per cent had self-harmed and 48 per cent had attempted suicide.[73]

LGBTIQ+ youth experience higher rates of bullying and exclusion than their heterosexual and cisgender peers.[74] LGBTIQ+ young people feel isolated, and face higher rates of homophobia and transphobia in rural and remote areas of Australia.[71] They often feel unsupported by peers and family members, are more likely to leave school due to discrimination, with many having experienced abuse.[75] LGBTIQ+ young people are more likely to use alcohol and drugs.[68] They 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.[70]

Health services need to be accessible and sensitive to the needs of LGBTIQ+ young people. Approximately 40 per cent of young trans people had reported reaching out to a service that did not understand, respect or have experience with trans young people. Trans young people reported higher rates of self-harm and suicide if they experienced isolation from health services.[73]

Primary health providers should reassure individuals about 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 gender identity.[76]

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 cure is rarely achieved.[77]

Rare disorders are chronic and complex with around 80 per cent 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.[78,79] There is a lack of information on the prevalence of chronic disease and rare disease in young people in Australia,[80] with approximately 400 000 children with a rare disease.[81]

Young people living with a chronic or rare condition face a number of issues including[82]:

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

Young people living with a rare disease face significant burdens including delays in diagnosis, access to appropriate health care and similar issues to their peers with other chronic conditions such as participation in school, employment and social activities.[80,81]

Living with a disability

In Australia approximately 9 per cent of young people aged 13 to 17 years are living with a disability, 4 per cent of those in the profound or severe range. Australian estimates suggest that the largest group of disability is intellectual (5%), followed by physical restriction (3%), psychological (3%), sensory and speech (2%).[83]

Young people with disabilities report poorer health outcomes compared to those without disabilities.[84,85] They are at greater risk of experiencing a number of health conditions 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.[84,85] Reasons include[84]:

- increased risk of health issues associated with genetic or biological causes of disability (e.g. congenital heart problems for young people with Down's 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.[86]

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 young people aged 16 to 24 years and decline with age.[87] It is important to focus on mental health and wellbeing in young people, to prevent mental health issues and as an opportunity to provide early intervention to reduce the severity of mental health issues that may develop in adulthood.[88]

Approximately 16 per cent of boys and 13 per cent of girls aged 12 to 17 years have a mental health disorder.[89] In WA, there have been significant increases in young people with hospital admissions for mental health diagnoses. Over 50 per cent of young people with mental health problems access treatment and support services in schools and health services.[90]

One in five adolescents had high or very high levels of psychological distress. Table 1 lists the common mental health disorders for young people aged 12 to 17 years. A third of young people with a mental disorder had comorbidities.[89]

Table 1. Common mental health disorders for young people aged 12 to 17 years in Australia[89]

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

Young people with mental health issues may experience stigma, which can lead to discrimination and isolation.[91] Headspace reported that 26 per cent of young people aged 12 to 25 years would not tell anyone if they had a mental health problem and 52 per cent who identified as having mental health problems in the last 12 months reported being too embarrassed to discuss the problem with anyone.[92]

One in five 12 to 17 year olds had used a service for emotional or behavioural problems in the past 12 months.[89] 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[89]:

- General practitioner (42%)
- Psychologist (29%)
- Counsellor or family therapist (29%)
- Paediatrician (19%).

Hospital emergency, outpatient or inpatient services were accessed by 8 per cent of young people aged 12 to 17 years who had a mental disorder in the last 12 months, with 6 per cent accessing a specialist mental health service.[89]

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.[89]

Self-harm and suicide

Approximately 10 per cent of young people reported having self-harmed with 8 per cent preferring not to say. Self-harm is more prevalent among older adolescents (8% for 12 to 15 years olds compared to 16% of 16 to 17 years) and more common among females than males (15% vs 7%).[89]

Of young people aged 12 to 17 years, 8 per cent had stated that they had seriously considered attempting suicide in the previous 12 months, with females more likely to state this compared to males (11 and 5%). A total of 3 per cent of young people (12 to 17 years) had ever attempted suicide, with more females (5%) attempting suicide compared to males (2%). 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).[89]

The suicide rates for Aboriginal 15 to 19 year old males (37.8 per 100,000 persons) and females (16.1) are around four times that for non-Aboriginal males (10.1) and females (4.0). For 20 to 24 year olds, the suicide rate for Aboriginal males (64.2 per 100,000 persons) is over three times the rate for non-Aboriginal males (19.3) and the rate for Indigenous females (20.1) is four times that for non-Aboriginal females (5.0).[93]

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.[39]

Living in regional and remote areas

Australians who live in regional or remote areas have worse health than those who live in major cities.[94] Young people in remote areas have higher rates of injury-related hospitalisations compared to their peers in metropolitan areas. Death rates are 2.5 times higher among young people who live in remote and very remote areas, mainly due to transport accidents and suicide.[32]

Asthma-related hospital admissions are higher for young people living in remote 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.[32]

Young people living in remote areas are more likely to be a daily smoker, drink at risky levels, be overweight or obese and use illicit substances. Young women in remote areas are five times more likely to give birth as a teenager compared to those in the city.[95]

Comparisons of health issues raised between urban and rural young people found both raised similar issues (e.g. alcohol and illicit drugs, bullying, body image, sexual health, stress and depression). However, young people from rural areas more frequently mentioned depression, youth suicide and teenage pregnancy. They also face difficulties accessing health services, limited number of health services, lengthy wait times, limited female doctors, lack of bulk billing, and concerns about confidentiality.[96]

The use of digital technology is important for young people living in regional and remote areas. Health services are encouraged to engage with young people using digital platforms, with internet-based mental health services having been shown to be effective in reducing symptoms of depression.[97]

Residing in or have left out-of-home care

Children who have experienced child abuse and neglect are at risk of a range of adverse outcomes in physical and mental health, education, and involvement with corrective services. In WA there were 18 446 children notified to child protection services for emotional, psychological, physical, sexual abuse or neglect.[98] Substantiated abuse or neglect was found following 4 335 safety and wellbeing assessments. In 2016 there were 4 658 children in out-of-home care.[98] Aboriginal children are over-represented in out-of-home care, making up 53 per cent of the WA children in care.[99]

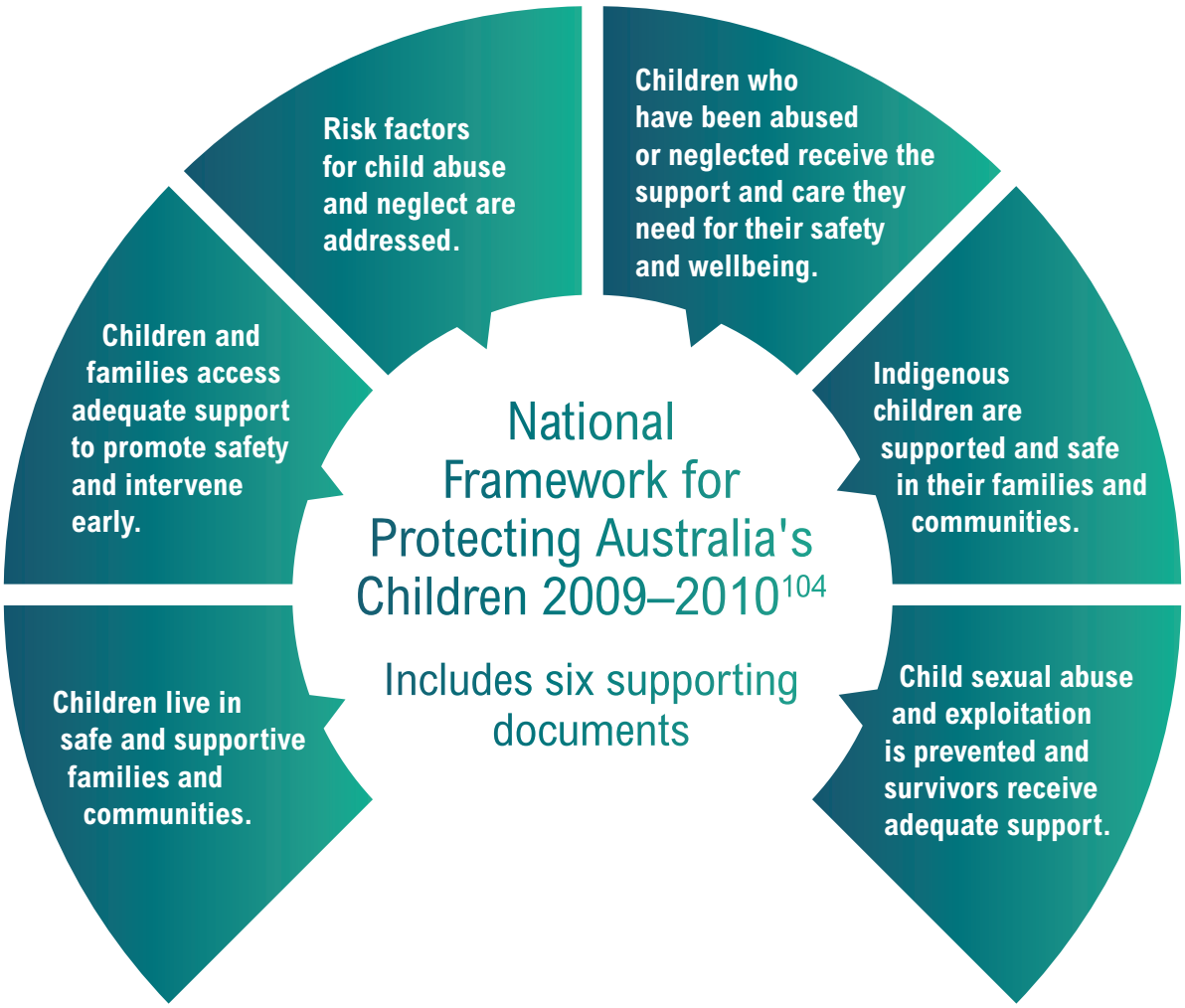
National and international data has consistently shown that care leavers have poorer outcomes when compared with their peers and are one of the most vulnerable and disadvantaged social groups.[100,101]

There is consistent evidence that child maltreatment, neglect and those who have experienced child abuse have an increased risk of[102]:

- 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).

Children with disabilities are at increased risk of child abuse and neglect, particularly those with intellectual disability and conduct disorder.[103]

In 2009 the Australian Government released the *National Framework for Protecting Australia's Children 2009-2020*.[104] Under the National Framework, protecting children is everyone's business.



The number of children and young people from CaLD and refugee backgrounds coming to the attention of child protection authorities in WA is unknown. In Victoria, approximately 13 per cent of children in out-of-home care were from CaLD or refugee backgrounds.[105]

There is 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.[105]

Migrants/refugees

Young people who are refugees are a vulnerable population with complex healthcare needs. They may have encountered multiple stressors, including[106]:

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

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 health care such as[106]:

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

Prolonged detention of young people who are refugees has been found to have detrimental effects on their emotional health and development.[107] Assessments conducted on young people in detention found that 34 per cent had mental health disorders in the clinical range and may have ongoing social and emotional issues following release into the community.[107]

Pregnant or parenting

The fertility rate of young women aged 15 to 19 has declined, though the fertility rate in young Aboriginal women has remained high (Figure 3).[108]

Pregnancy rates in young women are higher in rural and remote areas compared to urban areas. This may be due to lack of access to sexual health services, lower education levels, less employment opportunities and a stronger priority for family formation.[109]

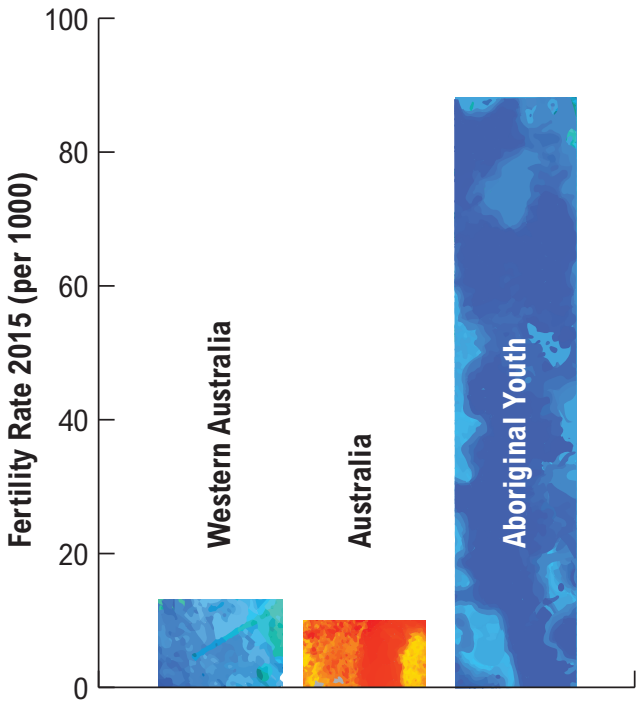


Figure 3. Fertility rate of young women aged 15 to 19 years[108]

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[110]:

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

Knowledge of effective contraceptive use is poor, with young people reporting a number of barriers to accessing contraceptives such as embarrassment, concerns regarding confidentiality and expense. This is exacerbated for young people in rural and remote regions who have limited providers.[110]

Many young mothers have healthy babies and adjust well to parenting, especially when they have a good support network (e.g. family and community support, access to high quality maternity services). Pregnancy offers a unique motivation to lead to healthier lifestyle changes such as reduced drug use and can be a motivation for young mothers to become more mature and responsible and have aspirations for the future.[111,113]

However, 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[111,113]:

- lack of healthcare knowledge and/or a fear of being judged may lead to delay in confirming pregnancy and /or seeking antenatal care
- higher rates of cigarette smoking, alcohol and drug use
- poor nutritional choices
- high levels of emotional stress.

Aboriginal young mothers have an increased risk for stillbirth and neonatal deaths compared to young non-Aboriginal mothers. Aboriginal mothers are more likely to die at an early age from external causes (e.g. accidents) and have a two to three fold increased risk of suicide compared with other mothers.[111]

Young parents are particularly vulnerable and at greater risk for reduced education and employment opportunities, poverty, mental health issues and relationship difficulties.[113] Comprehensive interventions pre- and post-birth are essential to support young parents to address these issues.[109]

Babies born to young mothers have an increased risk of preterm delivery, low birth weight and associated complications. There is 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. The concept of Developmental Origins of Health and Disease states that a healthy start to life can help reduce the risk of diseases in adult life through changes to parental lifestyle including, smoking and obesity.[114]

Young mothers may not always receive the support they need pre- and post-pregnancy. 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.[115]

Access to health services

Young people define health to include their physical, social and emotional wellbeing. The health seeking behaviours of young people is important to understand. They are more likely to seek health information and advice from family and friends, general practitioners and the internet. Young people are less likely to access services due to embarrassment, cost, stigma and concerns regarding their privacy and confidentiality.[10]

Young people want better access to 'specialised youth' services. These services should include[116]:

- health professionals who have an interest in young people's health and are sensitive to their needs
- easy to access locations
- appointment times convenient to young people
- services that are culturally sensitive and safe.

Social determinants of health

The specific health needs of young people stem from the ongoing process of physical, behavioural, psychological and cognitive development.[117]

The social determinants of health are defined by the WHO 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.[118]

The social determinants of health also underpin the Australian Research Alliance for Children and Youth's (ARACY) national plan for improving child and youth wellbeing with a vision that all children and young people[119]:

1. are loved and safe
2. have material basics
3. are healthy
4. are learning
5. are participating
6. have a positive sense of culture and identity.

1. Youth are loved and safe

Young people who feel safe and loved are more confident, have higher self-esteem and are resilient.[120]

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 are related to better educational outcomes, social skills, healthy behaviours and life satisfaction.[32] Poor family stability, cohesion and conflict are related to worse outcomes and can result in higher levels of risk taking behaviour and mental health issues including self-harm and suicide.[32]

There have been changes in the structure of families with a rise in the proportion of single parent families with dependent children from 19 per cent to 22 per cent. 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.[121]

Young people from single parent families are more likely to engage in high-risk behaviours (e.g. use of drugs, alcohol and tobacco), have low self-esteem and are at higher risk of leaving school at an early age.[122] They also have a higher prevalence of mental health disorders.[123]

Most young people rate their relationship with their parents as highly satisfactory (93%) or completely satisfactory (25%). For some young people there are a number of challenges confronting their families including parents with poor health, mental health issues, substance use issues and family violence.[32]

Among young people aged 12 to 14 years, 16 per cent were living with a parent who rated their health as fair or poor and 19 per cent of parents had poor mental health. A quarter of young people (15 to 24 years) lived with a parent with a disability and 7 per cent of young people were caring for a family member with a disability.[32]

While most families who have poor health, disability or mental health issues will not adversely affect young people, there are families in which these may impact on their ability to meet the needs of young people, increasing the risk of negative impacts on health, wellbeing and educational outcomes. Children of parents with mental health issues are at greater risk of developing their own mental health problems.[32] These young people are more at risk of medical problems, injuries, behavioural, developmental and emotional problems.[124]

Aboriginal children are subject to 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. There has been a rise in the number of family and domestic violence incidents attended by police in WA.[29] In 59 per cent of cases a child had witnessed the incident.[125] Young people who either experience or witness family violence are at increased risk of mental health issues, physical injury, health issues, poor educational outcomes, and engagement in risky behaviour.[104]

Friendships and peer influence

Friendships are consistently one of the top three things valued by young people. Friends are the top source of where young people go for help with important issues in their lives (83%).[126]

Peers can influence academic achievement and more risky behaviours such as smoking, drug and alcohol use. Good communication with parents and parental monitoring are protective factors for alcohol, tobacco and substance use.[127,128] Families, school and community environments play an integral role in providing the stability and support that assist adolescents in developing their health, social and emotional skills.[3]

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[129]:

- physical community (e.g. schools, residential care homes, and correctional facilities)
- faith-based
- recreational and sporting groups
- online community.

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 youth populations of the 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 and can affect their ability to overcome health and wellbeing issues include[113]:

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

For young people aged 15 to 17, approximately 51 per cent had daily face-to-face contact with family or friends outside of their household. This dropped to 24 per cent for those aged 18 to 24 years, although 55 per cent had contact at least once a week. Young people aged 15 to 17 years also had the highest rates of volunteering with 42 per cent having done voluntary work in the last 12 months, which was much higher than in the 18 to 24 year old group at 26 per cent.[130]

Actively participating in groups provides emotional and social benefits. Young people aged 15 to 17 years have high levels of group participation, with 66 per cent involved in a social group and 36 per cent 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%).[130]

Bullying and violence

According to the *Australian Mental Health Survey of Children and Adolescents*, 42 per cent of young people aged 11 to 17 years had been bullied every few months. One in 10 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 a young person's self-esteem and mental health, with 11 per cent of young people stating they were upset (either 'a lot' or 'extremely') following bullying in the last 12 months.[89]

Young people aged 15 to 24 were most likely to be victims of violence which can impact their physical health and emotional wellbeing.[31]

Approximately 7 per cent of young people aged 15 to 24 years were victims of physical assault and 9 per cent experienced threatened assault. Males are more likely to be victims of physical assault.[131]

Incidents of assault involving young people are more likely to occur [131]:

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

A total of 0.5 per cent 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.[132]

Approximately 40 per cent of Australians aged 18 and over had experienced violence since the age of 15, 16 per cent of women and 11 per cent of men (aged 18 years and over) experienced abuse before the age of 15. Men were more likely than women to have experienced physical violence since age of 15 (41% and 31% respectively). In comparison, women were more likely to have experienced sexual violence since the age of 15 compared to men (18% and 5% respectively).[133]

2. Youth have material basics

All youth should have access to material basics including safe homes and environments.[119]

Socioeconomic disadvantage and poverty

Poverty and socioeconomic disadvantage is associated with poorer health outcomes in childhood, adolescence and the life-course. Low socioeconomic status adversely impacts young adult physical, dental and mental health.[134]

The material basics necessary for children and young people include[119]:

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

In 2013-14, 4 million people in Australia were living in low income households; 20 per cent were children under 15 years of age and 11 per cent were young people aged 15 to 24 years.[135] In WA, low income households with dependent children are more likely to be composed of single-parent families (22%) compared to couple families (11%).[29]

The Aboriginal population face the highest levels of socioeconomic disadvantage in Australia, with 37 per cent of the Aboriginal population living in the most disadvantaged areas, compared to 9 per cent of the non-Aboriginal population. There is increasing socioeconomic disadvantage with increasing remoteness.[136] The Council of Australian Governments has 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 were not on track and further work was required.[137]

Housing

Safe homes provide stability for young people to maintain their health. Most young people do live in safe homes. However, many are affected by domestic violence which is the leading cause of homelessness for young people in Australia.[125,138]

Young people make up a large percentage of homeless people with 60 per cent of those who are homeless under the age of 35 years.[52] Homeless young people, in particular, have high levels of physical and mental health problems.[55,56]

Affordable housing remains out of reach for many young people. 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.[35] Overcrowding 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 7 per cent. Overcrowding for Aboriginal young people is much higher at 34 per cent (15 to 24 years), with rates even higher in remote areas.[29]

Environment

Environmental factors influence food choices, physical activity and social connection. These factors include neighbourhood layout, perceptions of neighbourhood safety, access to facilities or public open space, climate and public transport.[139,140] 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.[141]

3. Youth are healthy

Overall, the majority of young people consider themselves to have relatively good health.[29]

Key factors that impact on youth health include:

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

Being sun smart

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 increases the risk for skin cancer, ultraviolet radiation from the sun is still the main cause of skin cancer.[142]

In young people melanoma is the most commonly diagnosed cancer accounting for more than 25 per cent of cancers in young people aged 15 to 29 years.[32] However, there is a need to balance getting enough sun exposure to maintain adequate vitamin D levels with reducing the risk of skin cancer by avoiding excessive sun exposure.[142] It is reported that 24 per cent of 12 to 17 year olds and 19 per cent of 18 to 24 year olds have been sunburnt through forgetting to take precautions.[32]

Body image and eating disorders

Body image is one of the top three concerns for Australian young people.[143] A large proportion of young people aged 11 to 24 years have a high level of dissatisfaction with their appearance, with 28 per cent of young men and 35 per cent of young women dissatisfied. Concerns around dissatisfaction with body image can result in an increased risk of unhealthy diet and weight control methods and excessive exercise.[144]

Approximately 2 per cent of males and 3 per cent of females aged 11 to 17 years had low-weight problem eating behaviours (e.g. were underweight and practising weight controlling behaviours) or were binge eating and purging.[89]

Eating disorders can result in gastrointestinal problems, menstrual and fertility issues, kidney failure and osteoporosis; and can impact upon growth and development of young people.[144] Eating disorders have one of the highest mortality rates of mental health disorders. Over half (55%) of those admitted with an eating disorder to WA public hospitals were aged 16 to 25 years.[145]

Getting enough sleep

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.[146] Limited data from Australia shows that young people may not be getting enough sleep, with approximately 35 to 40 per cent of young people experiencing sleep problems.[147]

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).[147]

Sleep problems can affect wellbeing and functioning. Insufficient sleep, inadequate sleep quality and irregular sleep patterns impact on learning and academic performance, motor skills and mood. Sleep problems have been linked to excess weight gain, increased likelihood of stimulant, tobacco, alcohol or marijuana use, increased risk of suicidal thoughts and increased risk of unintentional injuries.[148,149]

Factors for not getting enough sleep include[150]:

- 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 than sleep
- sleep disorders – restless leg syndrome, sleep apnoea.

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.[151]

In 2016, the rate of complete immunisation of young children in WA was 91 per cent, slightly lower than the Australian rate of 93 per cent.[151] Recent figures regarding the Human Papillomavirus (HPV) vaccine indicate that while the uptake rate for the first dose 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.[152]

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 Bordetella Pertussis (whooping cough) (64 per 100 000), with low rates of notifications for Tetanus, Diphtheria, Haemophilus influenza b, Poliomyelitis, invasive Pneumococcal disease, invasive Meningococcal disease, Mumps, Measles and Rubella among young people. Rates for Mumps have increased from 0.9 to 3.1 per 100 000, following an outbreak in 2007 in the Kimberley region.[32]

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 per cent of Hepatitis C notifications.[32]

Injury and poisoning

For young people, injury and poisoning is the leading cause of death and a major cause of hospital admissions.[132] Injury deaths account for 30 per cent of deaths for 10 to 14 year olds and 70 per cent of deaths for 15 to 19 year olds. Transport accidents (46%) and intentional self-harm (33%) were the leading causes of death in the age group 13 to 17 years in WA.[29] Young males are more likely to die from injury and poisoning than females, particularly in the 15 to 19 year age group.[153]

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. During the period 2002-11 the rate of injury hospitalisation in WA was highest for 15 to 19 year males (See Table 2).

Table 2. Injury hospitalisation rates by gender and age group in WA 2002-2011[153]

	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 3 demonstrates differences in causes of injury hospitalisation by age group.

Table 3. Leading causes of injury hospitalisation by age group in WA 2002-2011[153]

Rank	10 to 14 years		15 to 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%

Rates of hospitalised injury are higher for Aboriginal youth compared to non-Aboriginal youth. Assault injuries were the leading cause of hospitalisation for Aboriginal youth aged 15 to 17 years and 18 to 24 years.[154]

Nutrition

Young people require good nutrition for physical growth and development. Eating habits across the lifespan are often formed during this period of life.[32] Approximately 5 per cent of young people (12 to 24 years) met the daily recommended serves of both fruit and vegetables. Young people consume more soft drinks, chips and burgers than any other age group, with 44 per cent of young people aged 14 to 18 years drinking soft drink and flavoured mineral water.[155]

Optimising mental health

Young people view their health as holistic, with both physical and emotional wellbeing identified as integral components. Coping with stress was rated by youth as the top issue of concern in the *Mission Australia Youth Survey 2016*, with 44 per cent of young people extremely concerned or very concerned about this issue.[126] Increasing an individual's self-efficacy (i.e. goal setting, persistence and constructive approaches to challenges) can improve young people's ability to cope with life's demands and perceived stress.[156] Issues which impact on young people's stress include concerns about academic performance and family relationships.[156,157]

In the most recent *Australian Child and Adolescent Mental Health Survey*, 20 per cent of young people (aged 11 to 17) had high to very high levels of psychological distress.[89] 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 - 80 per cent of young people with major depressive disorder report high to very high levels of psychological distress.[89]

Oral health

There is increasing evidence of the connection between oral health and chronic conditions such as cardiovascular disease, stroke and diabetes.[158] Certain populations are at higher risk of poor oral health, such as those from low income, socially disadvantaged, Aboriginal and living in rural and remote areas.[159] Adolescents have distinct oral health needs due to high rates of tooth decay or cavities and orthodontic care.[160] The Royal Australasian College of Physicians reported 64 per cent of young people aged 15 to 24 years had experienced dental caries and 19 per cent of young people had at least one tooth missing due to dental disease.[161]

Overweight and obesity

Obesity was frequently mentioned by young people in WA as an important health issue for them.[10] 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.[32]

Being overweight and obese can affect young people's psychological wellbeing and may lead to the development of poor body image.[32] It can also be associated with social isolation, reduced education and reduced income into adulthood.[162] In Australia, 26 per cent of young people (5 to 14 years) were overweight and 19 per cent were obese.[158] Overweight and obesity increased, with age with young adults more likely to be overweight (37% for 18 to 24 years vs 31% for 12 to 17 years) and obese (13% 18 to 24 years vs 9% 12 to 17 years).[32]

Physical activity

Physical activity in young people is integral for healthy growth, development and wellbeing. Those young people who are physically active are more likely to have positive adjustment, social competence and self-control.[163] 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).[164]

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).[164] Screen-based activity is a strong indicator of sedentary behaviour with reports indicating that 63 per cent of young people aged 12 to 14 years and 74 per cent of those aged 15 to 17 years have at least one screen-based item in their bedroom.[164] 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.[26]

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 young people (Table 4).

A total of 69 per cent of young people in Years 10, 11 and 12 surveyed had experienced some form of sexual activity, and 34 per cent had experienced sexual intercourse.[165] Young people are a high risk group for STIs due to lack of knowledge regarding sexual health and condom use as well as immature immune systems.[166]

Table 4. Notification rates of sexually transmitted infections in WA in 2016[167]

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
Infectious Syphilis	12.8*	16
HIV	4.3	12

Infectious Syphilis = primary syphilis, secondary syphilis and early latent syphilis (less than two years duration).
*Rate doubled from 2015 to 2016

Knowledge about HIV, STIs and use of condoms and contraception varied, with 59 per cent reporting using a condom the last time they had sex.[165] 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, where young people face issues such as distance, expense and lack of services and workforce.[168]

Smoking, drug and alcohol use

The rate of alcohol use among 12 to 17 year olds has declined over the last 10 years.[169] There has been an increase in the proportion of students who never drink, to 31 per cent,[171] A total of 44 per cent of students report drinking in the past year, 24 per cent in the past month and 14 per cent in the past week.[169]

For young people who do drink, the proportion that do so at risky levels is still high at 30 per cent.[170] Young people aged 18 to 24 years were most likely to drink at harmful levels on a single occasion and more males were likely to drink at harmful levels compared to females.[171]

The preferred drink for most students was premixed spirits (45%) and spirits (31%), with 12 per cent 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.[170]

While there was a decline in alcohol use among young people, the rate of hospital admissions for alcohol-related harm has risen. Admissions for alcohol-related harm in 13 to 17 year olds has increased by 2.3 per cent per year, from 1990 to 2009. Young boys aged 16 to 17 years old had the highest rate of alcohol related injury (27 per 10 000 in 2009. However, girls aged 16 to 17 years showed significant change in trends at 3.3 per cent per year compared to boys at 2.5 per cent.[172]

Smoking rates have declined among young people, with 14 per cent of 12 to 17 year olds smoking in the past year. The rates of current smoking increase with age from 1 per cent of 12 year olds to 12 per cent for 17 year olds.[173] The onset of smoking has been delayed with the average age of people smoking their first cigarette at 16 years.[171]

In WA the proportion of students who use illicit drugs has also declined with 19 per cent having ever used, 17 per cent using in the past year, 10 per cent in the past month and 6 per cent in the past week. The most commonly used drugs were cannabis (16%), tranquilisers (13%) and inhalants (10%).[173]

There have been changes in the types of drugs used among young people with, an increase in pharmaceutical misuse, a fall in ecstasy and gamma-hydroxybutyric acid (GHB) use, and stable use of methamphetamine; however, there has been a decline in the use of powder form and an increase in ice (or crystal methamphetamine). Young people aged 14 to 19 years were most likely to use synthetic cannabis (3%); however, only recent surveys are monitoring the use of these and other new emerging psychoactive substances.[171]

Individuals affected by alcohol and other drugs experience stigma which can impact on a young person's health. Stigma associated with alcohol and drug use can lead to exclusion from community, isolation, low self-esteem, difficulties in obtaining education and housing and can also discourage access to treatment.[174]

4. Learning

Education and employment

Education for young people is essential to gain literacy and numeracy skills, to participate in society and obtain employment. Educational attainment has an influence on young people's health and wellbeing with more education being linked to healthier lifestyle choices, such as reduced rates of smoking, alcohol, and inactivity.[32]

Schools have an important role as a provider of health information to help 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 issues and chronic illness.

> High quality education is a key health determinant, with completing education to 16 years of age the most impactful intervention for the future wellbeing of adults.[175]

Mental health issues are common in Australian adolescents,[89] and have significant adverse impacts on academic outcomes.

> Around one in seven 11 to 17 year olds had a mental disorder in the previous 12 months. Students with a mental disorder have more absences from school, lower levels of connectedness with school and engagement with their schoolwork, and lower levels of academic performance. Students in Years 7 to12 with a mental disorder are absent an average 24 days per year, compared with 11 days per year for students without a mental disorder.[176]

By Year 9, students with a mental disorder were 1.5 to 2.8 years behind in NAPLAN testing. Students with ADHD or conduct disorder were up to five years behind by Year 9.[176]

Students who used support services (in either the health or education sectors) for their mental disorder improved over time compared to students with a mental disorder who did not receive help, but they did not fully overcome the differences in academic performance compared with students who do not have a disorder.[176]

In 2016, over 60 per cent of young people aged 15 to 24 years were engaged in study, with 86 per cent of 15 to 19 year olds studying. Of young people aged 15 to 24 who were not enrolled in school level education, 35 per cent were employed full time, 35 per cent were in full time study and 12 per cent not in employment or study. Full time employment for young people aged 17 to 24 years had decreased to 35 per cent, from 47 per cent 10 years ago.[177]

5. Participating

Participating includes interaction with family, friends and community; and young people having a voice, expressing their views and being involved in decision-making.[119]

Privacy, confidentiality and consent

Between infancy and adulthood, a parent's influence and responsibility reduce in proportion to the young person's maturity, intellectual capacity, understanding of concepts and ability to make decisions.[178] Generally, a young person under the age of 18 years can[179]:

- consent to medical treatment and make other healthcare 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.

> The law in Australia recognises this concept of the 'mature minor', which is founded in common law. Health workers must assess each young person's competence on a case-by-case basis, informed by appropriate resources.[179]

A number of factors may be important when assessing a young person's competence, including[179]:

- 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.

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)* that provide for the provision of mental health and medical treatment without consent in certain circumstances.[180]

If a young adult over the age of 18 years is not competent to make his or her own healthcare 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)*.[181]

Health professionals must take all reasonable care for the welfare of young people. They have a duty of care and must 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.[179]

Situations include[179]:

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

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)*[182] and the mandatory reporting of child sexual abuse by doctors, nurses and midwives under the *Children and Community Services Act 2004 (WA)*.[183]

Technology

Access to technology (e.g. internet, social networking sites and mobile devices) is almost universal for Australians; even vulnerable groups are using technology in their everyday lives. For young people technology may be the preferred method of communication.[97]

Almost all (97%) households with children under 15 years have access to the internet. Young people aged 15 to 17 years had the highest proportion of internet users (99%) and spent on average 18 hours per week on the internet. Young people most commonly went online for social networking, entertainment, and formal educational activities.[184]

Technology can have positive impacts by increasing a 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.[184]

Technology is increasingly playing a significant role in access to mental health services such as telepsychiatry.[185] Services such as eheadspace provide a confidential, free and secure space for 12 to 25 year olds or their families to email, chat online or speak on the phone with a qualified youth mental health professional.[186] The use of technology allows mental health information and support to become anonymous, accessible, informative, engaging and timely.[187]

Use of electronic and social media e.g. cyberbullying and sexting

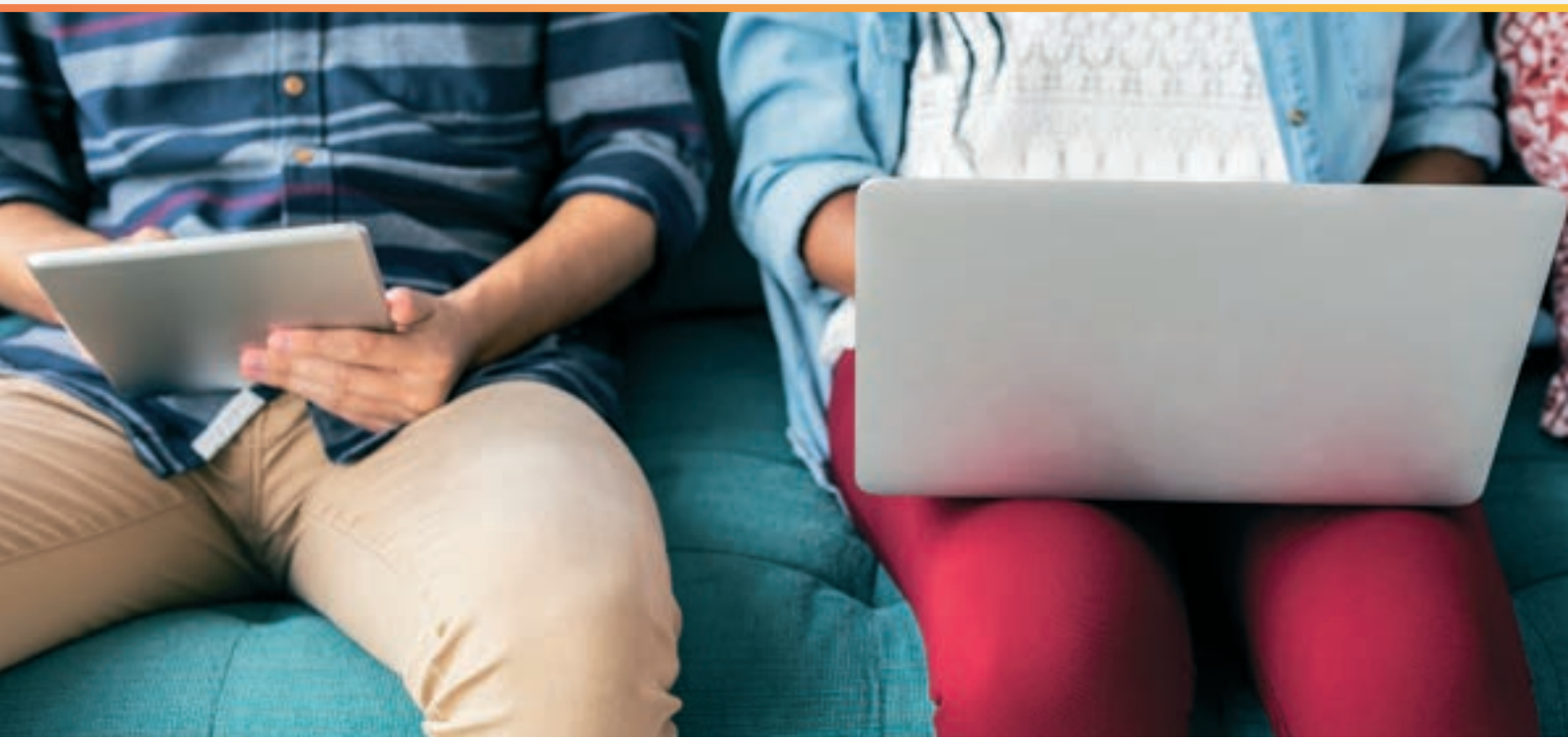
Cyberbullying

The online environment offers many positive opportunities for young people including greater access to information, employment, education, and extended social networks. However, it does have risks in terms of the safety.[188]

Cyberbullying has emerged as an important issue for young people with 10 to 20 per cent of young people affected.[189] Young people frequently under-report cyberbullying experiences to parents or other adults, for fear of having their access to technology restricted.

Cyberbullying can take many forms including:

- sending mean messages or threats
- spreading rumours
- taking unflattering pictures of someone and posting them online.[189]
- posting hurtful messages
- stealing a person's account information



Cyberbullying victimisation is associated with social and emotional harm and poor academic outcomes, and can be harder to prevent or escape due to its[131,190,191]:

- 24/7 nature
- the possibility of anonymity
- a lack of clear authorities online
- permanence of information shared online.

Young people who experience cyberbullying are at risk of depression, anxiety and loneliness, as well as poorer academic outcomes.[190,191]

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. 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.[191,192]

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'.[193] Approximately 70 per cent of young people had received a sexual picture or video, with almost half having sent a sexual picture or video of themselves.[194]

Negative outcomes of sexting include[193]:

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

Education has not kept pace with changes in social media. 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.[193]

Health services should promote sexual safety, which refers to the respect and maintenance of an individual's physical (including sexual) and psychological boundaries. Health services can foster a compassionate, sensitive and open culture that encourages reporting of incidents relating to the sexual safety of young people.

6. Positive culture and identity

A strong culture and identity is essential for a young person's physical and mental wellbeing. A positive cultural identity provides the young person with a sense of belonging and helps build self-esteem and resilience.[195]

Culture is important to Aboriginal young people, particularly traditional values such as respect for elders and being close to family. Absence of culture may lead to low self-esteem and a poor sense of self.[196]

Cultural factors can impact on diagnosis and treatment.[197] Health services need to be 'culturally competent' – they need to understand, communicate and interact with people from all cultures.[198] Identifying and implementing programs that develop youth resilience and create partnering opportunities for education in schools on youth health, wellbeing and resilience are important.[10]

Acronyms and terms

Acronym/term	Definition
Aboriginal	Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.
Access	Access refers to physical environment and attitudinal accessibility. When reviewing accessibility, consideration needs to be given to how well a person can be engaged to participate.
ARACY	Australian Research Alliance for Children and Youth
CaLD	Culturally and Linguistically Diverse
Cultural competence	Health professionals and services need to be 'culturally competent' to be effective; that is they need to understand, communicate and foster constructive interactions between people of different cultures.[198] 'Cultural competence is about developing empathy and connected knowledge, the ability to see the world through another's eyes, or at the very least to recognise that others may view the world through a different cultural lens'. It encompasses and extends elements of cultural respect, cultural awareness, cultural security and cultural safety as well as the knowledge, awareness and skills aimed at providing a service that promotes and advances cultural diversity and recognises the uniqueness of self and others in communities'.[198]
FASD	Fetal Alcohol Spectrum Disorder
Health services	A service for maintaining, improving, restoring or managing people's physical and mental health and wellbeing. It may include[199]: (a) a health service that is provided to a person at a hospital or any other place (b) a service dealing with public health, including a programme or activity for: a. the prevention and control of disease or sickness b. the prevention of injury c. the protection and promotion of health (c) a support service for a health service (d) the provision of goods for a health service.
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
LEP	Limited English Proficiency

Acronym/term	Definition
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'.[64]
STI	Sexually Transmitted Infection
Technology	Technology encompasses a variety of platforms including: internet, apps, social media sites, podcasts, webinar, mobile devices.
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".[66]
Vulnerable	Those who are physically or psychologically disadvantaged. Refers to the situation of individuals, households or communities who are exposed to potential adversity from one or more risks. Some underlying causes of vulnerability can be[200]: • barriers to participation • disadvantage • discrimination • inadequate access to resources and livelihoods • inequality • poor governance • social exclusion.
WHO	World Health Organization

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